A Process of Adjustment: Individuals' Experience of Weight Loss Surgery

Gemma Ellis

Volume 1

Submitted for the degree of Doctor of Psychology (Clinical Psychology)

Department of Psychology
Faculty of Arts & Human Sciences
University of Surrey

July 2009

© Gemma Louise Ellis 2009
CONTENTS

Acknowledgements 5

Academic Section

Academic Essays

Adult Mental Health Essay 6
Professional Issues Essay 27

Problem Based Learning Reflective Accounts

Exercise 1: The Relationship to Change 48
Exercise 2: Child Protection, Domestic Violence, Parenting and Learning Disabilities. 57
Exercise 3: Working with people in later life, their families and professional networks. 66

Summaries of Case Discussion Group Process Accounts

Year 1: Reflection on the CDG process in year one 76
Year 2: Reflection on the CDG process in year two 78

Clinical Section

Summary of Clinical Placements 80
Clinical Case Report Summaries:

**Adult Mental Health 1** 84
Cognitive Behavioural Therapy with a 49-year-old Woman Presenting with Social Anxiety

**Adult Mental Health 2** 86
Cognitive Behavioural Therapy with a 30-year-old Woman Presenting with Body Dismorphic Disorder.

**People with Learning Disabilities** 88
Cognitive Behavioural Anger Treatment and Psychoanalytical thinking with a Man with mild learning disability presenting with anger difficulties.

**Child, Adolescent & Family** 90
Narrative therapy with a 10 year old girl (and her family) presenting with sleep difficulties.

**Older Adults** 92
A Neuropsychological Assessment of a man in his mid sixties referred with memory difficulties.

**Research Section**

**Service Related Research Project** 94
A file audit study to investigate a Trust’s compliance with NICE guidelines for the treatment of Depression within secondary care.

**Qualitative Research Project Abstract** 129
How do Clinical and Counselling Psychology Trainees construct racism following the events of Celebrity Big Brother Seven?
Major Research Project

A Process of Adjustment: Individuals’ Experience of Weight Loss Surgery

Research Log
Acknowledgements

I would like to thank the following for their valued contribution to this research project; Professor Jane Ogden, the staff and participants from the obesity clinic and the qualitative research group. I am grateful to all my placement supervisors and the teams I have worked in over the past three years and Dr Vikki Petch and Dr Tessa Lippold, clinical tutors, for their support. Finally I would like to thank my friends and family for your unwavering patience. Especially, my Mum and Dad, Becca and my partner Si whose support and encouragement has been invaluable.
Academic Essay One

*Even people who feel paranoid have enemies!* Discuss the possible meaning and function of paranoid/persecutory ideas. How might clinical psychologists work with people who feel so afraid?

December 2006

Year 1
INTRODUCTION

I was drawn to this topic through my previous experience, when as a research assistant, I interviewed 180 clients with the diagnosis of schizophrenia or bio-polar.

I was firstly stuck by the number of people that had paranoid/persecutory beliefs and secondly by the fact the only a handful of people reported ever receiving psychological treatment, although this was something that many felt they would benefit from. Curiosity has also led me to this question as I sometimes found it hard to understand how someone could hold such strong and sometimes unusual persecutory beliefs.

Within the essay I will first attempt to understand what is meant by paranoia, how it is defined and who experiences it. I will present some of the main theories exploring the function of paranoid/persecutory ideas. These theories will include an evolutionary perspective, a cognitive view and the work of Bentall. The majority of recent advances in our understanding of persecutory beliefs have occurred within a cognitive framework. Therefore in order to present the latest work in this area the essay will have a Cognitive bias. This may also be reflective of my early stage in training and the Cognitive Behavioural culture that dominates the National Institute of Clinical Excellence (NICE) guidelines. I will then go on to discuss how a clinical psychologist might work with people that are so afraid. I plan to address the NICE guidelines and the evidence that these are based on, along with more generic elements of working with people that have persecutory beliefs. These elements are ones that I felt were particularly important from my experience such as issues of risk, ethnicity and working within a multi-disciplinary team.
THE FUNCTION OF PARANOID/PERSECUTORY BELIEFS

We All Feel Paranoid

Part of my last role was to look at symptoms such as suspiciousness or paranoia. This was not as easy as it appeared for as the title states ‘even people who feel paranoid have enemies!’ Many of the people that I interviewed lived in deprived areas, had been in contact with Mental Health services for years and were sometimes known locally for being ‘different’. Unfortunately they were often socially isolated with few friends or family. Concerns of being watched and potentially harmed were sometimes less of a paranoid thought and more of a reality. I found drawing the line between what was a paranoid thought and what was actually happening to someone very difficult. This led me to question that if I was finding this difficult how must it be for someone that is so afraid?

As Freeman et al (2006) write, we all have paranoid thoughts and these centre on the idea that people intend to harm us in some way. Extreme paranoia, therefore, lies on a continuum with normal feelings of suspiciousness (Freeman et al, 2006). Green and Phillips (2004) look at paranoia from an evolutionary perspective explaining that detecting threat is vital to species survival. The neurocognitive mechanisms that help us detect threat quickly may have ‘survived as an adaptive advantage in accord with Darwinian evolution theory’ (Green & Phillips, 2004, p334). It seems that suspiciousness like other emotions is something that can be to our benefit. One function of paranoia seems to be that it keeps us safe in potentially dangerous situations. For this reason it is also something that is actively encouraged within society (Freeman et al, 2006). We are told from an early age to be aware of strangers and as a woman I have always been warned of the dangers of walking alone at night. We are aware of a potential terrorist threat and are advised to shred our financials documents for fear of identity theft. However it is when suspicious thoughts become ‘unfounded’ (Freeman et al, 2006, p5), exaggerated and unrealistic that they are more likely
to be considered a delusion. They lose their helpful, protective property and become a preoccupation often leading to distress. According to Freeman et al (2006) it is when paranoia reaches the extreme end of the continuum that clinical help may be needed.

Searching for a Definition

Through reading the literature there seems to be some confusion over definitions with paranoia, persecutory beliefs and delusions being used inter-changeably. The debate over when a persecutory idea moves from being ‘vaguely held conceptions through to full-blown delusions’ (Bentall et al, 2001, p1144) is perhaps more of a reflection of the individual variability in delusional experiences. This is why Freeman and Garety’s (2006) definition appeals to me as it takes these issues into consideration. They clarified what constituted a persecutory delusion with two criteria which need to be met. Criteria A; ‘the individual believes that harm is occurring, or is going to occur, to him or her.’ Criteria B; ‘the individual believes that the persecutor has the intention to cause harm’ (Freeman & Garety, 2006, p406). However they acknowledge that persecutory delusions are multidimensional by nature and that the characteristics of a delusion will vary by how firmly it is held, how preoccupying it is, how distressing it is, how unfounded it is, how much it interferes with social functioning and to what extent it involves personal references (Freeman & Garety, 2006, p405). From my own experience I found that people’s delusions would vary greatly, particularly in terms of emphasis, conviction and the impact that it had on someone’s life. So Freeman and Garety (2006) are acknowledging that there are some common properties to persecutory delusions but also that these vary dramatically between individuals.

How Helpful are Diagnoses?

It is my experience that persecutory ideas are generally understood to be at their most robust and distressing in people that have been diagnosed with psychosis. However this is not always the case. As a research assistant I looked at the differences between care of
psychotic and non-psychotic clients. The two groups were separated by diagnosis; people with schizophrenia and bi-polar in the ‘psychotic’ group and people with personality disorder, severe depression, PDST and OCD in the ‘non-psychotic’ group. However through the interviews it became clear that symptoms which are normally associated with psychosis such as paranoid delusions and hallucinations where also occurring in people that had different diagnoses.

There are certainly clear advantages of having the common language and understanding that a diagnosis allows. A client can also feel relieved to have a name to put to what are often very distressing experiences. However a diagnosis is very powerful label and can affect how someone is seen, understood and treated. Read et al (2004) discusses how the conceptualisation of schizophrenia as a medical illness has had devastating effects on how people are treated and has caused stigmatizing and pessimistic views about recovery. In reaction to some of these ideas I have found it interesting to observe that the literature has shifted away from broad diagnosis, such as schizophrenia, towards understanding persecutory beliefs in their own right.

**Theories**

Bentall (2004) writes how people with paranoia typically had high self esteem with the ‘self-serving bias’ (blaming someone else for shortcoming and taking credit for achievements) being exaggerated within this population. Bentall argues that through persecutory delusions discrepancies between how someone perceives themselves to be (actual self) and would like to be (ideal self) are avoided and self-esteem is therefore protected. In a case study by Waska (2002) he supports this theory explaining that ‘most psychotic patients have been exposed to harsh, abusive or extremely conflicted childhoods that magnify feelings of envy, aggression and fear’ (Waska, 2002 p150). Sigmaringa Melo et al (2006) refer to the attributional model as a person’s ‘dysfunctional attempt to maintain a positive representation of the self’ (Sigmaringa Melo et al, 2006, p284).
However Bentall (2004) goes on to make an important distinction between external-situational attribution ('I lost my job because of the state of the economy') and external-personal attributions ('I lost my job because my boss hates me') (Bentall, 2004, p202). It makes sense that if this personalising bias is continually repeated over time this could potentially lead to paranoia.

Chadwick et al (1996) write about paranoia being separated into two distinctive types. ‘Poor me’ (PM) paranoia and ‘bad me’ (BM) paranoia. With PM paranoia the individual is inclined to blame other people, viewing themselves as the victim. With BM paranoia the individual views themselves as bad, worthy of persecution.

Bentall et al (2001) found that PM beliefs were associated with external attributions of negative events, with people that had BM beliefs being less likely to protect against low-self esteem and more likely score higher on levels of depression. Sigmaringa Melo et al (2006) work suggests that although two types of paranoia exist the concepts are not stable, with recent experiences affecting how clients presented their beliefs. Unfortunately Sigmaringa Melo et al (2006) were unable to demonstrate how scores on the psychological measures could potentially change for clients as their paranoid beliefs shifted. Just as feelings of paranoia shift, maybe, feelings of low-self esteem could shift from high to low. It is therefore debatable whether the function of paranoia is to protect low self esteem.

However Garety and Freeman (1999) argue that the defence hypothesis may only apply to a small minority of individuals that have persecutory delusions. They criticize Bentall’s model arguing that studies assessing attributional biases show mixed results and it is not possible to conclude that all people with delusions have an exaggerated self-serving bias. However Bentall et al (2001) argues against Freeman and Garety explaining inconsistencies in the evidence are mainly due to the difficulty of measuring self-esteem.
Freeman *et al* (2002) have developed a multifactorial model that looks at the formation and maintenance of persecutory delusions. It specifies that no single factor or function is likely to account for persecutory delusions. They argue that 'only a multifactorial understanding of symptom development and maintenance adequately reflects the phenomenon' (Freeman *et al* 2002 p332). 'The new model incorporates the attributional bias element of Bentall *et al*’s theory, but it argues that persecutory delusions are a direct reflection of the emotions of the individual and not a defence. That is, the delusions are consistent with existing ideas about the self, others and the world’ (Freeman *et al* 2002, p333).

For Freeman and Garety (2006) paranoia occurs as people try to make sense of their internal unusual experiences by often drawing on negative external experiences. ‘We interpret internal and external events in line with our previous experiences, knowledge, emotional state, memories, personality and decision-making processes and therefore the origin of persecutory explanations lies in such psychological processes’ (Freeman and Garety 2006, p408). Freeman and Garety (2006) write how anxiety plays an important role in the interpretation of internal and eternal events. Something external is more likely to be interpreted as a threat if someone is anxious. Therefore emotions are directly linked to the formulation of persecutory ideas.

For Freeman and Garety (2006) reasoning biases also play a vital role in the formulation of persecutory delusions. For example a jumping –to-conclusions’ (JTC) reasoning style (less information is required before making a decision), failure to consider alternative explanations and a strong belief confirmation bias are considered particularly influential within their model. I was very interested by the jumping to conclusions bias as this was something that I observed when interviewing clients that had strong persecutory delusions.
In Freeman and Garety’s (1999) review they demonstrated an impressive number of studies have confirmed a JTC bias and I found further support in Peters and Garety’s (2006) recent study. Participants with delusions were compared to a psychiatric control group and a non-clinical control at two time points. The study demonstrated that JTC bias was not only present in clients with delusions but that this bias stays stable over time. Similarly to Sigmaringa Melo et al’s (2006) study, Peter and Garety’s found that attributional styles did fluctuate over time.

A disadvantage of Peter and Garety’s study (2006) is the small sample size at follow-up and the fact the participants were not matched by age, gender or IQ. Despite these difficulties the study still demonstrates the importance of longitudinal work. Peter and Garety’s (2006) and Sigmaringa Melo et al’s (2006) approach has allowed some understanding about which processes remain stable over time and which ones change. This is useful in understanding which processes show a possible vulnerability towards delusional thinking and ‘those that appear reflections of delusional content and/or be implicated in the maintenance of delusions’ (Peters & Garety 2006 p508).

Freeman and Garety’s (2006) model also looks at how persecutory beliefs are maintained - ‘A lack of trust in others, an unwillingness to discuss emotions, or social isolation mean that the feelings of threat and intent are not shared with others but are ruminated on alone, preventing disconfirmation of their persecutory nature’ (Freeman & Garety 2006, p409). Understanding the maintaining factors is important within CBT.

Garety and Freeman (1999) highlight key points that are missing within the present cognitive research into paranoia. Since their review there is still limited detail regarding definitions and patient recruitment and refusal. In addition, ‘gender, ethnicity, medication, overall psychopathology, anxiety and duration of illness have been less systematically studied’ (Garety & Freeman 1999, p147). Despite these difficulties it is the cognitive
approach that seeks to normalise a person’s experience and break away from the idea of discontinuity between ordinary experience and psychotic experience. I find that I am drawn to the idea that persecutory delusions are understandable in terms of normal psychological processes, yet they do not have one single function as they are individual and multifaceted. This understanding is likely to have a positive impact on how we work with people that are so afraid.

WORKING WITH PEOPLE THAT ARE SO AFRAID

Have Perspectives Changed?

In the past people with paranoid ideas were encouraged to repress their thoughts and not to talk about them (Freeman & Garety 2006). As Freeman and Garety (2006) point out this was not only happening in psychiatry but within psychology too, where reinforcement techniques were used to limit the time that clients spent speaking about their delusions. In addition, although pharmacological treatments have clear benefits it is now also known that they are not always effective for all clients and have a limited impact on negative symptoms. Therefore, psychological interventions are now recognised as being an important part of treatment (Department of Health, NHS Executive, 1999). The National Institute of Clinical Excellence (NICE) (2002) recommends together with medication that clients are given the opportunity to talk through their beliefs with the use of CBT techniques (minimum of 10 sessions) and/or Family therapy.

Where is the Evidence?
Drury et al (2000) five-year follow up study looked at the effectiveness of individual cognitive therapy, group cognitive therapy, family psychoeducation and an activity programme on acute psychosis. The study is one of the first to look at psychological interventions within a hospital setting and emphasises the importance of relapse prevention. Within the study the input was intense with each group receiving 8 hours per week for 6 months. They found that those that received cognitive therapy showed fewer positive symptoms, reported better control over their illness and had no evidence of thought disorder. However no differences were found between groups with their targeted delusional beliefs, insight or awareness of stigma and negative symptoms. Among the participants with minimal relapse the impact of Cognitive therapy was found to endure 5 years, thus reinforcing the importance of relapse prevention in the early period of psychosis.

The lack of longitudinal research within the literature is very evident. Drury et al (2000) admit that it was very difficult to control the type of treatment clients receive after discharge from hospital. Although the study makes some valuable suggestions it is possible to pick this study apart due to the small sample size, the fact the assessors were not blind to the groups and the problems with treatment control. What is striking about Drury et al’s (2000) study is the amount of therapeutic input (8hrs/wk = 208 sessions per person in six months). Although the NICE guidelines (2002) suggest a minimum of ten CBT sessions I would imagine that the NHS does not have the resources for the therapeutic input demonstrated in Drury et al’s study.

Conversely studies have looked at the effectiveness of brief interventions with the hope that this will be more economically viable. Turkington (2002) found that brief CBT (up to six hour-long sessions) did not improve psychotic symptoms but improved insight. He felt that this could potentially improve adherence, increase coping skills and reduce the length of stay in hospital. However he acknowledges that further research into the long term effects of such a brief therapy needs to be carried out.
As demonstrated the evidence from the current research is far from conclusive. Pilling et al’s (2002) meta-analysis compared Family therapy and CBT for the treatment of schizophrenia and concluded that ‘Both treatments, in particular CBT, should be further investigated in large trials across a variety of patients, in various settings’ (Pilling et al 2002, p763). However the government hopes that psychological intervention such as Family therapy and CBT will reduce admissions and prevent relapse. The effectiveness of these interventions is evaluated on an evidenced based medical model using diagnostic categories. Whether psychological treatments can fit within this model is questionable. Are we trying to reduce symptoms or distress?

Recently there has been further movement away from the medical model with Chadwick (2006) directing the focus of therapy away from symptoms and onto distress. If a person is not distressed by their psychotic experiences then it cannot be called a problem (Chadwick, 2006, p2). ‘Our perspective that symptoms were problems only if they distressed or disturbed clients provided the rationale for therapy, and for collaboration’ (Chadwick, 2006, p2). So maybe the focus should be on measuring distress rather than symptom reduction. In a way studies have been doing this by looking at how insight and feelings of shame and stigma are affected by interventions but maybe studies should be solely focusing on the reduction of emotional distress as a sign of treatment success.

Treatment success in the psychoanalytical case studies (Waska 2002, Waska 2003) that I have read seem to be very different from the kind of success being measured within CBT. The psychoanalytical model uses the therapeutic relationship to understand the distress. ‘Many psychotic patients struggle with primitive phantasies of persecutory guilt, loss and annihilation. These phantasies are difficult for both patients and analyst to bear, but hopefully are explored within the transference and reshaped into something more tolerable, fulfilling and creative’ (Waska 2002, p160). However it is not easy to measure the success
of this therapy objectively or to generalise from case studies. This form of therapy clearly
does not sit comfortably under the evidenced based medical model but is it right to exclude
it for that reason? Surely clients should have choice in their treatment and is CBT
necessarily the type of therapy that people want? With the people that I interviewed I
generally got the feeling that people wanted to tell their story, in which case Narrative
therapy would seem more appropriate. As the evidence base is inconclusive perhaps the
NICE guidelines should try and incorporate other forms of therapy. Regardless of the type
of intervention there are some important issues that all practitioners need to consider when
working with people that are so afraid. These will be discussed next.

Assessing Risk

When working with someone who is so afraid it is important to understand the client’s risk
to self and others, risk of drug or alcohol abuse and risk of disengagement and non-
compliance. An understanding of the possible side-effects of medication and the possible
risk of developing health problems is also important.

Freeman and Garety (2006) write how persecutory delusions occur in almost 50% of people
with psychosis and they are the most likely type of delusion to be acted upon. The
Department of Health (DOH) (2001) reported 1,500 suicides under mental health services
with 23% of suicides occurring within three months of hospital discharge. Mental Health
teams regarded 22% of the suicides as preventable. 9% of homicides (around 55) were
carried out by people in contact with mental health services in the year before the offence.
‘Half the perpetrators with schizophrenia were out of contact with services by the time of
the offence’ (DOH, 2001 Safety First, p7). The report stresses the importance of continued
risk assessment and monitoring, the need to follow-up clients after hospital discharge, the
importance of working with clients that are non-compliant, and approved training for staff.
The NICE guidelines (2002) recommend the use of crisis resolution and home treatment teams.

**Issues of Continuity and Ethnicity.**

For me the report also draws my thinking towards other issues such as continuity of care. The service users that I interviewed stressed the importance of seeing the same members of staff so that they could build a relationship with someone that they knew and trusted. Therefore that person would be more likely to spot signs of relapse.

The report also raises questions for me about the accessibility and appropriateness of services being provided. The DOH (2001) reported that suicides within ethic minorities usually had severe mental illness with ¾ of black Caribbean suicides having a diagnosis of schizophrenia. ‘Delivering race equality in Mental Health’ is a report brought out by the DOH in 2005 which aims to significantly reduce discrimination within the NHS by 2010. It plans to do this through building links with communities and faith organisations, creating new pathways to care through communities, highlighting early intervention, offering choice and flexibility, providing information and gathering accurate information on ethic and cultural needs.

When working with someone from a different ethnicity to myself I found understanding someone’s faith and culture, and how this relates to feelings of stigma and shame, to be very important. One family I worked with felt they could not return home to Africa because of the shame their son’s illness had brought to the family and the possibility that he would be seen as an outcast. Such language and ideas are very powerful and important to value within the context of someone’s culture. It is also important to acknowledge that signs of distress could be communicated in very different ways. Turkington (2002) found that ethnicity affected drop-out rates with a statistically significantly increased drop-out rate in
those clients who were not White. He felt that this was related to problems in engaging and
developing explanations for clients from different cultures. Turkington (2002) suggests that
psychoeducational material should be made available in a number of different languages
and there should be more ethnicity awareness training for staff that deliver CBT. ‘There is a
huge diversity in what is considered an appropriate expression of distress in different
cultures. Indeed, different cultures vary on whether particular experiences are seen as signs
of ‘mental illness” or as normal religious/spiritual beliefs or even gifts (BPS
Understanding mental illness, 2000, p19). Although some psychotic experiences are
extremely distressing for some individuals these experiences can be ‘adaptive and life
enhancing’ for others (BPS Understanding mental illness, 2000, p19). Chadwick’s idea of
treating the level of distress rather than the symptoms enables cultural differences to be
incorporated more easily.

Engagement and the Therapeutic Relationship

In an article called ‘coping with paranoid thought’ (Canning, 2006) a client explains how it
felt to receive therapy in a trusting therapeutic relationship. ‘They offered a lot of
understanding……I felt they could cope with my problem and they wanted my assistance:
the therapy involved me. It wasn’t someone telling me what to do…..The most important
thing was that I felt well handled and cared for’ (Towards Mental Health, Number1, 2006,
p2). Nelson (1997) explains how a good therapeutic relationship creates a sense of safety
which enables a client to explore his or her frightening beliefs in a way that would not be
possible on their own. ‘Paradoxically, although it may be harder to build up a trusting
relationship with a paranoid patient, the therapeutic relationship may be a particularly
important component of therapy in these cases’ (Nelson, 1997, p32). When I worked with
the early intervention team it was so vital to build a good trusting relationship where the
clients felt respected and understood. A lot of time was spent on building this relationship
and time was spent discussing other things beside therapy before any intervention could be
introduced. I feel that the relationship you have with a client is so important to the success
of any intervention. ‘Paranoid patients are particularly likely to interpret challenging
questions as a personal threat and so you must have a correspondingly good relationship with a paranoid patient in order to counter any paranoid ideas about you that may arise when you are doing therapy’ (Nelson, 1997, p 31). Nelson writes that how long you spend on the therapeutic relationship will depend on how ill the client is and their level of insight. Often clients with persecutory delusions have not sought help themselves and this can of course affect the therapeutic relationship and the pace at which you work together. Therapy maybe considered inappropriate by the client, and within a CBT framework goals may not necessarily be able to be discussed and agreed upon openly. The client may be unable/unwilling to do homework assignments and may be unable to self-generate alternative explanations.

I feel that the NICE guidelines do not fully appreciate the importance of the therapeutic relationship and the amount of time that is needed to build a trusting relationship, especially when working with people that are so afraid.

Empathy is a very important element of the therapeutic relationship. I have learnt that you need to empathise with the client’s feelings of distress and be aware that you cannot always understand the client’s position. Nelson (1997) writes that you should ask about the impact that the delusion has and imagine that the delusion really is happening to give you a better understanding of how the client may be feeling. She also warns about being less empathic towards ‘impossible’ or ‘ridiculous’ delusions. I interviewed a client in hospital and one of his delusions was that there was an army of small people living on the floor above and that at night they climbed down through the ceiling of his room, cut open his head and got inside where they proceeded to damage him internally through his blood stream. I remember imagining small action men climbing down the wall and the idea sounded so bizarre to me that in that instance it was hard to be empathic. Nelson’s (1997) idea of imagining it was real, helped me to understand how terrifying it must be to believe that each night you are being attacked.
Treatment within Multi-Disciplinary Teams

It must be remembered that therapy will mainly be provided within a multi-model of treatment (Freeman and Garety 2006). Such as antipsychotic medication, assertive community teams, crisis teams, rehabilitations, employment support and family/carer interventions. I feel this is very relevant clinical practice and it is important to understand that the treatment I may be carrying out has to be understood in a wider context within not only a multi-disciplinary team but across different teams. When interviewing clients with psychosis one thing that was striking was a lack of information continuity. Service users felt that there was often little or no communication between team members. I think that this is something that is so important especially when team members are working from different models and understanding. If mixed messages and explanations are being communicated this can be both confusing and distressing for a client, especially when you are working with people that are so afraid.

CONCLUSION

Within the essay I hope to have demonstrated that paranoia is something that we all feel from time to time. One of the main functions of paranoia, from an evolutionary perspective, seems to be that it keeps us safe in potentially dangerous situations. However it is when paranoia becomes ‘unfounded’ and distressing (Freeman et al, 2006) that clinical help may be needed. I have discussed how there has been a shift in the literature away from broad diagnosis, such as schizophrenia, towards understanding persecutory beliefs in their own right. For Bentall people with persecutory delusions have a ‘self-serving bias’ to protect against low self-esteem. However I found that I was drawn to Freeman and Garety’s model (2002, 2006) which incorporates much of the research in this area, including Bentall’s
work, to explain how paranoid ideas are formulated and maintained. It allows individual variability in delusional experiences and it was possible to see how the model could be used within treatment. Within the cognitive model, paranoia is understood as lying on a continuum with normal feelings of suspiciousness and this has the potential to be both destigmatising and normalising for the clients.

I demonstrated how perspectives have changed when it comes to working with people that are so afraid. Psychological interventions are now recognised as being an important part of treatment and NICE (2002) recommends CBT and Family therapy.

However as I have demonstrated the evidence for these recommendations, from the current research, is far from conclusive (e.g. Pilling et al 2002). It is clear that further research is needed in this area and that perhaps other forms of therapy should also be considered in order to give clients choice. Within the essay I thought it was important to question how therapy success is evaluated and whether we should be concentrating solely on alleviating distress rather than symptoms. I have discussed important issues that I feel in practice I need to be aware of, particularly when working with people that are so afraid. These issues included assessing risk, being aware of ethical and cultural differences and good information transfer between professionals and between professional and client. I can conclude that one of the most important elements of working with someone that is so afraid is the engagement process to enable a safe and trusting therapeutic relationship to be formed.
REFERENCES


Academic Essay Two

What are some of the strengths and weaknesses of multidisciplinary teams from the perspectives of staff and service users? How can you as a psychologist contribute to team functioning optimally?

January 2008

Year 2
Introduction

I was drawn to this question because of my experience of working within two very different Multi Disciplinary Teams (MDT). It interested me how one team appeared to work well together, drawing on the benefits of inter-professional working, while the other team appears more fragmented and burdened by difficulties. I plan to evaluate the advantages and disadvantages of MDT working by drawing from the literature and reflecting on my own experiences. It appears that when teams do not function well the disadvantages of MDT working is felt. Therefore Psychodynamic understanding of team functioning and organisations will be explored as I have found this particularly helpful in understanding team difficulties. Particular space will be given to the service user perspective on inter-professional working and it will be demonstrated that research within this area is lacking. Finally I will look at how I as a trainee understand how the team in my current workplace functions and how as psychologists we can help teams function optimally.

Advantages of MDT working

The creation of MDT working in the communities outside the institution presents both opportunities and challenges. Research has demonstrated that when a MDT is functioning well there are significant advantages to this type of care for staff and service users (Yan et al 2006). Inter-professional working has been found to be associated with better client care, including a decrease in mortality rates, improved ways of providing care to clients, less errors being made within the working environment and more stratification and less stress for both staff and service users (Yan et al 2006). Working with other professions also
enables misperceptions to be addressed and allows a greater understanding of the challenges that other professions face (BPS 2007).

Research has demonstrated that inter-professional working has the advantage of improving access to care for service users (Hutchens, 1994). This could be understood by the fact that when working in an inter-professional team, members are more likely to have a larger social network which can improve access to services (Keller 2001). Advantages also include, from a service user and staff perceptive, decreases in hospital admissions, both in length of stay and premature admissions and an increase in met needs by a number of different professionals (Hutchens 1994). Similarly the BPS (2007) highlights the advantages of MDT working as it can improve the quality of care for service users by collaborative inputs from different disciplines. Inter-professional working can produce more holistic care planning and more effective use of resources by joint initiatives. I have found that working within a MDT also allows more creative ways of working. For example on my Learning disabilities placement a relationship group is run by psychologists and nurses. This enables a sharing of knowledge that is beneficial to the client and the staff. Although our knowledge bases cross, arguably physical and sexual health issues could be better understood and communicated by the nurse and relationship dynamics and difficulties by the psychologist. Working within a MDT allows a broader understanding of your own discipline, its role and inter-play within a system. It has enabled me to have a richer understanding of other disciplines and differences in perspectives. I have found that these differences can challenge your own thinking and increase awareness of your own limits in knowledge.

There are many other benefits of inter-professional working and research has demonstrated that MDTs can have the effect of relieving burden of treatment from staff, helping with the engagement process and enabling health professionals to empathise with clients and each other (BPS 2007). Continuity of care, particularly information continuity, can be increased when working inter-professionally. When I worked as a research assistant...
service users’ perspective on continuity of care, staff continuity was highly valued. However when this was not possible some service users felt that new or different health professionals should have an understanding of their history and difficulties, whether this is communicated verbally from other professionals within the team or through inter-professional records. The BPS (2007) writes how teams can integrate information in ways that would not be possible for individuals. It allows an understanding of a client’s relationship with services and with different members of a team. It is also beneficial for handling risk.

Client welfare and risk to self and others is paramount and inter-professional working can enable better handling of risk (BPS 2007). As described above, input from different professionals, continuity of information, increasing learning, increased speed and delivery of services, better accessibility to services all impact the welfare of service users and help minimise risk. Simpson (2007) writes that team meetings could provide professionals with a safe space to discuss difficulties and acknowledge the limits of their own understanding. Information, encouragement and support would often be offered by other members of the MDT, resulting in team members feeling empowered and more able to offer sufficient support to clients. The experience of friendship and emotional support lead to high staff satisfaction and professional stimulation, improving client care.

Disadvantages of MDT working

I have highlighted the advantages of working inter-professionally but what are the disadvantages? From the literature it seems that the disadvantages of inter-professional working tend to occur when MDTs are not functioning well (Hudson 2007, Simpson, 2007, Jones 2006). Foster (1998) explains that failure in an MDT means that members of the
team find the demands of working together too difficult and cease to work together as a team. This can be potentially harmful to staff and service users. Many of the difficulties of working in MDTs, cited within the literature, suggest problems regarding the different status and power of different disciplines with a given team. This is often represented by health professionals feeling that their ideas are not being heard or respected, undesirable shifts in status, insecurities about team worth, psychiatry dominance and professional defensiveness (Jones 2006, Simpson 2007). In addition; unequal benefits of team participation, difference in the organisation and administration, lack of shared values and consensus of client care and prognosis, unproductive and inconsistent communication are also understood as disadvantages of MDT working (Hudson 2007). Ultimately this can lead to low staff satisfaction, high stress and poor, inconsistent care for service users. Simpson (2007) found that when team members were not likely to receive encouragement they were far less likely to share sensitive or difficult information. The lack of containment and safety within one team that Simpson (2007) studied led to some information being withheld by care co-ordinators and not shared within the MDT, with potential damaging consequences.

Hudson (2007) writes ‘This is a problematic time for those involved with interprofessional working. On the one hand the legacy of professionalism is one of distinctiveness and differentiation, yet increasingly professionals are being urged to work across established boundaries’ (Hudson 2007, p3). Hudson (2007) explains how the evidence of MDT functioning effectively is somewhat pessimistic yet both the government and service users desire collaborate ways of working. Hudson (2007) believes that there is both a pessimistic and an optimistic model of inter-professional working. Within the pessimistic model distinctiveness of knowledge, trait, status, power, accountability and culture between professionals can be expected to inhibit MDT working. The culmination of these six features Hudson (2007) argues creates a professional identity that is closely linked to a valued part of personal identity which is then nurtured by the profession. This can lead to services being provided around the most powerful professions rather than around the needs
of the service users. However Hudson (2007) argues that there is now growing interest in the optimistic model of MDT working where what professionals have in common outweighs difference. Six features of commonality are identified; commonality of value, of accountability, of learning, of location, of culture and of case.

Although there are merits to Hudson's (2007) models, by explaining key features of MDT working, he seems to suggest the more similar we are within a team the more optimistic the outcome. However diversity within a team is a very important aspect, including diversity in values and learning. The literature suggests that team members bring three sets of attributes to the team: the core functions of their profession; specific post qualification skills; and different life experiences and social and ethnic background (BPS 2007). 'Diversity is another feature of effective teams. Team working does not mean that all disciplines within teams should become homogenised' (BPS 2007, p8). Indeed one advantage of an MDT is the diversity that it offers. In a well functioning team, diversity can allow for more creative ways of working and deeper learning. When I have worked with OTs and physiotherapists it has highlighted important physical aspects of someone’s care that I may not have otherwise considered. Research has demonstrated that diversity within teams, in terms of background and profession, is associated with more varied team discussions and allows multiple interpretations of information (Fay et al 2006 ). The BPS (2007) advocate that rather than focus on commonality diversity should be discussed and valued in order for new thinking and solutions to emerge.

Jones’ (2006) study considers changes within the NHS and how change can impact team dynamics and MDT functioning. Of particular interest to Jones (2006) is the introduction of care pathways onto acute mental health wards. He found that health professionals were threatened by the care pathway process as professionals were asked to comment on the value of their own role and that of others. A large amount of professional defensiveness
was displayed with each group claiming to work with a particular aspect of the difficulties that the client was experiencing. This had the effect of professionals affirming professional boundaries by not standardising care and disengaging from the team. Interestingly this was in direct opposition with the policy background of greater inter-professional collaboration and blurring of role boundaries (Department of Health 2002). Lydeard & George (1996) write that the emphasis on improving the quality of care and delivering ‘value for money’ has increased competitiveness between professions. Similarly Hummelvoll and Severinsson (2001) explain that when ‘treatment effectiveness’ and reducing length of hospital stay become dominant within acute care some professional groups experience feeling of blame and of being a ‘scapegoat’.

Change within management and organisational structures and roles is constant but it is important to understand how such changes impact team dynamics and why working in an MDT can sometimes be understood as threatening to staff.

Halton (1998) describes how ideas at a conscious level within a team can carry unconscious hidden meaning. He gives the example of a team complaining about the lack of car-parking spaces as perhaps a symbolic communication of the managers within the team having a lack of space for staff’s worries. In my current workplace there has been disagreement over a large display board in the team corridor. The whole board has become occupied with a display by speech and language and this has been understood as unfair by other members of the team. To me, it seems to represent an unconscious lack of room for different professional views to be considered and heard within the team. In an organisation with limited resources it also seems to represent a feeling that giving to one discipline is somehow taking from another.

Difficulties in working together and collaborating can result from ‘a sense of being an inevitable loser in a competitive struggle’ (Halton, 1998, p15). Halton (1998) writes about ‘spoiling envy’ which tends to exist in the current climate as a result of reducing resources.
Success in another discipline can be felt at the expense of another. 'The survival-anxiety of the less successful section stimulates an envious desire to spoil the other’s success. This spoiling envy operates like a hidden spanner-in-the-works, either by withholding necessary co-operation or by active sabotage' (Halton 1998, p15). Agenda for change has created an arguably needed transparency over pay and resources and ‘value for money’ which could create a ‘spoiling envy’.

Halton (1998) applies ideas developed by Klein to MDT. Through observations of children’s play Klein noticed that children would divide feeling into differentiated elements which she termed splitting. The process of splitting emotions enabled children to gain relief from their internal conflicts. Splitting is often accompanied by projection which enables feeling to be located in someone else rather than in oneself. Klein believed that splitting and projection were the dominant defences for avoiding pain and called this the paranoid-schizoid position. Through play these conflicting feelings and figures could be explored and resolved and eventually brought together as a more integrated whole. This stage Klein named the ‘depressive position’. Sometimes these splitting processes occur within groups and organisations. Halton (1998) argues that structural divisions and different disciplines in organisations and teams become ideal for splitting and projecting negative feelings and images. ‘Each group feels that it represents something good and that other group represent something inferior. Doctors are authoritarian, social workers talk too much, psychotherapists are precious, managers only think about money’ (Halton, 1998, p15). Halton (1998) explains that theses stereotypes are like the characters within a children’s play. The splitting and projection allows preservation of self-idealization. Interestingly he points out that the less the contact with other sections and disciplines the greater the capacity for projection of this kind. Therefore meetings may be unconsciously missed to preserve self-idealization meaning that the institution and team become stuck in a ‘paranoid-schizoid projective system’ (Halton 1998, p15). This can be particularly problematic when this interferes with tasks that need co-operation or collective change.
The service user perspective.

It is clear that a team stuck in the 'paranoid-schizod' position is not functioning well and this will impact the care offered. From a service user perspective there is potentially poor care and dangerous consequences if 'spoiling envy' is occurring within a team, if professionals feel under attack and information is being withheld. Health professionals have reported feeling disempowered to make changes to MDT working (Simpson 2007). However it appears that service users are even less empowered to make changes as I have found a lack of specific research looking at service users perspectives of team functioning and service delivery.

Hudson (2007) found that effective MDT working can lead to more effective service delivery and better user outcomes. Hudson (2007) asked six clients about their experience of a new integrated inter-professional service. They all responded positively about the support they received from the team and individual members. However Hudson (2007) felt that it was too complex to ask service users to make comparisons about their experiences of services before and after the team had been fully integrated into an MDT. I feel that this was a missed opportunity and that perhaps these comparisons could have been possible. Service users could have potentially identified differences in waiting times, information sharing and continuity of care to name just a few. Perhaps Hudson’s (2007) attitude helps us understand why research in this area is so lacking. Scoffe et al (2004) found that despite government policy service user involvement in system delivery was variable and sometimes lacking. One of the barriers to service user involvement is that service users still report not being listened too (Rose 2001). It has also been suggested that professionals with a more biological orientation are less likely to see service user involvement as leading to improvements in services (Kent and Read 1998). Scoffe et al (2004) interestingly reports
that the involvement of service users could be seen as threatening to staff. Scoffe et al (2004) found that some clinical psychologists feared that service user involvement could potentially reduce their role within mental health services. It therefore appears that health professionals are not only threatened by other professionals and changing roles within MDTs but also by increasing service user involvement.

Meddings and Perkins (1999) looked at how service users construed MDTs. They argued that if service users are to make informed choices it is important for service users to understand different professions and how the team works. 18 service users were interviewed and it was found that service users were not always clear about what professionals were in the MDT. Service users were more likely to name someone as part of the team if they were seeing them, but many service users were well aware of other members of the team that they were not seeing. Service users were able to give detailed explanations of the role of different staff/professionals but less of a team as an entity itself. This research reflects my own experiences. I had the opportunity to regularly attend a mental health interest group run by service users in my first year. One issue which was at the forefront of discussion was individual’s difficulties in accessing services. It struck me that people often did not know who was part of their MDT. As a result they often did not ask for the specific help that they needed.

Meddings and Perkins (1999) do identify one advantage of MDT working from a service users perspective. They write how highly valued ‘talking’ to different professionals is by service users. Service users identified various types of conversation with different disciplines, all of which were understood as helpful. For example nurses and OTs engage in helpful ‘social chat’, social workers were described as giving advice and psychologists were seen as enabling people to talk about sensitive areas. One disadvantage of MDTs from a service user perspective is the danger of becoming ‘over-serviced’ by multiple professional inputs (McGaw 1998). This can be confusing for a client and result in a
decreasing continuity of care. Again in a well functioning team good communication should prevent this from happening.

Campbell et al's (2007) qualitative study was designed to identify which aspects of care are important to clients with chronic mild-to moderate mental health problems. Service users felt that the healthcare system provides a generic services ‘one fits all’, which was felt to be inefficient at dealing with client’s individual experience and needs. Research does demonstrate that there is often a disparity between what professionals and service users view as priorities. Schulte et al (2007) found that reducing waiting time was the priority for service users whereas service providers wished for increased provision of complementary therapies.

**How can psychologists contribute to optimal team functioning?**

To answer this part of the question I wanted to draw on some observations between two MDTs I have worked in. I will also continue to draw from the BPS (2007) and Simpson (2007) who outline some useful ways that psychologists can contribute to teams functioning optimally.

I have had the opportunity to be part of two MDTs while in training. There have been marked differences in how these teams have been organised and as a result function. It has been interesting to observe these differences and attempt to make sense of the fact that one team functioned effectively together and the other has been more fragmented in nature.
There are fundamental differences between the two teams. Team X is far smaller with 15 members from a number of disciplines (social work, OT, nurses, psychologist, psychiatrists, support workers) and has regular team meetings (twice a week) whereas team Y is far larger with 50 members. In team Y meetings are held only by heads of each discipline and although other members of the team are invited they rarely attend. Simpson (2007) found in his study that most communication happened within team meetings. A large survey of CMHTs across the UK found that an association between safe participation in team meetings, improved the mental health of the team, communication and teamwork (Borrill et al 2000).

The BPS (2007) suggests that large teams may have difficulties in decision making processes and suggests teams break into smaller more manageable sizes. They also write that teams should have an identity which is recognisable to others. Team Y seems to lack a team identity and although both teams, X and Y, are located within their own building because of the size of team Y, members are more dispersed across a large area. Professionals tend to be placed according to discipline and ‘Away days’ are separated by discipline rather than by MDT. Staff turnover is far larger in team Y so much so that when I introduced myself to one member she said she had given up introducing herself because staff changes are so frequent. A sense of identity, cohesiveness and teamwork seemed to be missing in team Y and I wanted to try and understand this using my skills and knowledge as a trainee psychologist.

In team Y the social work team was integrated with health approximately three years ago in order to provide a holistic service for adults with combined learning disabilities and mental health difficulties. The MDT has however remained split into parts preventing health and social services from achieving their desired aims of an efficient system of referrals, assessments and allocation. As a result dis-satisfaction is felt by the team members, clients, carers and outside agencies leading to anxiety and blame within the system. As discussed earlier, teams benefit significantly from clear structures and procedures (BPS 2007). Of
particular relevance here is that research has demonstrated that teams were most impaired when there were unclear polices regarding referrals, assessments and work allocation (Simpson 2007).

One of the difficulties often expressed in team Y is the conflict between the professional values involved in working with very vulnerable adults and the business objectives of the managers who need to be able to manage the limited resources effectively.

According to Roberts (1998) the hatred directed towards management allows staff to split off the uncomfortable feelings associated with the conflict between financial considerations and the needs of clients.

Roberts (1998) described how managers who have lost faith in the value of the systems they manage are unable to offer their staff containment for their anxieties and negative projections. This can have the result of making team members within MDTs feel isolated and vulnerable as they work in a system which is uncontained and inadequately supported. As a result, as in team Y, people avoid working in an MDT as much as possible and adopt the 'head down' strategy, going their own way and ignoring any directives from other management in order to get on with the 'real' task of working with clients. Having talked to social workers in team Y expectations of being cared for by management and their failure to meet needs meant that their attempts to exert authority from a distance were frequently being disregarded or resisted. Halton (1994) describes how the withholding or refusal of workers, through both conscious and unconscious internal processes, can lead to increased risk of undermining and sabotage.

Psychologists should promote reflective practice within an MDT to enable healthy team functioning (BPS, 2007) and this could be particularly beneficial to team Y. Foster (1998) writes that it is only when teams take an observational position and thereby create space for
reflection that they function in the depressive position. They are then able to value differences and are secure enough to recognise their own individual strengths and weaknesses. The BPS (2007) report suggests that constructive conflict is valued within a team. MDTs can develop defences against emotions that are too threatening or anxiety provoking to acknowledge. A central defence is often referred to as ‘denial’ and involves blocking out thoughts and feelings from conscious awareness (Halton 1998). Halton (1998) points out that sometimes these defences are healthy enabling staff to cope with stress. However they can also detrimental preventing teams from adapting and completing tasks. If conflict is managed appropriately trust can develop and anxiety decrease (BPS 2007). Psychologists therefore have an important role in modelling reflective practice, using facilitation skills to promote reflective practice in teams and offering peer consultation.

Simpson (2007) writes that the skills required to work effectively as part of a team have rarely been addressed. As a result policies are introduced (e.g. CPA) with the assumption that effective teamwork already existed (Simpson 2007). This then has the effect of intensifying pre-existing tensions over status and role. Simpsons’ (2007) study looked at seven UK community mental health teams using qualitative methods of participant observation, semi-structured interviews and document review. Simpson (2007) advocates the importance of structure and procedure within a team. He found that team managers faced constant tensions of having to deal with day-to-day demands and trying to develop team structure. ‘Lack of structure tended to create a vacuum, within which uncertainty and anxiety grew’ (Simpson 2007 p412). BPS (2007) advocates that for teams to function well team design and operation needs to be confronted. This needs to happen while being aware of where the team is in terms of its own development. MDTs need to be organised around the service user, with teams being defined by who is needed to meet those needs, rather than a particular service configuration (BPS 2007).
In order for this to be achieved service user involvement is vital. The BPS (2007) states that psychologists can improve team functioning through teaching, training, research and evaluation. Of particular importance is effective involvement of service users and carers (BPS 2007). As I discussed service user involvement in system delivery is variable and lacking. Anthony and Crawford’s (2000) qualitative study found that factors perceived as increasing service user involvement included accessible and accurate information, gaining service user feedback and having high staff morale. Staff morale has also been identified as important in well functioning teams (Simpson 2007). The BPS (2007) advocates that psychologists should support badly treated staff and in order to achieve this psychologists need to be fully integrated into the team while maintaining role clarity. Role clarity is viewed as important by the BPS (2007) as it enables the limited resource of psychology to be used effectively and increases a positive sense of professional identity.

As discussed earlier in order to manage risk appropriately a MDT needs to be functioning well. The BPS (2007) outlines a number of factors to enable teams to work effectively and improve risk management. Of particular relevance here is the need for good supervision and support of professional development. Psychologists can play an important role in offering supervision, consultation and training.

Simpson (2007) found that respect was the most important element for functioning teams. Community Mental health Nurses (CMHNs), OTs and social workers stressed the importance that their views were sought, respected and considered. When skills and contributions of others were not recognised this significantly affected team morale. CMHNs spoke of taking a ‘defensive posture’ (Simpson 2007 p412) where staff would contribute nothing in meetings or avoid attending meetings as in team Y. These team dynamics had a negative impact on communication within the team and as a result were detrimental on team members’ ability to operate as care co-ordinators.
The BPS (2007) writes that psychologists have an important task within MDTs of offering a useful counter-balance to the medical model, which can be particularly helpful in decision-making. This valued role needs to be maintained by psychologists as they become more integrated into a team and they should continue to challenge this dominant discourse (BPS 2007). One way of achieving this is to promote the recovery model and person-centred care within an MDT. Formulation is a key and unique skill that psychologists can use to understand team functioning. It can be very useful with complex clients where transference and counter-transference issues can be played out by the whole team (BPS 2007). According to Foster (1998) ‘mental illness not only fragments the minds of those who suffer from it; it can fragment the minds of those who care for them and also the systems of care’ (Foster 1998 p 132). Foster (1998) explains teams can then take on the ‘chaos’ and unpredictability of the client causing powerful disagreement within teams as staff argue about how to work best with a particular client. Psychologists need to be aware that teams can also judge their functioning (and or sickness or health) by evaluating their success or failure by a particular client’s stability. It could be argued that if psychologists are too integrated within a team they are unable to objectively evaluate the system. Psychologists, therefore need to be aware of their own role and the impact of their professional and personal differences on team functioning.

Conclusion

I have presented the advantages of working inter-professionally with team diversity enabling greater learning and sharing of knowledge, increasing access to services, improving risk management, holistic planning and continuity of care with better staff and service user outcomes. The disadvantages of MDT working mainly occur when teams are not functioning well. Inter-professional differences can lead to low staff satisfaction, high stress and poor, inconsistent care for service users.
Through an exploration of the psychodynamic and systems of organisations I have been able to reflect on and understand the tensions and pressures within my own workplace. It has been an important process to consider my own role in relation to others in the team. It seems clear that different disciplines within an MDT cannot afford to work as individuals in isolation from the rest of the team. As a trainee it maybe more difficult to integrate into a team when you and the team are aware that you will be leaving soon however reflecting on my current MDT has raised my individual awareness of the need to behave thoughtfully and use skills as a psychologist to improve team functioning. As discussed these skills are presented in New Ways of Working (BPS 2007). I hope to have demonstrated that psychologists can optimise team functioning by helping to define teams, recognise effective team working, formulate around teams, offer supervision and consultation, model reflective practice, support staff, offer a counter- balance to the medical model and take part in research and evaluation. Psychologists can use their skills to lead and manage teams to help with decision-making, communication, conflict management and change. Psychologists should also encourage and improve service user and care involvement to ensure that teams are organised around client’s needs.
References


Problem Based Learning Reflective Account One

The Relationship to Change

March 2007

Year 1
The Task

In our case discussion groups we were set a problem based learning (PBL) exercise with the title ‘Relationship to change’. The task involved producing a presentation connected to this theme.

The Process

Our group began with seven members and our facilitator. Initially my concerns were how we would work as a group especially with the knowledge that the group was going to remain the same for three years and should become somewhere that we should feel safe enough to discuss issues of practice and personal reflection. I felt this pressure to bond initially but it quickly moved onto our confusion over what was meant by PBL and the task. Our facilitator remained very quiet during this first meeting and on reflection I think this was to enable the group to establish and build our own understanding of the task.

The chair and scribe volunteered during this first meeting and remained the same throughout the task. The chair was a calming influence ensuring we had all had a chance to speak. The notes from the scribe enabled us to stay connected between meetings whilst being able to reflect on the content.

Initially we looked at our own individual understanding of change. The diversity within the group in age, backgrounds, gender and previous experience added to the richness of the group and made the discussions both stimulating and varied. The diversity also meant that at times it was difficult to see how we were going to form an idea which everyone would agree on as our perspectives and styles of working seemed so varied.
With so many ideas we decided to write about our own relationship to change in relation to a common experience. Although this seemed a good idea in theory when it came to the next meeting and we shared our personal reflections it was interesting that no comments on the content of the reflections were made. I think this was due to the fact that some of the information was quite personal and people in the group did not feel safe enough to comment or discuss. Just as a therapeutic relationship needs to build to become trusting and collaborative so did our group. The exercise felt unconnected to the task and did not manage to take us any further forward in our thinking. This is important to hold onto when it comes to client’s homework. In clinical practice it is crucial to explore what has been produced by the client to build a better understanding. The exercise becomes pointless if it is not drawn upon.

One member of the group changed groups before an idea had been developed. I worried what impact someone leaving the group may have on morale. However I was relieved that the event had caused the remaining six of us to become closer and move the process on. As Finlay (1993) writes complex relationships always exist in groups as each member relates to every other member differently. These relationships can easily shift as goals, members and roles change.

There was a general sense of relief when an idea for the presentation was established. We decided to have some fun with the presentation by applying Prochaska and DiClemente (1983) model of change to the T.V. show called ‘What Not To Wear’ presented by Trinny and Susannah.

Not wanting to upset the balance of the group, especially after one member leaving, I notice how sometimes I would step back and detach from the process, especially if I had a concern. At the time I felt that this was to prevent myself being too dominating within the group. On reflection I also appreciate that this maybe was an easier, less controversial
position to take. When ideas are flowing and there is an enthusiasm within the group I find it difficult to highlight areas of concern. There is also a fear of being perceived negatively at this early stage. I decided to raise my concerns with part of the presentation and they were met with appreciation. It was decided that only things that we all felt comfortable with should be included within the presentation.

The Presentation

‘What Not To Wear’ is a make-over programme where they take individuals that are perceived to be dressed badly and change their appearance through clothes, hair and make-up. Often this change of appearance is correlated with an individual’s increase in confidence and self-esteem.

Not only is ‘What Not To Wear’ about change but to achieve this change Trinny and Susannah incorporated characteristics and methods of working with people, which are in direct opposition with some of our Basic Therapeutic training. Having spent some time watching the programme Trinny and Susannah tend not to work collaboratively with a client, little empathy is shown and change is often enforced. We thought that it would be interesting to exaggerate these characters to demonstrate ‘how NOT to be a therapist’ and the impact that this has on a client and the desired change.

We also decided to look at the change systemically incorporating the impact of family members on an individual’s ability to change and maintain the change.

The Trinny and Susannah script was based around Prochaska and DiClemente (1983) model of change. **Pre-contemplation:** When an individual may not perceive that they need to change. **Contemplation:** When an individual is actively thinking about change and has the intention to change. The third stage of **Preparation** combines intention to change and the beginning of small behavioural changes. **Action** is the stage in which individuals
modify their behaviour, experience, or environment in order to overcome their problems’ (Prochaska and DiClemente, 1992, p.1102) and finally Maintenance is viewed as a continuation of change where the individual works to prevent relapse.

A weakness with the presentation is the fact that we did not acknowledge that change may not occur in a linear progression. Research has shown that the procession is not linear and individuals go back and forth through stages in a ‘spiral pattern’ (Prochaska and DiClemente, 1992, p.1104).

Prochaska and DiClemente (1992) write how important it is to understand where a client is in terms of readiness to change and then to adapt both the therapeutic relationship and intervention accordingly. Prochaska and Norcross (2001) explains how often patients can be treated as if they are in the ‘action’ stage. To work in the ‘action’ stage without the ‘requisite awareness, decision making and readiness provided in the contemplation and preparation stage’ (Prochaska and DiClemente, 1992, p.1111) can result in high drop-out rates. Goals need to be realistic and the therapeutic relationship should be matched to the client’s stage of change (Prochaska and Norcross 2001). The therapist should move from a ‘nurturing parent’ to a ‘socratic teacher’ to an ‘experienced coach’ to an expert ‘consultant’ in accordance with the stages of change (Prochaska and Norcross, 2001, pp.444-445).

The characteristics of Trinny and Susannah were not sensitive to the client’s stage of change. They demonstrated ‘how not to be’ and we hoped that this exaggeration would enable the audience to see how important it is to adapt, listen, empathise and collaborate. Our character in the presentation was unable to maintain the change lacking therapeutic or family support.
Further Reflections

Within the PBL process and presentation there was no right or wrong way to go about the exercise. I noticed how the group would look to the facilitator for answers but she was unable to give any. The lack of boundaries within the task made it at times feel uncomfortable. This seems to be echoed in practice and many of the daily decisions that we make sometimes have no right or wrong answer. For example should you look at a client’s notes before a first meeting – will this information help the process or confine and shape your opinion. How much is it helpful to disclose to a client – will this normalise or threaten. Such judgements have to be made on an individual basis. There is no manual and as a therapist you will make mistakes. At this early stage in training there is something scary about this and something that I am aware I find difficult. I want to be able to trust my abilities and leave worries at work while also not becoming complacent or de-sensitised. I want to be able to sit on the edge of my seat while sitting comfortably.

Within supervision we have talked about training being a growing process and a time to try and experiment with what works for you. I think that this has helped me to embrace the concept that there is often no right or wrong, rather than be frightened by it.

This led me to question how a client may feel when they are introduced to a new way of working in, for example, Cognitive Behavioural Therapy (CBT). Some basic principles of CBT such as the need to work collaboratively can be alien to a client. A client that has a very medical understanding of their difficulties or a client whose previous interaction with services tends to follow the pattern of being told what to do by ‘experts’ may find working within CBT difficult. The PLB exercise helped me to see how daunting and confusing a new way of learning and interacting may be for a client. It made me aware of how I explain things to clients, the language I use and the information I give.

I did notice that I like to be very productive in each meeting so would find it frustrating when time was spent at the start chatting about things not related to the presentation. I
found productivity for me equals a decrease in anxiety. I had to learn to sit with my anxiety and re-evaluate why I feel things must be so productive. In fact how do you define productivity? I learnt that the process we went through at the starts of meetings may have seemed irrelevant but it was productive in forming and bonding the group. On reflection this enabled people to be open in their views and in turn produce a good presentation. I started to view this as a positive that I could partake in rather than detach from. Groups can be distinguished as activity-based groups, support-based groups or, as in our case, a mixture of the two (Finlay, 1993, p.8).

I have carried this idea into practice and just how it was important to build a rapport within the group this is essential within a therapeutic relationship (Chadwick 2006).

If I feel the pressure to pack sessions full I now find myself questioning why this is and reminding myself what I view as being productive and helpful maybe different from what the client feels is helpful.

**Conclusion**

Being in a diverse group in the PBL exercise and in a multi-disciplinary team it has been interesting to stand back and reflect on my own impact. I am white middle class and in the past I have tended to view my own cultural identity as being neither interesting nor important. But of course my education, my up-bringing, my family rules and values impact who I am and the ways that I work. An awareness of my own values, narratives, stereotypes is vital to ensure that I am not a subtle form of Trinny and Susannah enforcing change. As Finley (1993) explains groups heighten emotions enabling you to notice things about yourself that otherwise you may not.
It was only really after the presentation that the benefits of the task seemed to resonate. Originally much time was spent on trying to understand what was meant by PBL and on the content of what was being produced. It is only on reflection that I have been able to see the importance of the process and how this can be linked to practice.

Although the presentation did not draw on our personal relationship to change, the PBL exercise enabled us to change as a group, work effectively together and bond.
References


Problem Based Learning Reflective Account Two


March 2008

Year 2
The Task

The group was given information on a family called the Strides. There was a geneogram, the ‘problem’, some background information and some suggested areas to pay attention to. Using the case to generate thought, the task was to write and give a presentation.

The Case

Within the case the main concern was for the safety of Mr and Mrs Stride’s twin girls, Sally and Sarah, who were in foster care after being put on the child protection register, under the categories of emotional abuse and neglect. The Strides were committed to caring for Sally and Sarah however the Local Authority were concerned about the adequacy of this care and wished to place the children for adoption. We were asked to complete a risk assessment and a rehabilitation program.

Background

The case provoked discussion and issues of poverty, class, discrimination, disability, domestic violence, loss, family support, gender scripts, mental health difficulties and inappropriate support from services jumped out from the case.

We formulated ideas around the family and perhaps being female myself I was drawn towards Mrs Stride. Mrs Stride had a mild learning disability, had been brought up in the care system, had experienced domestic violence from her previous and current partner, had had two of her children removed from her care from a previous relationship and her twin
girls were now in foster care with a very real fear that they could also be adopted. Mrs Stride lives in poverty with little social support and is suffering from feelings of despair and depression. I tried to understand how Mrs Stride may be feeling and was particularly interested in how all these factors confounded and effected the Stride’s relationship with services. I wondered about how fearful the Strides could potentially be of services and the anxiety that professional support could trigger. The support that services had offered had been inappropriate with interventions not taking into consideration the level of Mr and Mrs Stride’s understanding and ability. In addition, a lack of sensitivity to current and past events was demonstrated by some health professionals in the case. What was particularly interesting to me was that the failure to succeed was understood by services to be a failure on the part of the family to engage.

While working in learning disabilities on placement the importance of paying attention to the client’s system has become even more apparent. Not just at a family level but at a staff and organisational level (across agencies). What is it within the system that is contributing or maintaining difficulties? How are different parts of the system relating to each other? How is this effecting engagement? One successful intervention on placement has focused on information sharing and communication across agencies. Risk issues were not being communicated with potentially damaging consequences for the client and staff. The client’s system was predominately staff. You therefore need to become aware of your own part, as a health professional, and the part of other health professionals within that system. This PBL case was a good example to try and understand health professionals’ perspectives and some of the advantages and disadvantages of working within a multi-disciplinary team (MDT). As a result, our presentation focused on these issues.
The group process

Compared to previous PBL exercises that we had taken part in this exercise was more directive. As I read the problem there were immediate questions and hypotheses came to mind. I was then surprised to find these already given to us at the end of the task. Although these areas could of course be debated and discussed within the group on reflection there was something different and interesting in the amount of information we had been given. In some way having this much information was more disabling to the group discussion. At first it seemed to prevent discussion as it felt like we were regurgitating the information that had been given and drawing attention to ideas that had already been stated. Was there something about receiving too much help, being 'over serviced' that was in fact debilitating us and the PBL exercise? Could this be a reflection of the fact that the Stride family had been ‘over-serviced’ (McGaw 1999 p201), over loaded with information and professional input that was in fact having the effect of increasing their own disability rather than supporting them to use their own resources and capabilities.

The group arranged to meet several times. There were times that some members could not attend which left decision to be made by the majority and the absent members to be informed. This was a different experience from the last PBL when set times had been outlined in the timetable and we all attended each meeting. By not attending that person’s right to disagree with the decisions seemed to be removed whether this had been a conscious or unconscious decision by the group. One meeting was arranged when I said that I would not be able to attend the first half as I had previously arranged to see a tutor. It was decided to go ahead with this meeting as everyone else could make that time. When I came to the meeting I was surprised that everyone’s role and area of research had been decided, including my own. It felt like an important decision had been made without my consultation and without my right to question it. I thought about this in terms of the Stride family and how it seemed that decisions had been made for them as a family with little consultation and little power to change these decisions. In the same way that services had
understood the behaviour of the Strides as disengagement, was the group perceiving my absence similarly? I also thought about our group in terms of an MDT itself and how decisions need to be made within this context. Many of the difficulties of working in a group or MDT are represented by health professionals feeling that their ideas are not being heard or respected, undesirable shifts in status, insecurities about team worth and professional defensiveness (Jones 2006, Simpson 2007).

I noticed that in our meetings there was an eagerness to concentrate on the end result, the form and nature of the presentation, rather than take note of the process. Again perhaps this echoed the approach taken by the health professional involved in the care of the Strides. The outcome of the children’s safety was paramount in the case however in the past there seemed to be a lack of reflectivity over the process of how this should best be achieved by the multiple health professionals involved.

One member of the group was perhaps more aware of this struggle and suggested that we all wrote narratives from the perspective of each member of the family, including the children. This helped slow down the process and ground our thinking, reminding us that these were real people with thought, feelings and complexities.

The presentation

Within our presentation we decided to present an MDT discussing the Strides, the risk, and support that they had received. Each member of the group took on the role of a different professional involved in supporting the family. From the narrative exercise we had carried out, we decided that it was very important to involve the family in the meeting. We wanted
to bring the family into the discussion in a safe, non-threatening way. We therefore filmed 'Mr and Mrs Stride' discussing their perspective on the situation and the difficulties that they had encountered. This was then shown during the MDT meeting.

We decided to semi-script the MDT meeting so clear characters and different ways of thinking and working were evident in the presentation. The content of the meeting aimed to demonstrate some of the strengths and weaknesses of working in a multi-disciplinary way.

One of the main weaknesses was this idea of being ‘over-serviced’ and the different professionals and agencies involved being unaware of their own impact on the system. The Barnardos (2000) report describes inter-agency planning as crucial as it avoids repetition, saves professional time and reduces ‘wear and tear on the family’ (McGaw, 2000, p4)

We wanted to demonstrate that the support offered needed to be tailored and appropriate for the Strides building on their strengths as well as their vulnerabilities. Interventions needed to combine group programmes and home-based teaching tailored to the client’s pace of learning. Interventions should be adapted to provide training in the actual environment in which the skills are needed and should include modelling, practice, feedback and praise. Sue MacGaw (1998) points out that for some client’s having children can remind people of their own difficult childhoods and in these cases, individual therapy may be appropriate.

A slide including why the Stride’s maybe currently declining or withdrawing from services was shown at the end (See Appendix One).
Further reflections

There was a need within the group to keep the Stride family together, the idea of the family breaking down seemed almost unbearable to the group. Time was spent focusing on how the family could be supported to enable a safe environment for the children. On reflection little discussion was given to the options of what would happen if the new interventions we discussed did not work. The idea that perhaps the children would have a safer environment outside the family was not tolerated by the group. This may partly be due to the way that the information in the case was presented to us but it may also reflect the need of the group to stay together. No overt conflict has been shown within our group however I had occasionally felt tensions between people. To name them or discuss them would be seen as unbearable to the group and not tolerated. Others (meaning other PBL groups) that have conflict are seen as bad whereas our group sees itself as conflict free and therefore good. Halton (1998) might argue that at this point our group is stuck in a ‘paranoid-schiziod projective system’ (Halton p15) which can be problematic when it interferes with the task. Success in the Stride family was understood, by the group, as staying together and success in our own group is understood in the same way. Being aware of how I think individually and within our group is important as some of these dynamics can be echoed in multi-disciplinary working.

In personal and group reflections we have thought about how easy, and perhaps safe, it was to stereotype our own profession and the professions of others (e.g. social worker, Occupational Therapist, nurse) for the presentation and how unhelpful this can in fact be. Halton (1998) argues that divisions in organisations by, for example, disciplines become ideal for splitting and projecting negative feelings. ‘Each group feels that it represents something good and that the other group represent something inferior. Doctors are authoritarian, social workers talk too much, psychotherapists are precious, managers only think about money’ (Halton, 1998 p15). Halton explains that theses stereotypes are like the characters within children’s plays (or perhaps our PBL presentation). The splitting and
projection allowing preservation of self-idealization. However our group was able to identify what had happened in the presentation and reflect on this together. Interestingly Halton (1998) points out that the less contact with other disciplines the greater the capacity for projection of this kind. The group discussed how important it is for psychologists to integrate within a team while being aware of their own role and the impact of their professional and personal differences on team functioning (BPS, 2007).

Conclusion

This PBL exercise has enabled me to think further about MDT working, my role and the role of others. Through reflecting on the group processes I have become aware that some of our strengths and difficulties can be echoed in MDT working. Being aware of the client’s system, my role and the role of others in the system is vital for understanding behaviours and tailoring appropriate interventions.
References


Problem Based Learning Reflective Process Account Three

Working with people in later life, their families and professional networks.

February 2009

Year 3
The Task

We were given a case which involved working with people in later life, their families and professional networks. The group consisted of second and third year trainees and the task was to produce a presentation inspired by the case.

The Case

The case involved a 69 year old man, Mr Nikolas, and his family. He was referred to the psychology department with short term memory problems and concerns around his personal care. He was originally referred to social services after an incident, while driving, when he had refused to follow instructions given by the police. The police understood this as a sign of a ‘psychological’ problem and informed the family.

There were conflicts within the family. Mr Nikolas’ oldest son, Alexander, accused Mr Nikolas’ new partner, Mrs Edwards, of financial abuse which led to social services invoking the court of justice and his ex-wife agreed to manage the finances.

Background

From reading the background information I became interested in the other members of the family. Mr Nikolas’ son, his ex-wife and his new partner and how the relationship between these members was influencing ‘The problem’. In fact what was ‘The problem’? The problem had been positioned with Mr Nikolas and his potential memory difficulties but suddenly this became more complicated as we read the background information. In our first
meeting we had discussions around identity, religion, definitions of financial abuse, the
effects of divorce on children and emigration within families.

I was particularly drawn to formulate the case in a systemic way. I was also drawn to
Alexander’s story and I wondered whether this is because he is closer to my own age than
other members. If I had been older would I have been drawn to Mr Nikolas’ experiences? It
was interesting that there were so many different ways to approach the case. In fact
working with the second years threw up different perspectives that were less systemic in
orientation. I think this highlighted how my thinking has changed during the second year,
while working with children and people with learning disabilities, where systemic thinking
has been dominant and working with family systems and professional systems has been
vital. However it is always important to hold other formulations and perspectives and I
enjoy working in a group because it allows this exploration and discussion. For this reason
our presentation focused on the number of ways that the case could be understood and
formulated. What was striking was the power of formulation and how different
formulations led to very different interventions. We were particularly interested in how
this fitted into the constraints of services. It was all very well having ideas but how realistic
are these within the NHS where resources are limited. In a culture of increasing
accountability and measurable outcomes as health professionals we need to provide a
clear coherent argument for providing a particular type of service. From this was born our
title; ‘The Commissioners Den’. Based on a TV programme called ‘Dragon’s Den’ where
entrepreneurs pitch their ideas to a panel that decided whether or not it will receive funding.
As Clinical Psychologists we were pitching our ideas to commissioners.

The group process

This was the first time that we had worked across years and it was interesting to notice how
this would impact the dynamics of the group. I felt excited about working with new people.
I wondered whether I would have felt the same if for example I had been the only third year in the group. If this had been the case would there have been a pressure to perform, to represent the ‘third years’? And does this link to how once qualified I will need to represent ‘psychology’ and show leadership skills (BPS 2007). This made me think about the transition from a third year to being qualified and how I would need to build on these skills over the year through being an active member of Multidisciplinary meetings and gaining experience in consultation work.

The group seemed to gel very easily and over time there was less divide between being a second or third year. For example we started the first few meetings sitting next to our own year, but this soon dissipated and the physical divide was no longer. The group mixed and ideas flowed seemingly easily. There was a new enthusiasm about the group that I had not experienced in previous PBLs. I wondered if this was due to both years trying to impress each other in some way and to share our knowledge. There were a few quieter members when it came to ideas but I noticed that they focused on the practical issues of the group, when and where we would meet, aims, minutes and organizing group emails to stay connected between meetings. I wondered why I never seem to take this position in a group and if it reflected a belief I hold about my own organizational skills. I also wondered why others take to these positions so readily and was it to give themselves a valuable role within the group and take some control over the process. These positions seemed containing for the members who took them as well as having a containing influence over the group.

I think others would have perceived me as a reliable, consistent member that attended all meetings and offered ideas. Most members missed one or two meetings due to illnesses or other commitments. I wondered why this would irritate me and I think it was less about others missing the meeting and more about my inability to miss a meeting. Did I worry about how others would perceive me if I missed one meeting? I have noticed how in the first year I tended to take a quieter position with a group, contributing but being very conscious not to dominate. I think that now I am more able to express my ideas but I am
perhaps expressing a need to be liked by demonstrating a very conscious commitment to
the group. This linked to the ‘Away Day’ that was held by the University about
‘Psychologists putting our heads above the parapet’. Being in the third year you suddenly
become aware that you will finish training and be without the support of your year, the
university or the protection that the title ‘Trainee’ allows. Psychology and Psychologist’s
ideas are not always liked but still need to be communicated and is there something about
tolerating not being liked in some occasions that I need to learn.

Presentation

From our discussions we decided to make three pitches for funding which would form the
basis of the presentation. The first pitch concentrated on an assessment to determine a
differential diagnosis between dementia and depression. The emphasis was on justification
of Neuropsychological assessment and possible Cognitive Behavioural Therapy (CBT)
depending on the outcome. The second pitch was for Individual Psychodynamic therapy for
Mr Nickolas and therefore the case was formulated using psychodynamic theory. Thirdly a
systemic formulation was pitched with possible family therapy as an intervention.

Our panel consisted of commissioners representing different perspectives. For example
there was the ‘NICE dragon’ who represented the NICE guidelines (showing a preference
to the first pitch), there was the ‘Service User dragon’ representing the service users
perspective, ‘The ‘New Way of working dragon’ and the ‘risk adverse dragon’. Our
pitches needed to please these dragons in order to receive funding.

I was involved in building the systemic hypotheses and as Quall (1999) writes families are
the most important social context for older adults, and thus are often an appropriate focus
of intervention’. We looked at a number of ways the difficulties could be understood
through triangulation (Minuchin 1974) and patterns of punctuation in interaction between Mr Nikolas and Mrs Edwards (Watlawick et al, 1967) (Appendix one). From a narrative perspective we described how a thin description of Mr Nikolas had been created by others (those in power) (White 2007) and Mr Nikolas had been placed in terms of weakness and disability (Morgan 2000) with his own voice being marginalised.

All our formulations needed to be communicated in a way that other professionals or commissioners could understand in order to receive funding. They needed to balance being the most appropriate intervention for the client while being cost effective. It was interesting to think about which ‘Dragon’ held the most power and how this could sometimes limit practice. Arguably the ‘NICE dragon’ was more powerful than the others and this was hinted at through the presentation.

**Further Reflections**

In our group we were all of a similar age, we were all studying to be clinical psychologists, we were all of a similar class and none of us had children. There were two men and five women and some diversity within the group regarding ethnicity with the majority being White British, one member was Irish and another member was Asian. What I did notice was our shared psychological language and that although we were at different stages of training we had the same training which made communication and learning new ideas surprisingly easy. This was helpful to speed communication but I wondered how our shared language could exclude other professionals. What was helpful about the presentation was the need to communicate these ideas to commissioners who were a diverse set of professionals and service users with different training and priorities from ourselves. In my current placement I have had the opportunity to give presentations to the MDT and also run a consultation group for nurses working on a continuous care ward. I have really valued these experiences and they link back to the skills needed in our PBL of having to learn to
communicate complexity in a non-complex manner in a limited amount of time. I am continuing to learn to reduce information without losing the richness and create a clear and credible narrative to aid communication with other professionals.

Weaknesses

One weakness of the group is that we tended to work on our different formulations separately between meetings. Although this made it logistically easier and the formulations were shared through email and in meetings it may have weakened the presentation. It was difficult to judge the level of support that the second years may have needed particularly with regards to the psychodynamic formulation. If we had worked on each formulation as a group this may have been a more effective strategy.

One interesting reflection within our group was the fact that we almost ignored the fact that Mr Nikolas was classified as an ‘older adult’ and age was rarely discussed. Was this because we were unable to relate to ‘old age’ as it seemed too far away for us? Yet we all have or had grandparents. In fact our own parents may be considered ‘older adults’. Literature suggests that there maybe anxiety around working in an older adult setting as it reminds us of death and our own mortality (Sheldon 1997). Were we in some way ignoring the relevance of age because it felt uncomfortable? Since the PBL I have been on my older adult placement and I think this experience of learning about transitions, life stage, generational factors, the complex relationship between organic and psychological experiences, the impact of health on mental health would definitely open discussion around age. In particular I have been struck by the amount of stigma that older adults can hold around aging and mental health. I have also noticed how I have often been positioned as ‘expert’ which can be containing for clients but is incongruent with the very collaborative approaches of CBT and Narrative therapy. Therefore our positions have had to be negotiated through therapy.
Conclusion

Through ‘Commissioner’s Den’ I found making comparisons between the NHS and business a useful exercise. It allowed us to think about how we position ourselves as Psychologists, how we advertise ourselves and how we are understood by other professionals, our clients and commissioners.
References


APPENDIX ONE:
Systemic Hypotheses

Conflict between ex-wife and son detoured through Mr Nikolas' illness

Triangulation (Minuchin, 1974). Mr Nikolas is troubled by the conflict between his ex-wife and his son and the conflict may be detouring through Mr Nicholas. This stress may be causing Mr Nicholas to becoming forgetful and impulsive.

Ex-wife -------- Conflict --------- Son

Mr Nicholas

Well

Pattern of punctuation in interaction between Mr Nikolas and Mrs Edwards

A sustaining pattern of punctuation (Watlawick et al, 1967) may be leading Mr Nikolas to an exaggeration in the presentation of any cognitive difficulties that he is experiencing. Mr Nikolas’ repeated pattern of being abandoned by those close to him may be leading him to belief that he must keep Mrs Edwards in close proximity to him when she appears to be withdrawing. Mrs Edwards’ history of domestic violence may be leading her to belief that to pander to Mr Nikolas’ demands could lead to an escalation and that she must therefore maintain her independence in the face of Mr Nicholas’ demands.

Nr Nikolas

Angry/Tearful

Proposes Marriage

Erratic behaviour

“Demanding”

- Maintains independence/own home

- Gets Mr Nikolas’ son involved in care

- Withdraws further from Mr N

Mrs Edwards

“Withdrawing”

A ‘thin description’. Mr Nikolas’ voice is becoming marginalised.

There are currently many competing versions of reality in relation to Mr Nicholas e.g. his son’s, Mrs Edward’s, the police’s, the previously presented models. Whilst some of these versions of reality may be more helpful than others Mr Nikolas’ voice appears to have become marginalised. This is likely to be distressing and disempowering to him and a possible lack of a coherent narrative may be sustaining his difficulties.
Case Discussion Group (CDG)

Reflective Account Summary

September 2007

Year 1
Within my first year Case Discussion Group (CDG) reflective account I outline the structure of the group, roles within the group, the development of the group and how this influenced my personal and professional growth. I reflect on the diversity of the group in terms of gender, age, class, values and previous experience and how this not only added to the richness of the discussions but impacted how the group developed. The group facilitator had a non-directive style that facilitated free discussion. The negotiation of time and boundaries needed to be set by group members. I positioned myself as the less experienced member and therefore was more likely to ask questions than offer advice at this early stage of the group’s development. This was a non-threatening position that enabled me to be liked but on reflection needed to be questioned in order to challenge/develop my own role within the group. Initially the group had a problem solving function in terms of clinical cases but this shifted through the year to allow wider discussion and debate. The group had both a supportive and a challenging function that enabled my thinking to remain critical in terms of my clinical work. The importance of being aware of individual differences in education, family rules and gender roles were highlighted. Within the report the use of humour within the group was discussed and the possibility of experimenting with more structure and systemic ideas was suggested.
Case Discussion Group (CDG)

Reflective Account Summary

August 2008

Year 2
The account described how our Case Discussion Group (CDG) had changed and evolved over the last year. In particular I felt it had developed into a space that was both safe and trustworthy. The function of the group had changed from an arena of discussing purely clinical cases to a place where professional issues, personal reflections and course and placement difficulties were discussed. The CDG became more systemic in its thinking, allowing all of the above elements to be discussed, processed and understood better. I felt this broader view reflected our stage in training in the second year and particularly the work we had been doing within Learning Disabilities and Child services.

How group members positioned themselves and are positioned by the group was discussed. This was linked to group psychotherapy where client’s experience in their family of origin influences the position that they take in the group and their attitude towards the leader (facilitator). The links between the CDG and practice are demonstrated through the presentation of clinical cases and reflections on multi disciplinary working. Reflections on effective team functioning were considered.

The group continued to be a place where I gained advice and guidance on clinical cases and a place to challenge my thinking and broaden by knowledge. I felt I was able to contribute to the group further in the second year and saw my role as changing from someone who asks questions and sought solutions to someone who could tolerate uncertainty, offer views and draw on clinical experiences.
Summary of Experience Gained on Clinical Placements
Adult Mental Health, Year 1

Title of Placement: 12 Month Adult Mental Health (core)

Setting: Community Mental Health Team (outpatients, client’s homes, community day centres), Acute Mental Health Ward & Prudence Skynner Family Therapy Clinic.

Clients: Adults between the ages of 18 to 65 years.

Theoretical Models: CBT, Systemic family therapy, CAT informed work.

Presenting difficulties: Psychosis, Depression, Social Anxiety, Health Anxiety, Body dysmorphia, Bereavement issues, relationship difficulties.

Range of Experience: Direct 1:1 work, co-facilitation of relaxation group on acute mental health ward, co-therapist family work, member of the reflective team, psychometric assessment and neuropsychological assessment, service related (SRRP) audit, dissemination of SRRP results in Trust presentation, attending all MDT meetings and risk meetings, presentation to MDT, Regular attendance of the service user lead group with the development of service user leaflet about accessing psychological therapies, group supervision in CBT. Child protection and MDT training.

Learning Disabilities, Year 2

Title of Placement: 6 Month Learning Disabilities Placement (core)

Setting: Community Team for People with a diagnosis of learning disabilities (outpatients, residential, client’s homes, day centre) and Specialist Learning Disability Psychotherapy department

Clients: Adults between the ages of 18 to 65 years.

Theoretical Models: Psychodynamic, Behavioural, CBT

Presenting Difficulties: Anger management, aggressive behaviour, sexually inappropriate behaviour, sex education, interpersonal difficulties, bereavement issues, repetitive distressing behaviours, anxiety, dysfunctional eating behaviours, supporting transition from residential homes, challenging behaviours.

Range of Experience: Direct 1:1 work with clients, work with families/carers, Staff consultation/training in residential setting, indirect work with staff and carers, formal observations and functional analysis, formal risk assessment with consultation sought from forensic services, Psychometric assessments, capacity assessments, visits to a number of
services, attended service user lead carer group, presentation to carers about role of clinical psychologists and developed carer group to have regular contact with the Assistant Psychologist. Attended weekly case discussion groups within the psychotherapy department. Presented a case within the psychotherapy group.

**Child and Adolescent, Year 2**  
**Title of Placement:** 6 Month Child and Adolescent Placement (core)  
**Setting:** Child and Adolescent Mental Health Service (outpatients, client’s homes, community centres, schools), Looked after Children team.  
**Theoretical Models:** Systemic/Narrative Therapy, CBT, Behavioural.  
**Clients:** Children and adolescents aged from 5 to 18 years.  
**Presenting difficulties:** OCD, Depression, Anxiety, Anger and emotional difficulties, school attendance difficulties, difficult family relationships, separation anxiety, parenting difficulties, sleep difficulties, bullying difficulties, chronic physical problems, ASD, young carers – caring for parents with mental health or physical difficulties.  
**Range of Experience:** Direct 1:1 work with clients and parents, family work, co facilitation of Foster carer group, parenting skills training, staff training at young carers group, joint work with social worker in children in need team, attended training on Tourettes, presentation of narrative work to MDT, attended risk management meetings, psychologist development group in neurological assessments. Psychometric and neurological assessment, consultation to SENCO within school, liaison with teachers. Observation of eating disorder clinic, Observation work within schools and joint assessment work for ASD.

**Older Adults, Year 3**  
**Title of Placement:** 6 Month Older Adult Placement (core)  
**Setting:** Community Mental Health Team for Older Adults (outpatients, clients home, organic ward, acute mental health ward, continuous care ward, day centre)  
**Clients:** Adults aged 65 years and over  
**Theoretical Models:** Systemic/Narrative Therapy, CBT
**Presenting Difficulties:** Depression, anxiety, bereavement issues, memory difficulties, psychosis, chronic health difficulties, interpersonal difficulties, dementia related difficulties such as dis-inhibited behaviour.

**Range of Experience:** Direct 1:1 work, couples work, work with carers, consultation group with nursing staff on a continuous care ward, co-facilitated a well being/ replace prevention group at a day centre. Psychometric and neurological dementia assessments. Attended CBT training for older adults training, Dementia day, team meetings, presentation of Clinical work at the Multi Disciplinary interest groups.

**Advanced Competencies, Year 3**

**Title of Placement:** 6 months Advanced competencies placement, Disabled Children’s Team and a Children's Centre providing multi-disciplinary, specialist neurodevelopment and neurodisability care. Additional experiences at Children and Adolescent Eating Disorder Unit.

**Setting:** Children Disabled Team within social services (outpatients, client’s home, schools). Hospital health setting, Eating Disorders Adolescent ward.

**Clients:** Children and adolescents age 0-19 years.

**Theoretical Models:** CBT, behaviourial, integrated, developmental.

**Present difficulties:** Autism Spectrum Disorder and other neurodevelopmental difficulties, restricted feeding, challenging behaviours (e.g. biting), chronic physical difficulties, sleep difficulties, toileting difficulties, aggressive behaviour, anger management, parenting difficulties. Eating disorders.

**Range of Experience:** Direct 1:1 work with children with disabilities, parents and carers. Neuro-developmental assessments. Play based/ cognitive and developmental tools, ASD diagnostic clinic, observations within schools to aid diagnosis, observation work and consultation within nursery care regarding challenging behaviours, Therapeutic interventions for children with ASD and their families, Consultation to the disabled children team and community paediatrician, Work in the restricted feeding clinic. Attendance of a number of meetings (Autism Development meetings, Meeting with service managers, Identify policy and framework, CAMHS review). MDT eating disordered assessment for inpatient care. Co facilitation group on ward.
Summary of Clinical Case Report

Adult Mental Health 1:

Cognitive Behavioural Therapy with a 49-year-old Woman Presenting with Social Anxiety.

All identifying details of services, service users and their families have been removed. Some details may have been changed to preserve anonymity.

February 2007

Year 1
Ruth is a 40 year old woman of white British Origin. She was referred to the community mental health team by her General Practitioner. Ruth had long-term difficulties with social anxiety with associated panic attacks and agoraphobia. At the time of the referral leaving the house and caring for her 12 year old son who had a diagnosis of Asperger syndrome was becoming increasingly difficult. She lived alone with her son and had limited social support. At the point of the case report I had seen Ruth for ten therapeutic sessions and had offered a further eight. As recommended by NICE (2004) we worked together using Cognitive Behavioural Therapy (CBT). Standardised measures showed high anxiety particularly related to health and social situations. Ruth was experiencing a number of physiological symptoms associated with anxiety but was interpreting these as potential physical health difficulties. To aid formulation Clark and Wells (1995) cognitive model of social phobia was used.

Psycho-education and socialisation to the CBT model was a powerful initial step. In addition monitoring anxiety enabled Ruth to understand her physical responses. We worked cognitively on beliefs, assumptions and rules that were understood to maintain the self-focus and intensify the social anxiety. A fear/avoidance hierarchy was developed to allow graded exposure and behavioural experiments were used to challenge conditional assumptions with decreasing safety behaviours allowing a shift from self-focus to external focus. Building a strong and trusting therapeutic relationship was an important part of the work particularly because of Ruth’s fear of negative judgment. Ruth struggled to tolerate any anxiety so behavioural work needed to be well planned and delivered at an appropriate pace. Ruth made a number of positive outcomes and her level of anxiety started to reduce as she increased social situations.
Summary of Clinical Case Report

Adult Mental Health 2:

Cognitive Behavioural Therapy with a 30-year-old Woman Presenting with Body Dismorphic Disorder.

All identifying details of services, service users and their families have been removed.
Some details may have been change to preserve anonymity.

September 2007

Year 1
Hannah is a White British 30 year old woman referred to the Community Mental Health Team by her General Practitioner (GP) for low mood, anxiety and difficulties around obsessional thoughts and checking behaviours in relation to her facial skin. She feared that her skin was flushing red and looking 'abnormal' or 'ugly'. This caused a number of behaviours (mirror checking (40 times a day), reassurance seeking, constant comparing to others and avoiding social situations) which were maintaining difficulties. Standardised measures suggested that Hannah was suffering from severe depression, mild anxiety and ‘extremely low’ self esteem.

A number of early experiences and idealised/dominant values associated with appearance contributed to create selective and excessive attention to her facial skin. Heightened awareness caused a distorted mental representation of her skin as bright red and extremely blemished. Hannah tended to ignore global aspects of her appearance which further distorted her self-perception. A negative appraisal of her skin led to rumination, changes in mood (depression/anxiety) and the use of safety behaviours (camouflage, standing away from bright lights) and avoidance. An unstable internal body image increased mirror checking, which increased feelings of distress/uncertainty about appearance increasing further checking.

15 sessions of Cognitive Behavioural Therapy (CBT) were completed. We worked on reducing behaviours that were found to increase symptoms such as reassurance seeking and mirror checking. A hierarchy of behavioural experiments were set with the final goal of wearing no make-up in public. Hannah was able to achieve this goal which enabled her to further challenge her beliefs about her facial skin. Hannah learned to challenge her negative automatic thoughts, increase her day time activities and no longer avoided social situations. Repeat measures of depression, anxiety and difficulties with self esteem were all significantly reduced to ‘mild’.
Summary of Clinical Case Report

People with Learning Disabilities:
Cognitive Behavioural Anger Treatment and Psychoanalytical thinking with a Man
with mild learning disability presenting with anger difficulties.

All identifying details of services, service users and their families have been removed.
Some details may have been change to preserve anonymity.

April 2008
Year 2
Michael is a White British male in his late thirties considered to have a mild learning disability, the aetiology of which is unknown. He has chronic difficulties with close relationships which are linked to controlling his anger. These anger difficulties reflect his lifelong experiences of being exposed to anger and violence in the family. His physical disabilities (speech and epilepsy) and learning disabilities compound these problems in a number of ways (low self esteem, lack of employment or meaningful activities and problems with self expression). 12 sessions of Anger treatment based on structured CBT by Taylor & Novaco (2005) were attempted, however it became clear that Michael responded better to non-direct therapy. A psychoanalytical reformulation using Malan’s theory (1995) allowed Michael’s patterns of interactions to be explored and communicated.

Michael demonstrated that he was able to use behavioural strategies in situations that made him feel angry. He started to understand the role that thoughts have in mediating his feelings and behaviours. He had more difficulties challenging his thoughts or taking the perspective of others in order to alter his cognitions. Risk issues affected the work and the intervention that followed. Consultation from the forensic service was sought and multi-agency meetings were organised to increase communication and minimise risk. Michael reported a greater understanding of where his anger had come from and increased a number of activities to allow himself a sense of belonging and self-worth.
Summary of oral presentation of clinical activity

Child, Adolescent & Family:

Narrative therapy with a 10 year old girl (and her family) presenting with sleep difficulties.

All identifying details of services, service users and their families have been removed. Some details may have been change to preserve anonymity.

September 2008

Year 2
Emma is a ten year old White British girl referred to the Child and Adolescence Mental Health Service for sleep difficulties by her General Practitioner. For six months Emma had been unable to sleep alone without her mother. Emma had some obsessional elements to her behaviour and low self-esteem. Pressures from school regarding late attendance and a family history of mental health difficulties had left Emma’s parents feeling unable to cope and concerned regarding the meaning of Emma’s difficulties.

Narrative Therapy (NT) was used as it was felt a contextual focus was needed, with all members of the family coming together to address ‘the problem’. Thin conclusions regarding Emma had been drawn from a problem-saturated story that placed Emma in a position of disability and dysfunction. Using NT we were interested in finding alternative stories and then thickening and richly describing them in order to produce change. Two narrative techniques that had been particularly powerful within the work were discussed in the presentation. These were externalizing the problem and the use of therapeutic letters. I saw Emma and her family for seven sessions. At the end of the intervention Emma was able to sleep alone and her story had shifted from vulnerable, to capable and brave. Emma reported increased confidence and was better able to voice her concerns in family meetings. A reward ceremony with outside witnesses enabled the system to notice these developments in order to maintain the positive changes. For Emma’s parents it gave them a sense of self agency and they began to come up with ways of tackling the problem.
Summary of Clinical Case Report

Older Adults:

A Neuropsychological Assessment of a man in his mid sixties referred with memory difficulties.

All identifying details of services, service users and their families have been removed.
Some details may have been change to preserve anonymity.

April 2009

Year 3
Mr Johnson is a White British 65 year old man referred to the Older Adult Team for neuropsychological assessment by his General Practitioner. His wife had reported concerns around his memory and ability to learn new tasks. Following an assessment by the team Psychiatrist I met with Mr and Mrs Johnson. Mr Johnson had retired six months ago and reported noticing some changes in his memory and ability to process information at work. His wife, 18 years younger, was more concerned. Mr Johnson’s presentation and particularly his medical history (hypertension, raised cholesterol and smoking) increased his risk of vascular dementia (VaD). Other hypotheses such as Alzheimer Disease, Mild Cognitive Impairment (MCI) and depression/anxiety were considered. A battery of neuropsychological assessments were completed to assess all aspects of Mr Johnson’s cognitive functioning including orientation, attention, processing speed, language, memory, executive functioning and visuospatial skills. Assessments of depression and anxiety were completed. Mr Johnson’s results all fell within the average to superior range and were within or above his estimated pre-morbid IQ. A slightly weaker area identified was his executive functioning although this was still in the average range. It was difficult to ascertain whether this was connected to the reported difficulties, a pre-morbid variation and/or fatigue effect. It was concluded that there was no evidence to suggest he was suffering from a dementia, MCI or depression/ anxiety. His difficulties could be understood as part of normal ageing and a perceived slowing of functioning since retirement. The results were fed back to the client. It was recommended that Mr Johnson continues to reduce risk factors associated with VaD and if necessary repeat testing should be completed in 12 months time.
Service Related Research Project

A file audit study to investigate a Trust’s compliance with NICE guidelines for the treatment of Depression within secondary care.

All names including boroughs and CMHTs have been withheld in the report to preserve confidentiality.

June 2007

Year 1
ABSTRACT

The study was a file audit project (N=57) designed to assess whether the standards set by the NICE guidelines for the treatment of Depression (2004) for clients in secondary care were being met by the Trust. The study focused on the standards regarding combined treatment for severe depression, resistant depression and recurrent depression. The standards were met if there was evidence that the client had received or been considered for combined treatment. Combined treatment, as specified by the NICE recommendations, meant that clients had received or been considered for SRRI medication in combination with CBT or IPT.

The main results demonstrated that not all standards were consistently met. However a higher proportion of the sample could be classified as receiving combined treatment if other psychological therapies and anti-depressants were included.

These results will contribute to the gathering knowledge base within the Trust to understand which areas of the NICE guidelines are and are not being met. The wider aim of the Trust is to develop a robust plan for ensuring that the Trust’s services operate according to the NICE guidelines. The results of this audit point towards the importance of further research within the Trust into the decision making processes that take place around what treatment a client does and does not receive. This may help produce specific recommendations which address some of the barriers which prevent guidelines being followed and aid understanding around the difficulties that health professional have in following NICE guidelines.
ACKNOWLEDGEMENT

Thank you to Dora Brown for her supervision and to Jane Street, Vicky Vidalaki and Chris Gilleard for their support in the audit. Thank you also to the Community Mental Health Teams (CMHTs) across the Trust which allowed their practice to be audited.
INTRODUCTION

In the UK, depression affects between 5% and 10% of individuals (Singleton et al 2001) having a substantial impact on public health. There has been a widespread focus on depression and the difficulties it causes individuals, communities and health services (Chisholm et al 2004). Depression is known to cause extremely distressing symptoms yet it is a condition which is often misunderstood and mistreated (Middleton et al 2005).

Middleton et al (2005) points out ‘variations in its treatment within the NHS are striking and perplexing’ (Middleton et al 2005, p267). The National Institute for Clinical Excellence (NICE) have produced guidelines aimed at improving standards of care and reducing variation across services (Middleton et al 2005). The guidelines for depression in primary and secondary care have been in development since 2001 and were delivered in December 2004. This report looks at the NICE recommendations for the treatment of depression and the degree of compliance within an NHS Trust.

A large body of research has focused on treatment interventions to reduce symptoms and relapse in individuals that suffer from depression. Although the evidence base has its limitations effective treatments for depression have highlighted the importance of combining both anti-depressants and psychological interventions with a particular emphasis on Cognitive Behavioural Therapy (CBT).

Goldberg (2006) found that combined treatment, anti-depressants and psychological therapy, is likely to be the most effective treatment in secondary care for severely depressed individuals. Gloaguen et al (1999) meta-analysis found that Cognitive therapy was effective for mild and moderate depression and was more effective than anti-depressants in preventing relapse. From a service users perspective de Jonghe et al (2001) study explains that ‘Patients found combined treatment significantly more acceptable, they were
significantly less likely to drop out of combined therapy and, ultimately, significantly more likely to recover’ (De Jonghe et al, 2001, p217).

The guidelines for Depression (2004) advocate a stepped care model distinguishing between mild, moderate and severe depression. They seem to be clear on the treatment of moderate to severe depression recommending anti-depressant medication in the form of a selective serotonin reuptake inhibitor (SSRI) and the use of Cognitive Behavioural Therapy (CBT) or Interpersonal therapy (IPT). The guidelines have been met with some skepticism and as Parker and Fletcher write ‘there is no high level evidence base suggesting or identifying CBT and IPT as distinctively superior than other psychotherapies for major depression’ (Parker & Fletcher 2007 p359).

The NICE guidelines state that the case notes for individual clients with severe depression, resistant depression or recurrent depression should indicate that combined treatment of anti-depressants and CBT has been received or considered.

**Severe Depression** -The NICE guidelines state that ‘When patients present initially with severe depression, a combination of anti-depressants and individual CBT should be considered as the combination is more cost-effective than either treatment on its own’. (NICE, 2004 p54)

**Treatment resistant depression**- ‘For patients whose depression is treatment resistant, the combination of antidepressant medication with CBT should be considered’ (NICE, 2004, p55)

**Recurrent Depression**- ‘CBT should be considered for patients with recurrent depression, who have relapsed despite antidepressant treatment, or who express a preference for psychological interventions’ (NICE, 2004, p56).
However it is firstly not known if the guidelines are being implemented across the Trust and secondly whether there are particular difficulties in its implementation.

**Objective:** To assess whether the standards set by the NICE guidelines for the treatment of Depression (2004) for clients in secondary care are being met by the Trust. The study is focused on the standards regarding combined treatment for severe depression, resistant depression or recurrent depression. The standard will be met if there is evidence that the client has received or been considered for combined treatment. Combined treatment, as specified by the NICE recommendations, will mean that clients have received or been considered for Selective Serotonin Reuptake Inhibitor (SRRI) medication in combination with CBT or IPT.

The wider aim of the Trust is to develop a robust plan for ensuring that the Trust’s services operate according to the NICE guidelines. The results from this audit will contribute to the gathering knowledge base within the Trust to understand which areas are and are not being met and therefore inform future strategies.

**Hypothesis 1:** Not all clients with severe depression will have received combined treatment (SRRI and CBT or IPT).

**Hypothesis 2:** Not all clients with resistant depression will have received combined treatment (SRRI and CBT or IPT).

**Hypothesis 3:** Not all clients with recurrent depression will have received combined treatment (SRRI and CBT or IPT).

**Hypothesis 4:** The number of clients receiving combined treatment will increase when combined treatment includes all psychological therapies and anti-depressants.
METHOD

**Ethical Considerations.** The study fell under the remit of a clinical audit by comparing set standards (NICE guidelines for depression 2004) with practice (Baker *et al.* 2002). The audit is also part of a wider project that intends to lay the foundations for providing services at the Trust that meet the criteria for best practice guidelines. The wider project has received approval from all the relevant committees. As this project is an audit and part of the wider project it did not need either ethics or R and D approval (See appendix 3 for Ethical Scrutiny Form).

**Audit Design.** The audit tool was designed by the Trust. In February 2006 a strategic framework for the implementation of NICE guidance was developed by the Trust. A NICE implementation team was established to assist with ensuring that the strategy is implemented. This tool forms one of seven tools developed by the Trust as a baseline audit for compliance with NICE guidance.

The standards measured in the audit reflect the evidence base and the key priorities for implementation outlined by the NICE guidelines ‘Management of depression in primary and secondary care’ (December 2004). The development of the tool was facilitated by a pilot study and discussions with trainee clinical psychologists. The audit focused on a number of areas including initial presentation, drugs, and psychological interventions and incorporated treatment in primary and secondary care (Appendix 1). As outlined in the introduction this study is particularly interested in the psychological interventions that clients receive and will therefore focus on this specific part of the audit tool.
Setting: Seven Community Mental Health Teams (CMHTs) across the five boroughs in the Trust were selected by the Trust to ensure each borough was represented.

Sample Inclusion Criteria: The selected CMHTs produced a list of client names (maximum 10 per CMHT) with a primary diagnosis of depression under their care. CMHTs were informed that clients needed to be referred or re-referred and accepted for secondary care during a 13 month period (1st January 2006 to 31st January 2007) and have received at least two months care with the CMHT.

The sample consisted of 57 clients (28 male and 29 female) under the care of secondary care with the primary diagnosis of depression. The mean age of the sample was 42.5 years (ranging from 18 -71 years). 53 % of the sample were White British, 14 % were from other White backgrounds, 14 % were Asian, 1.8% were Black Caribbean, 1.8 % were mixed race and 1.8 % were Cypriot. 14 % of the samples first language was not English.

Procedure: All team managers from the selected CMHTs were informed of the audit via email. This was followed by a telephone call to each team manager. They were asked to inform all professionals working within their CMHT of the audit in the next team meeting. The CMHTs were aware that participant information would remain anonymous and confidential and that results of the audit would be fed-back to each team.

The five trainee clinical psychologists involved in the wider project were emailed the finalized audit tools by the Trust. Trainees were asked to collect data using six audit tools developed by the Trust for six NICE guidelines (Depression, Schizophrenia, Bipolar, OCD, Eating disorders, PTSD). Trainees collected data from two CMHTs each (N =20 per CMHT).
The selected CMHTs generated a list of client names by the specific inclusion criteria for each diagnosis. Trainees travelled to the allocated CMHTs and the audit tools were used to collect data from the client’s case notes. Data was collected from when the client was referred or re-referred to the team to date of collection. This was to ensure that participants referred to the team near the end of the referral period (January 2007) had received at least two months of care with the team. Where evidence was not located in the notes, information was requested from the client’s care co-ordinator. Data was then exchanged between trainees for their specific guideline of interest.

RESULTS

Analysis

Two-way contingency tables are presented to enable comparisons of frequencies and percentages across groups. Chi-square was considered for the analysis however some groups violated Chi-square assumptions with the size of expected frequencies being less than 5 (Green & Salkind 2003). It was therefore decided that only two-way contingency tables and bar-charts should be reported here.

Table 1: Severe Depression and Combined Treatment (SRRI and CBT or IPT).

<table>
<thead>
<tr>
<th></th>
<th>SSRI &amp; CBT or IPT</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Met</td>
<td>Not Met</td>
</tr>
<tr>
<td>Severe</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(%)</td>
<td>10</td>
<td>6</td>
</tr>
<tr>
<td>non severe</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(%)</td>
<td>15</td>
<td>26</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>25</td>
<td>32</td>
</tr>
<tr>
<td>(%)</td>
<td>43.9</td>
<td>56.1</td>
</tr>
</tbody>
</table>
Table 1 is a two-way contingency table showing the number of participants with severe and non severe depression receiving (Met) or not receiving (Not Met) combined treatment (SRRI & CBT or IPT). The results show that 62.5% of clients classified as having severe depression had treatment which met the standards set by the NICE guidelines. As recommended these clients had received combined treatment in the form of an SRRI and CBT or IPT. 37.5% of clients with severe depression did not receive the recommended treatment. Of the participants who were not classified as having severe depression 36.6% received combined treatment and 63.4% did not.

Table 2: Treatment Resistant and Combined Treatment (SRRI and CBT or IPT).

<table>
<thead>
<tr>
<th></th>
<th>SRRI &amp; CBT or IPT</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Met</td>
<td>Not Met</td>
</tr>
<tr>
<td>Treatment Resistant</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>(%)</td>
<td>(25)</td>
<td>(75)</td>
</tr>
<tr>
<td>Non Treatment Resistant</td>
<td>24</td>
<td>29</td>
</tr>
<tr>
<td>(%)</td>
<td>(45.3)</td>
<td>(54.7)</td>
</tr>
<tr>
<td>Total</td>
<td>25</td>
<td>32</td>
</tr>
<tr>
<td>(%)</td>
<td>(43.9)</td>
<td>(56.1)</td>
</tr>
</tbody>
</table>

Table 2 is a two-way contingency table showing the number of participant described as treatment resistant and non treatment receiving (Met) or not receiving (Not Met) combined treatment (SRRI and CBT or IPT). The results demonstrate that the treatment for 25% of the participants classified as treatment resistant met the standards set by the NICE guidelines.
Table 3: Recurrent Depression and Combined Treatment (SRRI and CBT or IPT).

<table>
<thead>
<tr>
<th></th>
<th>SRRI &amp; CBT or IPT</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Met</td>
<td>Not Met</td>
</tr>
<tr>
<td>Recurrent episodes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(%)</td>
<td>11 (40.7)</td>
<td>16 (59.3)</td>
</tr>
<tr>
<td>Non recurrent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Episodes (%)</td>
<td>14 (48.3)</td>
<td>15 (51.7)</td>
</tr>
<tr>
<td>Total (%)</td>
<td>25 (43.9)</td>
<td>31 (56.1)</td>
</tr>
</tbody>
</table>

Table 3 is a two-way contingency table showing the number of participants with recurrent and non recurrent depression receiving (Met) or not receiving (Not Met) combined treatment (SRRI & CBT or IPT). The results demonstrate that of the participants described as being treatment resistant 40.7 % met the treatment standards outlined by the NICE guidelines.
Figure 1: A bar-chart showing the percentage of participants which received the recommended combined treatment (SRRI and CBT or IPT).

The bar chart shows that 43.9 % (N =25) of the sample received the specific combined treatment (SRRI & CBT or IPT) as recommended by the NICE guidelines. 56.1 % (N=32) of the sample did not receive combined treatment.

Figure 2: A Bar-chart showing the percentage of participants who received the recommended treatment of SRRI.
The bar-chart shows that 84.2 % (N=48) of the sample had been prescribed the recommended SRRI medication. 10.5 % (N=6) of the sample were prescribed anti-depressants other than SRRI and 5.3 % (N=3) were on no medication.
Figure 3: Bar-chart showing all Psychological Interventions and the percentage of participants who received them.

The Bar graph shows the psychological interventions that the sample had received since referral. 40.4% (N=23) of the sample had received the recommended CBT with an additional 5.3% (N=3) participants receiving CBT plus another psychological intervention. 5.3% (N=3) had been referred for psychological therapy outside the CMHT and were awaiting treatment. 1.8% (N=1) refused psychological therapy and 1.8% (N=1) received psychological therapy through work. Only 3.5% (N=2) had received IPT and 31.6% (N=18) had received no psychological therapy.
The remaining results section presents two-way contingency tables and percentages but with ‘combined treatment’ expanding outside the specific recommendations of the NICE guidelines. Therefore ‘Combined Treatment’ will now include all psychological therapies and anti-depressants. Again participants are classified as having severe, treatment restraint and recurrent depression.

Table 4: Severe Depression and Combined Treatment (all psychological therapies and anti-depressants).

<table>
<thead>
<tr>
<th></th>
<th>Combined Met</th>
<th>Combined Not Met</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe (%)</td>
<td>14 (87.5)</td>
<td>2 (12.5)</td>
<td>16 (100)</td>
</tr>
<tr>
<td>non severe (%)</td>
<td>24 (58.5)</td>
<td>17 (41.5)</td>
<td>41 (100)</td>
</tr>
<tr>
<td>Total (%)</td>
<td>38 (66.6)</td>
<td>19 (33.3)</td>
<td>57 (100)</td>
</tr>
</tbody>
</table>

Table 4 is a two-way contingency table demonstrating that when combined treatment includes all anti-depressants and all psychological intervention 87.5% of the participant with severe depression are receiving combined treatment.
Table 5: Treatment Resistant and Combined Treatment (all psychological therapies and anti-depressants)

<table>
<thead>
<tr>
<th></th>
<th>Combined</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Met</td>
<td>Not Met</td>
</tr>
<tr>
<td>Treatment Resistant (%)</td>
<td>3 (75)</td>
<td>1 (15)</td>
</tr>
<tr>
<td>Non Treatment Resistant</td>
<td>35 (66)</td>
<td>18 (34)</td>
</tr>
<tr>
<td>Total (%)</td>
<td>38 (66.6)</td>
<td>19 (33.3)</td>
</tr>
</tbody>
</table>

Table 5 is a two-way contingency table demonstrating that when combined therapy included all anti-depressants and all psychological interventions 75% of participants with treatment resistant depression receive combined treatment.

Table 6: Recurrent Depression with Combined Treatment (all psychological therapies and anti-depressants)

<table>
<thead>
<tr>
<th></th>
<th>Combined</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Recurrent episodes (%)</td>
<td>16 (59.3)</td>
<td>11 (40.8)</td>
</tr>
<tr>
<td>Non recurrent Episodes (%)</td>
<td>22 (75.9)</td>
<td>7 (24.1)</td>
</tr>
<tr>
<td>Total (%)</td>
<td>38 (66.6)</td>
<td>19 (33.3)</td>
</tr>
</tbody>
</table>
Table 6 is a two-way contingency table demonstrating that when combined treatment included other all anti-depressants and all psychological interventions 59.3% of participants with recurrent depression received combined treatment.

**DISCUSSION**

The literature review highlighted that depression is a condition that can be misunderstood and mistreated. Middleton *et al* (2005) points out that there are large variations in the treatment of depression across the NHS. The NICE guidelines go some way to address these variations by recommending combined treatment with the use of SRRI and CBT or IPT. This report focused on the specific standards within the NICE guidelines regarding combined treatment for severe depression, resistant depression and recurrent depression. The overall aim of the wider project is to develop a robust plan for ensuring that the Trust’s services operate according to the NICE guidelines.

An audit was carried out on seven CMHTs across the five boroughs of the Trust. The results confirmed hypothesis one, two and three demonstrating that NICE guidelines were not always followed for clients classified as having severe, treatment resistant or recurrent depression. For clients with severe depression the guidelines were followed for 62.5% of the sample, for treatment of resistant depression this dropped to 25% and for recurrent depression this was 40.7%. As recommended by the guidelines SRRIIs were prescribed for 87.5% of the sample. CBT was the psychological therapy most often used with 45.7% of the sample having received CBT at some point since referral. 31.6% of the sample had received no psychological therapy since referral. 43.9% of the whole sample had received the recommended combined treatment of SRRI and CBT or IPT.
There was an increase in the number of clients that received combined treatment in each category when combined treatment included all psychological therapies and antidepressants, confirming hypothesis four. When combined treatment simply meant antidepressants and psychological input, combined treatment was received by 87.5% of clients with severe depression, 75% of clients with treatment resistant depression and 59.3% of clients with recurrent depression.

I felt that it was important to expand combined treatment to include other psychological therapies. Depression can be a complex condition and although there is evidence for CBT and IPT other approaches also appear effective (Parker & Fletcher 2007). It is worth acknowledging that my position in training and curiosity has directed the focus of this project. As Parker & Fletcher write ‘the clinical implications of over-selling CBT and IPT as specific and superior treatments for depression impact on both patients and practitioners. We need then to interpret ‘the evidence’ more critically’ (Parker & Fletcher 2007, p359). The audit has demonstrated the amount of compliance with the NICE guidelines but it is unable to tell us why the guidelines are not always followed. During my time working within the Trust there seems to be two factors that strike me as possible explanations. Firstly, and perhaps most importantly, health professionals sometimes feel a particular psychological therapy would be more appropriate for a particular client under particular circumstances. Secondly, the lack of trained professionals with CBT skills within a CMHT means that clients may be referred to other departments such as psychotherapy and family therapy to ensure psychological input. These interpretations are speculative and further research is needed on these important decision making processes.

The impact of client demographics such as gender, age and ethnicity on the Trust’s compliance with NICE guidelines also needs to be addressed. The limits of this report did not allow this relationship to be explored further but this would be an important consideration in further analysis.
The results of this audit need to be understood within the methodological limitations of the study. Firstly the pilot study highlighted that of the referrals identified in the last six months, 96% of new referrals and 88% of re-referrals accepted for care did not have a CMIS recorded diagnosis. This meant that CMHTs were made aware of the inclusion criteria and asked to generate their own sample. It could therefore be argued that bias within the selection process may have occurred creating a less representative sample. Secondly the sample size for some groups was small. For example only 4 clients were classified as treatment resistant limiting analysis and causing conclusions from the study to remain tentative.

In addition a number of different auditors were asked to collect the data. No training took place and inter-rater reliability was not assessed. This seems to be of particular importance when some audit items, needing further development, relied partly on subjective judgements. For example whether a client has severe or non severe depression was sometimes difficult to assess. 82.7% of clients did not have formal measures of severity (e.g. BDI) in their case notes. The auditor often needed to make these decisions either through conversations with the care co-ordinator or other evidence within the case notes. It could be suggested that the ambiguity over whether a client has severe, recurrent or treatment resistant depression is not only a problem within this study but for health professionals themselves. If these classifications are unclear, then arguably, health professionals maybe unclear about when to follow particular NICE recommendations. Again further research is needed within this area.

The project has been successful in auditing the extent to which the Trust is compliant with NICE guidelines for the treatment of depression. It has raised a number of important issues which warranted further investigation. Of particular interest to the Trust maybe research into the decision making processes that take place around what treatment a client does and does not receive. This may help produce specific recommendations which address some of
the barriers which prevent guidelines being followed and aid understanding around the
difficulties that health professional have in following NICE guidelines.
REFERENCES


Appendix 1 – Audit Tool.
NICE Baseline Clinical Audit Tool – Adult

Clinical Audit Methodology
- Request new referrals and re-referrals accepted for care between 1st January 2006 and the 31st January 2007
- Select cases where the service user diagnosis is covered by the NICE guidelines and who have had at least two-three months care
- Audit 20 notes per team (from a pool of 25) – Maximum 10 depression cases, Minimum 5 psychosis (Schizophrenia/Bipolar Disorder), Remaining 10 Eating Disorders, PTSD, OCD or additional schizophrenia/bipolar disorder. (Select the audit tool according to primary diagnosis. This should be recorded in the initial assessment letter or discharge summary).
- For each case complete the generic information pages as completely as possible
- Initially collect the data from the service user’s case-notes. Where evidence is not located, seek evidence from the client’s care co-ordinator. Where there is ambiguity, make a written record of the information available in the notes for discussion.

<table>
<thead>
<tr>
<th>Auditors Details:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Auditor:</td>
<td>Date:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Site Details:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Borough:</td>
<td>CMHT/Team</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service User Details:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Audit Number:</td>
<td>Please cross-reference this audit number with users hospital</td>
</tr>
<tr>
<td>the service number in a separate sensitive data table</td>
<td></td>
</tr>
<tr>
<td>Diagnosis:</td>
<td>ICD Code:</td>
</tr>
<tr>
<td>Gender:</td>
<td>Age:</td>
</tr>
<tr>
<td>Ethnicity:</td>
<td>Referral Date:</td>
</tr>
<tr>
<td>Service User details continued:</td>
<td></td>
</tr>
<tr>
<td>--------------------------------</td>
<td></td>
</tr>
<tr>
<td>Is English their first language</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Where appropriate, the service user has been offered access to an interpreter</td>
<td></td>
</tr>
<tr>
<td>Met</td>
<td>Not Met</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>There is a record of the treatment given in primary care</td>
<td></td>
</tr>
<tr>
<td>Met</td>
<td>Not Met</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>If met, record treatment received:</td>
<td></td>
</tr>
<tr>
<td>Has the service user received: (Please tick)</td>
<td></td>
</tr>
<tr>
<td>- Occupational/vocational assessment</td>
<td></td>
</tr>
<tr>
<td>- Physical health checks</td>
<td></td>
</tr>
<tr>
<td>- Information about their current condition?</td>
<td></td>
</tr>
<tr>
<td>- Information about medication, how to take it, side effects?</td>
<td></td>
</tr>
<tr>
<td>Is there an identified carer?</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Standard</td>
<td>Other Comments</td>
</tr>
<tr>
<td>----------</td>
<td>----------------</td>
</tr>
<tr>
<td>Valid Exceptions</td>
<td>Met (Following conversation with the care co-ordinator)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>1.0 Identification and Diagnosis</th>
<th>2.0 Referral to secondary care</th>
<th>3.0 Prescription of an SSRI</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 The service user has received a clear diagnosis</td>
<td>1.2 The service user has had a formal assessment of the severity of their depression using either a self-report questionnaire or rating scale and the results have been documented</td>
<td>2.1 The referrals to secondary care was at the appropriate level of severity and/or lack of response to earlier treatment which is documented</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>3.1</th>
<th>Has the service user been prescribed antidepressants?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>If 'yes' a prescription of an SSRI has been given</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service users who:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Have had previous adverse reactions to SSRIs</td>
</tr>
<tr>
<td>□ Are on other medication that may have interactions with an SSRI</td>
</tr>
<tr>
<td>□ Have evidence of benefit from a non-SSRI when previously treated with an antidepressant</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Standard</th>
<th>Valid Exceptions</th>
<th>Met (Evidenced in Case-notes)</th>
<th>Met (Following conversation with the care co-ordinator)</th>
<th>Not Met</th>
<th>N/A</th>
<th>Other Comments</th>
</tr>
</thead>
</table>

**Note:** - SSRIs (Selective Serotonin Re-Uptake Inhibitors) citalopram, escitalopram, fluoxetine, fluvoxamine, paroxetine, sertraline
| 4.1 | *Has the service user been prescribed antidepressants?*  
If ‘yes’ the service user has been informed that, although the drugs are not associated with tolerance and craving, discontinuation/withdrawal symptoms may occur on stopping, missing doses or occasionally, on reducing the dose of the drug. These symptoms are usually mild and self-limiting but can occasionally be severe. |
| 5.0 | **Combined Treatment for Severe Depression** |
| 5.1 | *Has the service user presented with severe depression?*  
If ‘yes’ a combination of antidepressants and individual long-term psychological therapy (CBT or IPC) have been offered. |
| 6.0 | **Repeated Episodes** |
6.1 Has the service user had two or more depressive episodes where significant functional impairment was experienced?

If 'yes' the service user has been advised to continue antidepressants for two years.

<table>
<thead>
<tr>
<th>Standard</th>
<th>Valid Exceptions</th>
<th>Met (Evidenced in Case notes)</th>
<th>Met (Following conversation with the care co-ordinator)</th>
<th>Not Met</th>
<th>N/A</th>
<th>Other Comments</th>
</tr>
</thead>
</table>

7.0 Treatment-Resistant Depression
| 7.1 | **Has the service user's depression been described as treatment-resistant?**
If 'yes' the service user has been offered one of the following treatment options:

7.1.1 A combination of SSRI or SNRI (e.g. venlafaxine) antidepressant medication with CBT or IPT or (where relevant) couple therapy

7.1.2 A combination of SSRI or SNRI (e.g. venlafaxine) antidepressant with additional augmentation medication including either (a) augmentation of one antidepressant with another or (b) augmentation of an antidepressant with lithium |

| 8.0 | **Psychological therapies**
Has the service user been offered psychological therapy?

8.1.1 CBT
8.1.2 IPT
8.1.3 Couple focused therapy
8.1.4 Mindfulness based CBT |

**Note:** - SSRIs (Selective Serotonin Re-Uptake Inhibitors) citalopram, escitalopram, fluoxetine, fluvoxamine, paroxetine, sertraline
Appendix 2 – SRRP - Evidence of Feedback
To whom it may concern;

Please accept this letter as verification that Martyn Bignold, Fay Coster, Gemma Ellis and Anna Preston, Trainee Clinical Psychologists, each presented their Service Related Research Projects on September 14th 2007. The CMHTs enjoyed the feedback and it sparked an interesting discussion around NICE guidelines and other related projects in the Trust. Their contribution both through the projects and their presentations, was very much appreciated.

Yours Sincerely

Jane Street
Consultant clinical psychologist
Appendix 3 – SRRP – Ethical Scrutiny Form
The nature of the proposed project is such that I am satisfied that it will not require scrutiny by the trust’s ethical committee.

Name of Field/Placement Supervisor: V. Vidalaga

Signature of Field/Placement Supervisor:

Name of Trainee: Gemma Ellis

Title of SRRP: A pilie audit study to investigate a trust’s compliance with NICE guidelines for the treatment of depression within secondary care.

Date: 6/08/07
Abstract of Qualitative Research Project

How do Clinical and Counselling Psychology Trainees construct racism following the events of Celebrity Big Brother Seven?

May 2007
Year 1
Concerns regarding racism on the seventh series of Celebrity Big Brother (CBB7) were highlighted by media when several of the housemates’ comments were interpreted as being racist. Racism has long been of interest to researchers interested in social behaviour. The present study used a focus group and semi-structured interview with eight self-selected clinical and counselling trainees on post-graduate training. It aimed to explore their interpretations of the issues raised in the media following CBB7 and how they shaped their construction of the concept of racism in light of this. Interpretative Phenomenological Analysis (IPA) was used to develop a joint thematic framework. Six main themes emerged: expressions, causes and emotional reactions, British identity, fear of perception and confusion. The main analysis focussed on the themes expressions and causes of racism. Trainees perceived racism as expressed in a variety ways from individual to wider media portrayal and that it could be communicated in a range of ways. They perceived the media portrayal of racism to be narrow with a failure to address wider issues within society such as institutional racism. In relation to causes, participants viewed group boundaries, social change, negative assumptions and ignorance as important in racism. The research further highlighted the concept that racist views are “taboo” and no longer socially acceptable and perceptions that ignorance was an important determinant of racism. The limitations of the use of focus groups in relation to the impact of group dynamics and the possible loss of personal experience (focus of IPA) were reviewed. Implications of the research and clinical practice included the importance of remaining mindful of ignorance in relation to racism when formulating with service users as well as the macro-level concept of racism (e.g. institutional racism).
Major Research Project

A Process of Adjustment: Experiences of Unsuccessful Weight Loss Surgery.

July 2009

Year 3

Word Count: 19988 (excluding numbers in table).
## CONTENTS

Abstract .................................................................................................................................... 134

1. Introduction ......................................................................................................................... 135
   1.1 Overview ....................................................................................................................... 135
   1.2 Background .................................................................................................................. 135
   1.3 Questionable ‘success’ following WLS ................................................................. 137
   1.4 Eating behaviours following WLS ........................................................................... 138
   1.5 Psychological and social adjustment following WLS ............................................ 141
   1.6 Understanding WLS within theoretical frameworks .............................................. 143
   1.7 Rationale ....................................................................................................................... 146

2.0 Method .............................................................................................................................. 148
   2.1 A qualitative approach .............................................................................................. 148
   2.2 Interpretative Phenomenological Analysis (IPA) ................................................... 148
   2.3 Participants ................................................................................................................... 150
   2.4 Development of semi-structured interview questions .......................................... 152
   2.6 Procedure ...................................................................................................................... 152
   2.7 Ethical Considerations ............................................................................................... 153
   2.8 Analysis ........................................................................................................................ 154
   2.9 Credibility checks ...................................................................................................... 155
   2.10 Through the lens of the interpreter ......................................................................... 156

3.0 Results ............................................................................................................................. 158
   3.1 Overview ....................................................................................................................... 158
   3.2 Theme 1; Struggling with multiple explanations of ‘unsuccessful’ weight loss. 160
      3.2.1 A gradual ‘creep up’ of weight........................................................................... 160
      3.2.2 Comfort .................................................................................................................. 162
      3.2.3 Cheating the band ................................................................................................. 163
      3.2.4 Who is in control? ................................................................................................ 166
   3.3 Theme 2. The bringing together of the mind and body .......................................... 169
      3.3.1 A shift in ‘mind set’ .............................................................................................. 169
      3.3.2 Changed Eating behaviours ................................................................................. 170
      3.3.3 The forgotten mind ............................................................................................. 173
   3.4 Theme 3: Adjusting to a new self .............................................................................. 175
      3.4.1 Adjusting to a new external appearance ............................................................. 175
      3.4.2 A shifting identity ................................................................................................. 177
      3.4.3 Adjusting to attention from others .................................................................... 179
      3.4.4 Struggling with excess skin ................................................................................. 180


3.4.5 Was it worth it? ................................................................. 181

4.0 Discussion ........................................................................... 184

4.1 Theme 1; Struggling with multiple explanations of ‘unsuccessful’ weight loss. 185
4.2 Theme 2. The bringing together of the mind and body ................... 187
4.3 Theme 3: Adjusting to a new self ....................................... 189
4.4 Conclusion ........................................................................ 191
4.5 Clinical Implications ......................................................... 192
4.6 Methodological Issues and Future Research Implications ...... 194
4.7 Final Reflection .................................................................. 195

5.0 References ......................................................................... 196

6.1 Appendix 1: Participant Information Sheet ......................... 210
6.2 Appendix 2: Interview Schedule ....................................... 214
6.3 Appendix 3: Consent Form .............................................. 217
6.4 Appendix 4: Demographic form ....................................... 219
6.5 Appendix 5: Debriefing Letter .......................................... 222
6.6 Appendix 6: Ethical Approval Documentation .................... 224
6.7 Appendix 7: Transcript to Illustrate the Process of Analysis  232
Abstract

Obesity is recognised as a major public health concern because of the related physical and psychological difficulties. In light of failed behavioural interventions, Weight Loss Surgery (WLS) is considered the treatment of choice for morbidly obese individuals. However, questions have been raised about the long-term durability of weight loss with some individuals requiring a second WLS. Previous research has lacked an individual focus on how people adjust post WLS both in terms of eating behaviour and the potential psychological impact of dramatic weight loss. No study has exclusively looked at individuals that have had more than one form of WLS.

This qualitative study aimed to explore participants’ understanding of unsuccessful weight loss surgery (WLS). In-depth, semi-structured interviews were conducted with five participants (female n=4, male n=1). All participants had undergone a laparoscopic gastric banding (LABG) which had taken place between 3.5 -10 years ago. Weight loss following LABG was defined as unsuccessful if weight had either been re-gained post surgery or weight loss has been minimal enough to warrant further WLS. All participants had a second form of WLS (gastric by-pass n=3, sleeve gastrectomy n=2) between 1.5 - 7 years post LABG and achieved more successful weight loss.

The interviews were analysed using Interpretative Phenomenological Analysis (IPA). It was found that participants struggled with multiple explanations of weight gain after the first surgery with explanations of control shifting from the self, to others and the surgical mechanism. Food continued to be used to self-regulate emotions but in an altered way because of the restrictive nature of the surgery. Following the second surgery, participants understood successful weight loss as a ‘bringing together of the mind and body’ and they explained how the process of WLS tended to treat the body but silence the self. In order to produce behavioural change, participants described the mind being ‘in gear’. Following dramatic weight loss, participants struggled to adjust to a new appearance. Weight loss caused a number of vulnerabilities that could produce tensions between an old and new self. It appears that how well individuals adjust to WLS in terms of eating behaviours and a new appearance/self is particularly important in that this may be related to more successful outcomes. The results suggest that research should focus less on predictors of postoperative weight loss and more on improving postoperative guidelines and psychological interventions.
1. Introduction

1.1 Overview

Obesity is recognised today as being a major public health concern because of the related physical and psychological difficulties to the individual and the cost to health services. In the light of failed behavioural and medical interventions Weight Loss surgery (WLS) is considered the treatment of choice for morbidly obese individuals (NICE 2006). However questions have begun to be raised about the long-term durability of weight loss following surgery with some patients either showing no substantial weight loss or weight regain over time. The present study aims to explore participants’ understanding of unsuccessful WLS and requiring a second surgical procedure. The introduction will outline the current research in relation to obesity and WLS and introduce theoretical models that have been used to understand weight gain, regain and maintenance.

1.2 Background

The World Health Organisation (WHO) describes the increasing rates of obesity as a ‘global epidemic’ impacting both industrial and developing countries (WHO 2003). WHO (2006) projects that by 2015, approximately 2.3 billion adults will be overweight and more than 700 million will be obese. In the UK there are 9,000 deaths a year caused by obesity related illnesses (NAO, 2001). Adult obesity rates have almost doubled over the last 15 years, and a quarter of UK adults are now considered obese (24% of men and 24% of women) (McPherson et al 2007).

Overweight and obesity are defined as abnormal or excessive fat accumulation that may impair health (WHO 2006). Excessive fat is usually estimated by the body mass index (BMI), which is calculated as weight divided by height squared (Bray, 1998). WHO (2006) has defined ‘overweight’ as a BMI equal or more than 25 and ‘obesity’ as a BMI equal to or more than 30, as has the National Institutes of Health/National Heart, Lung and Blood Institute (NIH/NHLBI 1998). This criteria for defining obesity was selected principally on the basis of the strong relationship between BMI and mortality. At a BMI equal or greater than 30 mortality increases by 30% and at a BMI equal to or above 40...
this rises to 100% (Manson et al. 1995). Obesity is associated with a number of physical health problems including cardiovascular disease, type two diabetes and several cancers (Pi‐Sunyer 1993, House of Commons Health Committee Report, 2004). There has also been an increasing emphasis on psychological difficulties associated with obesity including depression and low self‐esteem (Bocchieri et al., 2002a; Ogden, 2003) as well as negative social consequences such as prejudice, social isolation, discrimination and difficulties in intimate relationships (Torgerson & Sjostrom, 2001). The demographic profile of morbidly obese women tends to include low education and income and high rates of poverty. Lower rates of marriage are found in both obese men and women (Gortmaker et al. 1993).

In 1991 the National Institutes of Health Consensus Development Conference panel met to address obesity treatment in the context of an increasing obesity prevalence and failure of behavioural and pharmacological treatments to demonstrate both substantial and long‐term weight loss (Vaidya 2006). Weight loss programmes have been shown to produce modest results with many individuals unfortunately tending to regain weight (Elfhag & Rossner, 2005). The 1991 panel recommended bariatric surgery to be considered for well‐informed, motivated, severely morbidly obese individuals (BMI equal or greater than 40) and for moderately obese individuals (BMI 35 or greater) with high‐risk co‐morbid conditions and this continues to be recommended by the National Institute of Clinical Excellence (NICE 2006).

The laparoscopic gastric banding (LAGB) and the laparoscopic Roux‐en‐Y gastric bypass are the most widely used procedures in the US and Europe (Nguyen et al. 2006). These procedures are known as gastric restriction operations and involve a surgically reduced stomach capacity (ibid). They both come under the umbrella term of Weight Loss Surgery (WLS). The operations require the individual to change their eating habits dramatically with postoperative diets having extremely strict guidelines, such as only eating three small meals a day, eating very slowly, avoiding high fat foods and liquid with meals (Bocchieri et al. 2002a). Interestingly there is a gender ratio of 4:1 women:men, undergoing WLS (Bocchieri et al. 2002a). It has been suggested that this may be due to women feeling more socially stigmatised by their size (ibid).
1.3 Questionable ‘success’ following WLS

Although WLS is still considered the treatment of choice for morbid obese individuals (NIHC 1996, NICE 2006) and is currently one of the most frequently performed procedures in the US and Europe (Nguyen et al 2005), questions have begun to be raised about the long-term durability of weight loss following surgery, particularly at 18-24 months post surgery when research indicates that a substantial proportion of individuals begin to regain lost weight (Hsu et al 1998). In a review of 45 studies Bocchieri et al (2002a) concluded that long-term follow-ups of individuals post WLS had not demonstrated successful maintenance of weight loss. Studies continue to find that not all clients achieve a successful weight outcome or are able to maintain weight loss following WLS (Buchwald et al 2004, Larsen et al 2004). Herpertz et al (2004) carried out a review of the literature and reported that 30% of clients regain weight post surgery and Magro et al (2008) recently found that some weight regain was observed in approximately 50% of the clients (46% within 24 months and 63.6% within 48 months). In addition Muller et al (2008) was the first study to compare quality of life after LAGB vs. bypass. Interestingly during the study period of 3 years they found that 30% of all clients operated with LAGB had the band removed and were converted to a bypass procedure. This was due to poor weight loss with the band. Such a high portion of clients needing to convert from a LAGB to bypass was not known or anticipated. No understanding around insufficient weight loss with the band is offered by Muller et al (2008) or the potential impact of requiring a further operation.

The literature tends to define ‘success’ following WLS in terms of weight reduction, a reduction in comorbid conditions and an improvement in quality of life (Herpertz et al 2004). Research has demonstrated success in these three areas following WLS (ibid) but has been criticized for focusing only on years 1-2 as a measure of outcome (Niego et al 2007). Long-term follow up studies within the field are lacking and therefore the long-term benefits of WLS remain questionable. For example Bocchieri’s et al (2002a) review suggests that the psychological benefits found at 6 months were not maintained at 2-3 years post surgery. Bocchieri et al (2002a) advocates the importance of research looking at outcome post 3 years in order to understand which effects are stable or temporary. In addition it has been found that healthier eating behaviours and the
frequency of physical exercise post WLS decrease over time, suggesting long term follow up is important (Mathus-Vliegen 2007). Indeed it has been proposed that 2 years post surgery should be considered an ‘interim’ time period for measuring outcomes (Torgerson & Stostrom 2001) yet most research on WLS takes place within this period.

In a reaction to growing evidence that WLS does not work for everyone research has attempted to understand this variability by concentrating on pre surgical factors that may predict poorer weight reduction. However results are inconclusive with economic status, class, mental health difficulties and personality characteristics not being predictive of postoperative weight outcome (Latner et al 2004, Larsen et al 2004). Some research has suggested that age is an important predictor with younger individuals tending to do better post surgery (van Hout et al 2005) although Singhal et al (2009) recently found being 50 years old or above does not influence outcome in WLS. At what point weight was gained has been considered important with earlier onset resulting in better results following surgery (van Hout et al 2005). Colles et al (2008) found that at 12 months the strongest predictors of weight loss following LAGB included a higher baseline BMI, lower rating of subjective hunger, high quality of life related to physical functioning and leisure activities. However research has produced contradictory results and consistent pre surgery predictors of longer term weight loss post WLS are yet to be established (Herpertz et al 2004).

1.4 Eating behaviours following WLS

One area that has received increasing attention to help explain the variability in weight loss following surgery is the individual’s eating behaviour. It is now appreciated that weight loss following WLS is dependant on modification of behaviour to bring about long-term changes in energy balance (Colles et al 2008). Difficulties complying with post operative eating guidelines have been linked to poorer weight loss or weight regain (Rusch & Andris 2007). It is becoming more widely understood that some individuals continue to have ‘maladaptive and psychologically distressing eating behaviour’ post WLS (Niego et al,p356, 2007).
It has been found that 40% of individuals seeking WLS would identify themselves as ‘emotional eaters’ (eating in response to emotions rather than hunger) (Walfish, 2004). Yet, interestingly research exploring the impact of WLS and previous tendency of eating in response to emotional cues is limited. It has been suggested that ‘emotional eaters’ have difficulty articulating negative emotions and eating may act as a transient shelter to avoid confronting those emotions (Glinski et al 2001). Similarly the mood modification theory of overeating (Polivy and Herman 1999) suggests that individuals may eat as a way of shifting responsibly of their negative mood from uncontrollable aspects of their lives to their eating behaviour. It has been suggested that eating in response to emotions is reduced post WLS as eating high-fat food leads to the negative consequence of nausea or vomiting (Rusch & Andris 2007). Again the studies tend to have short-term follow ups with Torgerson & Stostrom (2001) finding that at 6 months post WLS individuals reported less hunger and increased restraint. Fischer et al (2007) found when comparing ‘high’ and ‘low’ emotional eaters pre and post surgery that emotional eating was not predictive of surgical outcome at 8 months. However Fischer et al (2007) acknowledges that the 8 month follow-up time may not have allowed pre surgical eating behaviours to reoccur.

Conversely, Saunders (2004) reported that for some people difficulties with adjusting to the restrictions of surgery left individuals more likely to over eat post surgery. In a twelve week support group post surgery individuals reported being less able to use food to avoid emotions. This in turn triggered a return to uncontrolled eating post- surgery but in an altered way because of the stomach’s smaller capacity. Saunders found that individuals would ‘graze’ which involves eating small amounts of food over a period of time accompanied by feelings of loss of control. Colles et al (2008) writes that further understanding, recognition and management of those that engage in non-hungry eating appears important to optimise weight loss and psychological well-being post WLS (Colles et al 2008).

It is interesting that for many years the fields of eating disorders and obesity have been considered separately but recently their connection has become more evident (Saunders 2004). Although there is continuous debate within the literature about what constitutes an ‘eating disorder’ and whether these should be understood as distinct categories or seen on a continuum including eating behaviours such as dieting and binge eating which
are common within western society (Saunders 2004). Yardley (1999) writes that new bodily conditions can develop 'as the socio-cultural and physical aspects of existence feed into one another' (Yardley 1999, p41). Yardley (1999) gives the example of conflicting social pressures to both eat and stay slim, together with increasing 'medicalisation' of diverse forms of behaviour, produce new eating 'disorders' such as Binge Eating Disorder (BED).

BED is now understood as a serious and prevalent disorder that has particular relevance for WLS clients (Saunders 2004). BED is defined in the DSM-IV as binge eating (BE) where an individual would consume in a period of time an amount of food that is 'definitely larger' than most people would eat in the same time period in the same circumstances. The behaviour is accompanied by a feelings of a loss of control over eating followed by self-recrimination and feelings of distress, with no compensatory behaviour. To meet the criteria this needs to occur twice a week for a period of 6 months (DSM-IV, 1994).

BED has been found to be one of the most prevalent psychiatric disorders in individuals having WLS (Saunders, 2004), with estimates of 30% of individuals presenting for weight loss surgery meeting the criteria for BED as compared to 2% of the general population (Saunders 1999). It has become clearer that continued maladaptive eating behaviour after surgery, such as binge eating, is likely to contribute to unsuccessful weight loss following WLS (Niego et al 2007). However the relationship between pre-identified BE and WLS outcome has produced some mixed results in the literature. Niego et al (2007) explain that the results depend on at which point the client is followed-up. It appears that BE tends to re-emerge at 18-24 months post-surgery often following a period of good weight loss or a 'honeymoon' stage (Niego et al 2007). Better initial weight loss for clients with BE after WLS has been understood in that these individuals are likely to have larger stomach capacity and therefore the restrictive nature of WLS yields greater results initially (Niego et al, 2007).

There is some debate whether BE should be defined by the amount eaten or whether the sense of a loss of control over an eating episode may be more of a defining feature (Telch et al,1998). Saunders (2004) found that grazing post WLS can often be accompanied by feelings of a loss of control. Saunders (2004) and Niego et al (2007) both propose that after WLS that an assessment of BE should focus less on consumption
and more on a subjective loss of control over eating. It is hoped that if BED is identified then possible interventions can be used to improve outcome post-surgery. BE has also been connected to a history of weight-cycling (Pekkarinen et al 1994) and would reflect prior failures often identified in maintaining weight loss (Elfhag & Rossner, 2005). Surgeons report some attempt to screen for BED before WLS but practice tends to vary widely about how it is identified and the following decisions and management afterwards (Devlin et al 2004).

1.5 Psychological and social adjustment following WLS

As a further means to explain the success or failure of WLS some research has explored the role of psychological and social adjustment. For example, Sabin’s et al (2005) best practice recommendations suggest that individuals should be prepared for the potential impact of surgery on relationships and ‘common’ psychological adjustment issues. However the literature is not clear as to what those potential impacts are and which individuals should expect which outcomes (Wolfe & Terry, 2006). Two extensive literature reviews (Hout et al, 2005; Herpertz et al, 2003) were unable to identify any consensus on predictors of psychological outcome.

Many studies have focused on preoperative psychopathology, particularly individuals with a diagnosis of depression or personality disorder; however such studies have found no consistent associations between the quality of weight loss and psychological adjustment post surgery (Wolfe & Terry, 2006). General psychopathology tends to decrease following surgery but appears to do so independently of the degree or rate of weight loss (ibid). Although other research suggests that the greater the weight reduction, the greater the improvements in coping ability, distress levels and mood disorders (Ryden et al, 2003). This again highlights the inconsistencies within the literature.

There is limited insight in adjustment issues post surgery regarding for example relationship with others, occupation and general satisfaction with outcome (Wolfe & Terry, 2006). With regards to romantic relationships the literature is mixed (Hafner et al, 1991, Kinzl et al 2001). The few studies examining occupational status tend to report
improvements (Herpertz et al 2003) and almost all studies asking about outcome report a general satisfaction post surgery (Wolfe & Terry, 2006).

However Bocchieri et al (2002b) ask if dramatic weight loss has 'unequivocally positive benefits and if the individual is surgically reconstructed in order to physically regain control over their weight, then how do we explain the finding that a significant number of patients do not succeed in reaching goal weight or in maintaining postoperative weight loss?' (Bocchieri et al; p787, 2002b). In her interviews of individuals that have had WLS Bocchieri et al (2002b) explains that contrary to many popular and researcher assumptions weight loss does not exclusively result in positive changes. In fact there are a number of challenges with regards to how the individuals see themselves and others which create a number of tensions that are not always resolved. It appears that there is a need to identify potential difficulties in adjusting to life following surgery in order to improve the likelihood of successful outcome following WLS.

Byrne et al (2003) compared maintainers to weight regainers in a qualitative study finding that satisfaction with current weight/shape (i.e. meeting an anticipated goal) increased weight maintenance behaviours. Other goals that were hoped to be achieved through weight loss e.g. increase in self-esteem, improved health and appearance also tended to have been met by the maintainers. Similarly Bocchieri et al (2002b) found that individuals that felt disappointed by the effects of weight loss and lacked the quality-of-life gains would have little justification to follow strict dietary guidelines. Zijlstra’s et al (2009) recent qualitative study found that individuals were disappointed with their postoperative outcome in terms of weight loss. They found that some individuals were unaware of their own role in maintaining weight loss while others were aware but struggled to turn awareness into action.

Kinzl et al (2002) found that the majority of individuals are interested in psychological support post WLS in adjusting to new eating restrictions, the risk of developing new eating disorders, changes to self-esteem as a consequence of weight loss and difficulties with problem solving abilities. This is concurrent with authors that have found that individuals can struggle to adjust to a new body size post surgery (Delin et al 1995). However what remains to be fully understood is the impact of significant weight loss following WLS on the psychological well-being of individuals (Bocchieri et al 2002a).
Therefore although WLS can result in weight loss maintenance not all individuals show this pattern of weight change. To address this, research has explored the role of eating behaviour and psychological adjustment. In a further attempt to understand this variability WLS can be explored within the context of a number of different theoretical frameworks which will be considered now.

1.6 Understanding WLS within theoretical frameworks

Research has suggested that through partaking in WLS individuals may be seeking external control for their eating behaviour in the mechanism of the surgery itself (Ogden et al 2006). However it is becoming understood within the field that weight loss following surgery is not only dependant on the sufficiency of the procedure (Larsen et al 2006). Indeed, successful weight loss depends on the degree to which individuals successfully adopt healthy and enduring dietary changes (Zijlstra et al 2009). To avoid vomiting, food intolerance and ‘dumping syndrome’ (sweating, palpitations, headaches, nausea) there must be dramatic changes to eating habits which involve smaller portions and avoidance of some foods. Lifelong medical monitoring is also necessary as WLS involves a large change in life style (Ryden et al 2003).

The ability to change behaviour in this way is entwined with beliefs about one’s capacity to control eating and weight gain. Behavioural actions needed to manage health threats depends on self-regulation cognitions; the belief in one’s capability to regulate health behaviour and the course of a condition (Leventhal et al 1998). The self-regulation model by Leventhal et al; common sense model (CSM) distinguishes five cognitions that an individual is likely to hold about a condition 1) Identify the label given to the condition and symptoms (obesity), 2) time-line; the belief about how long the condition might last, which is likely to be re-evaluated as time progresses, 3) cause; the putative cause, such as stress, genes and overeating. Such representations will be based on personal experience and common discourses of significant others, health professionals, and the media. 4) Consequences: the individual’s belief about the condition will impact them physically and socially and lastly 5) Curability/controllability: the beliefs about whether the condition can be cured or
controlled and the individual’s role within this. Such cognitions are linked to the behavioural actions of the individual.

Another important self-regulation cognition is self-efficacy, the judgment of one’s capability to manage life obstacles and accomplish a desired effect such as regulating one’s eating behaviour (Bandura et al 1982). Glynn and Ruderman (1986) developed the eating self-efficacy questionnaire to measure overeating. The emphasis is on a ‘motivational collapse’ that suggests overeating is a result of failed self-control (Ogden 2004). Self-efficacy regarding weight loss, the ability to handle emotions and life situations and exercise have all been related to weight loss maintainers (Elfhag & Rossner 2005). Weight maintainers have shown a higher level of confidence in their ability to manage their weight than individuals that regain weight following a weight loss programme (DePue et al 1995). Eating behaviour self-efficacy has also been found to be predictive of weight loss after dietary interventions (Roach et al 2003, Martin et al 2004, Wamsteker et al 2005).

The results of Zijlstra’s et al (2006) study suggest that WLS strongly changes individuals’ beliefs about their capability to regulate eating behaviour. Zijlstra et al (2006) found that before WLS individual’s self-regulation cognitions reflected helplessness and pessimistic states associated with ‘learned helplessness’ (Seligman 1975). Research has demonstrated by the time individuals come for WLS they have tried a number of different behavioural and pharmacological interventions to lose weight but with little long term gain (Ogden et al 2006, Zijlstra et al 2009). In fact in order to qualify for obesity surgery individuals will have had to have tried a number of different interventions that have subsequently produced poor long term results (NICE 2006). Some individuals have thus viewed needing WLS as further evidence of failure as not being able to achieve results on their own (Bocchieri et al 2002b). It is therefore not surprising that individuals’ cognitions are associated with ‘learned helplessness’ as they have learnt that their repeated efforts to lose weight have failed and that the situation seems unchangeable before WLS (Zijlstra et al 2006).

The process of WLS, however, seems to produce a number of cognitive shifts for some individuals. Ryden et al (2003) reported shifts in coping styles from emotional-focused to problem-focused following weight loss post-surgery. This shift in thinking could contribute to behavioural change and therefore greater weight loss (Ryden et al 2003).
Similarly Zijlstra et al (2006) found that after WLS three self-regulation cognitions from Leventhal’s et al common sense model had changed in a positive way. Individuals were more confident about their eating behaviour self-efficacy, less negative about the changeability of their obesity and they perceived a reduced psychological impact of their obese state. They concluded that these changes in self-regulation may affect the outcome of WLS. It has been demonstrated that self-efficacy and optimism in terms of expectancy are related to positive behavioural changes such as avoiding fatty food (O’Hea et al 2004), increased physical activity (Wilbur et al 2005) and reducing alcoholic drinks (Blume et al 2003).

Self-efficacy can be understood as having some resemblance to internal locus of control (Holt et al 2001). Locus of control refers to the degree to which people believe that their own behaviours determine the outcome of their lives (internal locus of control), as opposed to chance or impact of other people and external events (external locus of control). Internal locus of control measured by the weight locus of control scale (Saltzer 1982) has been associated with having more confidence in weight loss behaviours. Whereas external locus of control was related to perceiving external reasons for being overweight such as perceiving barriers to physical exercise and being unhappy with the level of social support received (Holt et al 2001). Most recent trials continue to indicate that internal locus of control is beneficial with regards to weight loss and weight management; not one study to date has shown that external locus of control is more beneficial in terms of weight loss (Teixeria et al 2005).

Models used to understand overeating and weight loss cycling may be a useful framework of understanding why some clients struggle to maintain weight loss following WLS. The causal analysis of overeating (Herman and Mack 1975) suggests that restricting intake paradoxically increases the likelihood of overeating. In attempt to explain this model Herman and Polivy (1984) developed the ‘boundary model of overeating’ where it was found that individuals that are attempting to restrict intake replace physiological hunger control with cognitive control. They explain that the restrictor can maintain a low calorie intake as long as limits or boundaries set by the individual are not pushed. At this point with a dichotomous thinking style the restrictive eater may eat something that is ‘not allowed’. With this boundary broken food is then consumed until satiety boundaries are activated. This model proposes a form of dual
regulation; with food intake limited by either the individual’s boundaries or satiety boundaries (Ogden 2004). The model has been used to understand binge eating with cognitive boundaries being replaced by the boundaries set by physical capacity.

Such cognitive shifts have also been related to a break down of self control and reflect a passive model to eating; ‘the what the hell effect’ as suggested by Herman and Polivy (1984) with a sense of giving in to the overwhelming desire to eat. However an alternative model is offered by Ogden and Wardle (1991) who suggest that ‘the what the hell effect’ is not a passive process but a reactive reaction against the self-imposed food restrictions. In this model the individual may actively decide to overeat as a ‘rebellion’ against the imposed boundaries.

1.7 Rationale

To conclude, the majority of studies initially focused on weight loss and psychological improvements following WLS within the first 1-2 years. The results were promising and WLS surgery became considered the treatment of choice for morbidly obese individuals. However it has become clear that WLS did not work for everybody and that between 18-24 months some clients started to regain weight (Torgerson & Stostrom 2007). To understand this variability research has tended to focus on what individual factors may predict good outcome but with inconclusive results (Herpertz et al 2004). It is now appreciated that weight loss following WLS is dependant on modification of behaviour to bring about long-term changes in energy balance (Colles et al 2008). Adjusting to new eating behaviours has been found to be difficult for many individuals and that previous dysfunctional eating patterns reoccur after WLS (Niego et al, 2007). Such research has started to broaden our understanding regarding adjusting to an imposed restricted intake however this research is still very much within its infancy and calls for further understanding.

In addition the vast majority of studies have used quantitative measures in an attempt to assess what researchers ‘assumed to be the constructs associated with psychosocial outcome of surgery’ (Bocchieri et al, 2002). These studies typically do not allow for a heterogeneity of individual’s responses meaning that the individual’s experience is only
partially understood. What still remains unclear is the extent of the psychosocial impact of surgery and the way that this is may be related to the ability to maintain weight loss. Only one study to date has looked solely at individuals experiences of ‘unsuccessful’ surgery in terms of weight loss (Zijlstra et al 2009). Although it appears that 30% of individuals need two forms of surgery to achieve sufficient weight loss (Muller et al 2008), no study has exclusively looked at individuals that have had more than one form of WLS.

Indeed within the literature there is a lack of focus on individuals’ adjustment to WLS both in terms of eating behaviour and in terms of the potential psychological and psychosocial impact of dramatic weight loss (Bocchieri 2002a). Bocchieri (2002a) suggests that within the field there is a research bias that prevents such experiences being fully understood. This may represent a wider cultural bias of contemporary western society that tends to see the ‘fat body’ as a problem that needs to be solved (Thorsby 2007). Common discourses of an ‘epidemic’, an obesity crisis and individual moral responsibility in terms of obesity predominate (Thorsby 2007). WLS within this context is understood as the most effective tool against the “war on obesity” and to challenge its effectiveness may create anxiety.

However to develop understanding of all aspects of WLS is imperative in terms of explaining the variability of results and developing and improving interventions. A qualitative approach allows an exploration in detail and is particularly useful when the variables associated with an outcome are unclear or poorly understood (Fitzpatrick & Boulton 1996).

1.8 Research Aims; The study aims to gain an in depth understanding of individuals’ experiences of ‘unsuccessful’ weight loss surgery requiring further surgery.

1.9 Research Question; The study was designed to answer the following broad question:

How do individuals that experience ‘unsuccessful’ WLS and require further surgery make sense of this experience?
2.0 Method

2.1 A qualitative approach

A qualitative approach was chosen to enable the researcher to gain a rich understanding and analysis of how individuals who experience unsuccessful Weight Loss Surgery (WLS) and require a second operation make sense of this experience. Requiring two forms of WLS is an unexplored area within the field therefore a qualitative research method is recommended to offer insight about phenomena that is unavailable elsewhere (Silverman 2006).

Most qualitative research methods share the assumption that there is no ‘objective’ reality or universal truth. The assertion is that they are underpinned by the belief that knowledge, and the processes which lead to its production are context specific (Lyons, 2000; Willig, 2001). It is based upon a relativist constructivist ontology which assumes multiple realities are generated by human beings who experience a phenomenon of interest (Krauss, 2005). The goal of qualitative research aims to understand and explore the meaning that participants attribute to the phenomenon under investigation; in this study, for example obesity, weight loss surgery, weight change and adjustment. Interpretations of these experiences are influenced by the interaction between the participant and researcher.

2.2 Interpretative Phenomenological Analysis (IPA)

In this study Interpretative Phenomenological Analysis (IPA) was used and its epistemology fitted the aims of the study. IPA was developed within health psychology and is underpinned by ideas from two branches of philosophical thought: phenomenology and hermeneutics (Smith & Eatough, 2006). These contribute to the knowledge that IPA aims to produce, or its epistemology. Phenomenology is a philosophy initiated by Edmund Husserl in the early twentieth century and is centred on
the way people perceive, experience and gain knowledge of the world within their particular social, cultural and historical contexts (Willig, 2001). The approach places more emphasis on the individual’s personal perception of an event rather than an objective statement of the event, or the event itself (Smith, Jarman & Osborn, 1999). It is assumed that it is possible for different individuals to experience the same phenomenon in a number of varied ways (Lyons & Coyle 2007). It is also assumed that by interviewing clients about their experiences, the researcher would gain insight into the client’s perceptions on WLS. IPA holds the assumption that there is a connection between what the participant says, thinks and feels. Such connections can be complex however this still enables the researcher to interpret a participant’s emotional state. IPA is thus considered particularly useful when one is concerned with complexity (Smith & Osborn, 2003).

IPA also adopts the hermeneutic approach which advocates that meaning is hidden and is accessible through reflection. Smith & Osborn (2008) writes that IPA involves a double hermeneutic process in which interpretation occurs both within the individual’s understanding of their experience and also with regards to the researcher’s interpretation of meaning from the individual’s account. As such it can not be understood as a truly objective process, the understanding of the data will be coloured by what the researcher brings to the meaning making. This is not considered undesirable but a necessary precondition of making sense of the participant’s meaning (Ahern, 1999). The process of interpretation therefore involves a dynamic interaction between the participant and the researcher.

One of the key aims of IPA is to explore in detail how participants view the phenomena under investigation while considering socio-cultural and historical influences on interpretation. The focus on how experiences are made meaningful and understanding the uniqueness of the person’s experience fits well within the aim of this study.
2.3 Participants

Purposive sampling was used to identify a homogenous group for whom the research question had significance (Smith & Osborn 2003). Five participants (four female and one male) were recruited who had all undergone two different forms of WLS in a London based obesity clinic. All participants had undergone a LABG which had taken place between 3.5-10 years ago. Weight loss following LABG was defined as unsuccessful if weight had either been re-gained post surgery or weight loss has been minimal enough to warrant further WLS. All participants had then undergone a second form of WLS (gastric by-pass n=3, Sleeve gastrectomy n=2) following the original LABG. At the time of the first operation participants had all fallen under eligible criteria for WLS, according to NICE (2006), with an initial BMI of 40 kg/m² or more putting them within the ‘morbidly obese’ category (BMI ranged 45.65 -66.81). All participants had long term weight difficulties for 34 years or more (ranged 34 -40 years). Participants ranged in age from 50-56 (mean age 53) and four participants defined themselves as white British and one as black British/Caribbean (See Table 1 for further details).

An idiographic method assumes small sample sizes (Brocki & Wearden, 2006) with Smith & Osborn (2003) advocating that there is no correct sample size when using IPA. However in order for a researcher to hold complex ideas within their mind and usefully make sense of the data Smith et al (1999) suggests 7 participants, plus or minus 2.

Within the obesity clinic twelve participants (approximately 15% of clients from the database) were identified as eligible for the study. These participants were contacted by telephone and asked if information regarding the study could be sent to them by post or email (See Appendix 1). All those that volunteered (n=5) to participate in the study were interviewed.
Table 1 – Participant’s Demographics

<table>
<thead>
<tr>
<th>Names Anonymised</th>
<th>Gender</th>
<th>Age</th>
<th>Ethnicity</th>
<th>Marital Status</th>
<th>Current Occupation</th>
<th>Height</th>
<th>Weight Pre LAGB (Stone / BMI)</th>
<th>Lowest Weight After LAGB (Stone)</th>
<th>Time between 1st &amp; 2nd WLS yrs</th>
<th>Weight Before 2nd WLS (Stone)</th>
<th>Current Weight After 2nd WLS (Stone / BMI)</th>
<th>Time Since 2nd WLS (yrs)</th>
<th>Length of time Overweight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ruth</td>
<td>Female</td>
<td>51</td>
<td>Black British/Caribbean</td>
<td>Single</td>
<td>Nurse</td>
<td>5ft 7</td>
<td>24 / 52.6</td>
<td>20</td>
<td>4 years</td>
<td>26</td>
<td>17.5 / 38.5 (by-pass)</td>
<td>1.5 years</td>
<td>Since 1975 when went into nursing (17 years old)</td>
</tr>
<tr>
<td>Jane</td>
<td>Female</td>
<td>50</td>
<td>White/British</td>
<td>Married</td>
<td>Teacher</td>
<td>5ft 4</td>
<td>26.5 / 63.5</td>
<td>23.5</td>
<td>1.5 years</td>
<td>23.5</td>
<td>17 / 40.9 (by-pass)</td>
<td>3 years</td>
<td>Since Childhood 10 years old</td>
</tr>
<tr>
<td>Pam</td>
<td>Female</td>
<td>56</td>
<td>White/British</td>
<td>Married</td>
<td>Unemployed</td>
<td>5ft 6</td>
<td>30 / 66.8</td>
<td>27</td>
<td>1.5 years</td>
<td>30</td>
<td>15.5 / 35.2 (by-pass)</td>
<td>2 years</td>
<td>Since 19 years old. After 1st child</td>
</tr>
<tr>
<td>Dawn</td>
<td>Female</td>
<td>56</td>
<td>White/British</td>
<td>Married</td>
<td>Clinical team leader in ED unit</td>
<td>5ft 4</td>
<td>19.5 / 45.7</td>
<td>15</td>
<td>7 years</td>
<td>17</td>
<td>14 / 33.6 (sleeve)</td>
<td>3 years</td>
<td>Since 19 years old. After 1st child</td>
</tr>
<tr>
<td>Robert</td>
<td>Male</td>
<td>52</td>
<td>White/British</td>
<td>Married</td>
<td>IT Systems Engineer.</td>
<td>6ft 1</td>
<td>29.5 / 54.6</td>
<td>26</td>
<td>1.5 years</td>
<td>26</td>
<td>15 / 27.7 (sleeve)</td>
<td>2 years</td>
<td>Since 14 years old.</td>
</tr>
</tbody>
</table>

151
2.4 Development of semi-structured interview questions

The semi-structured interview (Appendix Two) was developed through conversations with the researcher’s field supervisor who has experience of conducting research within the obesity field and with the surgeon based within the obesity clinic. The literature review highlighted that limited research had explored unsuccessful weight loss surgery in terms of weight loss and psychological and social adjustment and no research had exclusively looked at individuals needing two surgical interventions. Acknowledging these gaps within the literature, a number of broad areas were identified to be covered through the interview (see below). Questions and prompts were developed and revised through a feedback process. A service user, separate from the research, that has had WLS was identified and the suggested questions were discussed. As a result the term ‘Obesity surgery’ in the interview and information was replaced with ‘Weight Loss Surgery’ (WSL) as it was felt to be a less judgmental term.

2.5 Broad Areas covered in Interviews (see Appendix Two for Interview Questions)

The areas covered in the interview were: personal weight history; previous weight loss experiences before surgery; experience of both first and second WLS (operation, eating, relationship with food, weight loss/gain post WLS).

2.6 Procedure

Interviews were conducted at the participant’s obesity clinic in a private consultation room. A semi-structured interview was used in order to allow flexibility to explore the individual’s experience whilst enabling the participant to remain the expert with regards to their experience of WLS (Smith & Osborn 2003). Prior to the interview each participant had received an information sheet (Appendix One). This was then given to
each participant again on the day of the interview to ensure there was an opportunity for questions to be asked. Participants were then asked to complete the consent form (Appendix Three). The researcher decided the demographic form should be completed at the end of the interview once a rapport had been built as this included sensitive questions regarding weight loss and regain (Appendix Four).

In order to build trust and rapport a broad open ended question was used initially around initial weight gain. The aim of the interview process was to enable the participant to feel open and relaxed and to talk freely regarding their experience of WLS. The role of the researcher was to guide the interview with minimal prompting. The flexibility with regards to the questions is recommended in order to enable a deeper understanding and a more valid representation of the participant’s experiences (Sidani & Sechrest, 1996). At the end of each interview a debriefing letter (Appendix Five) was given to each participant. Each interview lasted between 40 to 90 minutes. All interviews were audio-recorded and transcribed. All identifying information was anonymised.

2.7 Ethical Considerations

Ethical approval for the research was gained from the NHS Local Research Ethics Committee (LREC), the Research and Development (R&D) Committee and Surrey University Ethics Committee (Appendix Six).

Participants were aware that the interviews were being audio taped and that anonymity would be ensured. They were also told that they were free to withdraw from the research at any point and that this would not affect the treatment they received within the clinic.

When applying for ethical approval it was acknowledged that participants may find talking about their WLS distressing due to the personal and sensitive area of interest. Debriefing was offered after each interview and information regarding further psychological support was requested by one participant. The researcher’s email address
was given in a debriefing letter if further questions/concerns arose following the interview. In practice this additional means of information was not required by participants.

2.8 Analysis

IPA (Smith & Osborn, 2003) was used to analyse the data. An idiographic approach to analysis was used, beginning with particular examples and slowly working up to more general categorisation or theory (Smith et al., 1999; Smith & Osborn, 2008). The analysis began by reading one transcript in detail before reviewing the others. This first transcript was read a number of times and the left hand margin was used to highlight points of interest, summarise concepts and connections. Smith & Osborn (2008) advocates that at this stage, it is important to read and re-read the transcript in order to become as intimate as possible with the material as each reading may well highlight new insights.

The researcher then used the right hand margin to document and abstract the emerging themes from the initial notes, using psychological concepts to aid understanding (Eatough et al., 2008). Smith & Osborn (2008) advises that at this stage, all of the data is deemed important and no attempt should be made to discriminate or focus upon particular sections of the account.

The next stage involved listing all the emerging themes from the first transcript. This is an intense process as the researcher needed to continue to stay as close as possible to the text and while applying their own interpretation. It was important to stay continually reflective during this process (Smith et al. 1999). To aid transparency (Yardley 2000) please see Appendix seven for an example transcript.

The next stage was to try and structure the many ideas and concepts from the account into a logical order. To do so, a master table of themes was created with both superordinate themes and subthemes below. As the table was created, each theme was validated once more with the text to ensure that it was fully represented in the account so that the researcher's own bias did not distort this selective process.
Once the master list from the first transcript reached a Gestalt state, in that the researcher was comfortable that little more iteration and consolidation could be completed, the researcher continued onto to complete the same process with all the remaining four transcripts. All the master lists were then read together and a consolidated master list was produced. This process was cyclical as themes from different transcripts were tested against one and other (Smith et al 1999). This worked well with the study’s small sample as the researcher was able to keep track of all associated themes and was able to compare, contrast and make connections.

2.9 Credibility checks

A number of sources were used in order to reduce research bias and enhance 'commitment and rigour' to the method (Yardley 2000). Supervision with an experienced qualitative researcher with expertise in health psychology and obesity aided the researcher’s analysis to stay grounded in the text. The researcher was able to discuss the initial interpretations of the text, the emerging cross-case analysis and themes.

The IPA group held at the University of Surrey enabled further understanding of the theoretical basis of the analyses and the researcher’s position within it. The researcher was able to discuss the emerging themes in these meetings where there was always an emphasis on staying close to the text. Finally an IPA group was set up with colleagues in south London which involved regular meetings. During these meetings researchers read one transcript and this was discussed in detail. The researcher was able to reflect on her position and how this may influence the interpretations. Themes and quotes to demonstrate sub-themes were discussed allowing alternative meanings to be considered.
2.10 Through the lens of the interpreter

As discussed, IPA is particularly aware of the interaction between the participant and the researcher both in terms of how the researcher may explore and understand the participant’s experience during analysis and within the interview process when communication and specific meanings will develop as a result of the interplay between the participant and researcher (Yardley 2000). What is important is that the researcher reflects on their beliefs, assumptions and experiences in order to communicate how they may influence the interpretations (Elliot et al, 1999).

I am a 29 year old white British female who has struggled with being overweight since my early teens. My BMI puts me in the overweight category (BMI between 25 -29.9). My relationship with food is one of enjoyment and at times of stress, comfort. For example I am aware that at points of academic pressure my weight has tended to increase and my understanding around this is due to both a lack of physical activity and increased intake of high calorific food in attempt to decrease stress levels. Food at these times in some ways is being used to help regulate my emotions. Having successfully dieted in the past through restricting food intake and putting in place behavioural changes such as exercise I have then struggled to maintain the weight loss over a long period of time. From this position I am interested in a process of maintaining or regaining weight. However I acknowledge that my experience would be different from someone that is morbidly obese and required weight loss surgery. My weight has not limited me with regards to health, relationships or day to day functioning.

I need to also acknowledge that the culture I live in has influenced my perceptions. Within the western culture being thin is often linked to success and attractiveness. There is a pressure, particularly on women but also increasingly on men to be ‘body perfect’. Being thin seems to be understood as leading to happiness. My background in psychology would tell me that happiness is a far more complex concept yet interestingly I see myself and people I know fall into this trap regarding body image.

The current media coverage on the ‘obesity epidemic’ is hard to miss. It is creating concern, debate and even panic around understanding, prevention and how resources
should be spent as the obesity population grows. Child obesity has become a particular priority. With increasing recognition and acknowledgement that WLS does not always produce the results wanted I felt that it was important to understand why this may happen from the perspective of those that have experienced it. No doubt influenced by training to become a clinical psychologist I held the belief that obesity was a complex issue that maybe being over-simplified through a purely medical intervention and the use of common cultural discourses regarding laziness and greed. Obesity is rarely understood as a mental health illness yet restrictive eating (e.g. anorexia nervosa) tends to be conceptualised in this way. With this conceptualisation psychological interventions appear more readily acceptable and accessible to treat this client group. I was curious to find out more but still found myself surprised at the degree of difficulties individuals had with regards to eating behaviours, imposed restrictions and the adjustment process after WLS.

Prior to conducting the interview I did wonder how my own appearance and occupation would impact participants. One participant told me that she had a ‘thing’ about coming to see ‘skinny dieticians’. Being neither ‘skinny’ nor a ‘dietician’ was perhaps viewed as favourable in this situation and freed dialogue. I did wonder how being white, middle class and a young female impacted upon participants’ responses. I was conscious that at times my gender along with social ideals around masculinity may have impacted the male participant’s ability to share what he termed as ‘vain’ concerns. I also did wonder how psychology was viewed and whether coming from a psychological background created an emphasis on the lack of support received by participants. However the depth of expression and feeling around a lack of psychological support felt very sincere and maybe being interviewed by someone outside the obesity clinic enabled these views to be shared.

The interview was the only time that some of the participants had shared how they felt about WLS and current difficulties with food and adjustment. Being able to share feelings of vulnerability with a researcher is very different from sharing their experiences more widely for fear of judgement. This highlighted how isolating the WLS experience could be and how limiting the psychological understanding regarding obesity seemed to be. I needed to be aware of these beliefs during the analysis process.
3.0 Results

3.1 Overview

IPA of the transcripts produced three master themes (Table 2). All participants described a good initial weight loss after the LAGB (1st WLS) of three to four stone in the first 3 months to a year. The weight was then described as stabilising or reaching a plateau that was considered an unsatisfactory weight loss for the individual. Most participants then started to regain weight with the band in place.

At this point participants struggled with multiple explanations of unsuccessful weight loss following the LAGB. They described a gradual ‘creep up’ of weight, continuing to use food to seek comfort, ‘cheating’ the restrictions of the band and shifting understanding of where control/responsibility should be placed. The second surgery seemed to enable a bringing together of the mind and the body with participants describing a ‘shifting mind set’ resulting in behavioural change.

Participants challenged the conceptualisation and treatment of obesity by describing how the body but not the mind is treated through WLS. Finally the process of adjusting to a new self after weight loss is explained by participants with tensions around appearance, identity and the reactions of others being described.

These sub themes will now be described and illustrated with exemplar quotes.
Table 2: Themes

<table>
<thead>
<tr>
<th>Theme 1. Struggling with multiple explanations of ‘unsuccessful’ weight loss. Post 1\textsuperscript{st} WLS (LABG).</th>
</tr>
</thead>
<tbody>
<tr>
<td>A gradual ‘creep up’ of weight.</td>
</tr>
<tr>
<td>Seeking comfort</td>
</tr>
<tr>
<td>Cheating the band</td>
</tr>
<tr>
<td>Who is in control?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Theme 2. The bringing together of the mind and the body. Post 2\textsuperscript{nd} WLS.</th>
</tr>
</thead>
<tbody>
<tr>
<td>A changed ‘mind set’</td>
</tr>
<tr>
<td>Changed eating behaviours</td>
</tr>
<tr>
<td>The forgotten mind</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Theme 3. Adjusting to a new self. After weight loss.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adjusting to a new external appearance</td>
</tr>
<tr>
<td>A shifting identity</td>
</tr>
<tr>
<td>Adjusting to attention from others</td>
</tr>
<tr>
<td>Struggling with excess skin</td>
</tr>
<tr>
<td>Was it worth it?’</td>
</tr>
</tbody>
</table>
3.2 Theme 1; Struggling with multiple explanations of ‘unsuccessful’ weight loss.

Erm, yeah, you think about it because you hear these different theories about there’s a fat gene, I think, so have I got a fat gene, <laughter>, I don’t know. Erm, you think, oh god, perhaps am I one of these greedy people (Dawn).

Throughout the interviews participants struggled to understand unsuccessful weight loss following LABG. In order to create meaning participants seemed to search for who or what may be responsible. Connected to this was the level of control the individual felt they had over their own weight loss. The unsuccessful outcome caused individuals to evaluate themselves and the process in detail but they found themselves entrenched in the complexity of obesity and eating behaviours and unable to position themselves neatly in one explanation. The placement of control continually shifted from the self, to the intervention, to external pressures of life and to a lack of support from health professionals. All explanations seem to lead to behaviours that involved ‘cheating the band’ and the re-emergent or development of dysfunctional eating patterns suggesting that participants struggled to adjust to the limits of the band.

3.2.1 A gradual ‘creep up’ of weight

All participants describe a gradual creep up of weight after a good initial weight loss following LAGB.

But of course as time goes on and you start to introduce more food that is when you know that you have got a lot of lee-way and I mean you could quite easily enjoy having the enjoyment of food, having chocolate and replacing meals you know quite easily you
could get into that thinking well it is a lot easier to have a couple of bars of chocolate who cares sort of thing. I won’t put that weight on but you will cos it will gradually, as it did with me, it will gradually creep up on you and before you know it you are back to square one. So I think there should be more education about how the operation works, what it is really going to do for you and what part you have to play with it and that you are emotionally ready to do it. (Dawn)

As with other participants Dawn describes a gradual ‘creep up’ of weight that has an unknowing element to it ‘and before you know it you are back to square one’. Her behaviour and thinking around food changes as the band becomes less controlling and more ‘lee-way’ was available. Chocolate then replaces meals. By saying ‘You could’ Dawn places some distance between herself and the behaviour. Like most participants she suggests that more education may have helped her in this process with regards to understanding her own role post WLS. Dawn simultaneously acknowledges her own role while placing some of this responsibility outside herself.

Ruth: I started to slowly put on because what happens over time is that you can actually stretch this area (stomach) and you can accommodate more food and there was times when I could accommodate more food and I knew I was accommodating it and I would say to myself ‘no no stop’. And also it depends on the type of food that you take in. ...I used to deliberately not eat rice because the rice would fill me up very quickly but you are supposed to have rice and pastas for a slow carbohydrate release etc. But I deliberately didn’t

Int: You deliberately didn’t because....

Ruth: Because I would rather have meat because I could taste it more and I felt a bit more satisfied.

Ruth describes a gradual gaining of weight over time and being conscious that she was able to stretch her stomach to ‘accommodate’ more food. The word ‘accommodate’
implies her stomach contains the food in almost a helpful obligated way. She physically needs to adjust (‘stretch’) and make room for the food. There is a tension between her accommodating stomach and her self which seems to not want to be accommodating at all ‘I would say to myself no no stop’. At this point it feels almost powerless and out of her control yet at other points she seems to make ‘deliberate’ decisions to avoid advice in search for food that provided satisfaction. In this example it is unclear whether Ruth is seeking physical or emotional satisfaction (or both). During the interview all participants describe using food when lonely or stressed to offer comfort.

3.2.2 Comfort

Post surgery food continued to be used to self-regulate emotions and offer ‘comfort’ for all individuals. ‘Comfort eating was still around’ (Robert). This tended to manifest itself in an altered way post WLS because of the physical capacity of the stomach but it was experienced as equally distressing for the individual.

Some participants battled with themselves as they continued to use food for comfort. For Dawn chocolate had become synonymous with comfort.

‘I SHOULD have had the meal and I’d avoid having the meal, do you see what I mean, I preferred to have the comfort (chocolate). And I’d think to myself, ‘what am I doing to myself is ridiculous’ because I’m like causing myself more problems’ (Dawn).

Most participants felt distressed by their behaviour but felt that they were unable to control how they ate. Eating was understood as an addiction for many participants.

Yeah, I felt guilty when I pushed it. Felt extremely guilty, but it didn’t matter. Erm, again it’s like alcohol, you know, you want to drink, you want to drink, and I wanted a bit of food and I was going to have a bit of food. (Robert).
Most participants describe external pressures leading to food continuing to be used to self-regulate emotions despite the restrictions now enforced by the band.

_"I had a lot of family commitments at the time, there was a lot of problems with my husband and my daughter who didn't get on and I was depressed over it, you know, and I just felt that I was in the middle. And erm I think that was the main problem and we had money problems and what have you and my way of coping was eating" (Pam)._

### 3.2.3 Cheating the band

For some participants adjusting to the smaller portions and the different types of food post surgery was an extremely difficult transition involving large lifestyle changes. Participants described feeling unsupported during this process and this lack of support was often attributed to ‘non-compliance’ (Ruth). Some participants reverted to unhelpful eating behaviours that prevented further weight loss as soon as the band allowed. In a process of ‘pushing the boundaries’ (Robert) or ‘cheating the band’ (Robert) participants described over time understanding the ‘limits of what the band allowed’ (Robert) and how the band worked to enable increased food intake.

_And I found that if I chewed the food tremendously to a pulp I could actually get more of it, quite frequently.....I actually ate anything I felt like eating even though the dietician was advocating rabbit food and stuff like that and my philosophy behind it was that, I'm going to eat a little bit of it so I might as well eat what I like" (Robert)._
Techniques such as chewing food to a ‘pulp’, ‘flushing’ food through the band, or eating small portions continually through the day and night (‘grazing’) allowed a larger food intake.

*Ruth:* And apparently they say that you mustn't drink in-between eating because it causes a flush but I would drink during eating.

*Int:* Why do you think you did that?

*Ruth:* Umm Because I felt hungry and I felt that, I think psychologically if I was able to eat my two chineses why can't I eat that now.... that is how I felt. Why can't I eat that now? So I would try to find ways of eating it.

*Int:* And what kind of ways did you find?

*Ruth:* I mean I would have chinese half well quarter of the chinese at night, I'd get up in the middle of the night and have some more and then I would get up and the rest probably for breakfast.

Physically Ruth cannot eat more without flushing the food through the band therefore in theory this should signal a sense of fullness however psychologically Ruth describes still being hungry. There is a sense of injustice by the new limits imposed by the band and perhaps by others. There seems to be a battle with the band as she thinks of ways to 'get round the band' by flushing the food or breaking the food down into smaller quantities and eating through the night.

'Cheating the band' was also achieved through drinking high calorific liquid drinks or eating high calorific soft foods.

*But after a while I was getting ruddy sick of eating this baby food, because that was what it was like in the beginning and then I found that things like rice pudding and I*
don't know, custard stuff and cake, soft sponge and that could go down a lot easier and was satisfying my needs but the trouble was and I learnt this afterwards that obviously its not the amount of food that you eat, but what you eat (Dawn).

For Dawn the restrictive nature of the band meant that 'baby food' was replaced by soft food with a high calorific content. These soft foods were both easier to eat and led to higher satisfaction 'satisfying my needs'. Many participants experienced moving from soft food and liquid to solid food difficult and described eating as a 'trial and error' (Ruth) process. Eating for all participants during this stage was often accompanied by vomiting as they tested the limits of the band. It was at this point that most participants felt that they needed most guidance and support.

_I was very keen at the beginning diet exercise or sort of things. But when it sort of slowed down and I found. I found that if I had been given more support at the beginning maybe then I wouldn't have tried ways to get round the band, do you get what I mean? I've heard stories of people that liquidise Mars bars and in fact I even when was in, when I was having my band put in, I was in at the same time as a young girl whose mother she had a gastric band done or something like that and the mother was bringing her in chocolate and it ended up that this girl ended up in intensive care and all sort of things because it blew up (Ruth)._}

Ruth describes a lack of support at a point where it may have been helpful when the positive reinforcement of weight loss has stopped 'but then it sort of slowed down'. It was at this point (after a 'honeymoon' period of weight loss) that difficulties began and she found ways to 'get around the band'. Through social comparisons, stories of others 'cheating the band' are told. In one example the idea that something that is meant to be loving and knowing (in this case the girl's mother) can also be damaging is expressed and maybe used to normalise Ruth's own behaviour.

The complexity of understanding why weight loss was not achieved after the surgery leads some to conclude:
It's a mystery. I suppose, it still remains a mystery' (Jane) with health professionals positioned as equally confused ‘Well, they were flummoxed' (Jane).

One participant understood unsuccessful weight loss to be due to being ‘unlucky'.

_They (health professionals) just said it can happen with some people. Some people it can work better than it does with others and I'm just one of these unlucky people I suppose_ (Pam).

To help with struggling explanations participants often used the voices of the health professionals. The surgeon or nurse was positioned as the ‘expert' by participants. Their voices could allow a temporary resolution for the individuals as they struggled with multiple explanations.

### 3.2.4 Who is in control?

Understanding where control was positioned following the first surgery shifted for all participants. The main emphasis was on ‘cheating the band’ within a context of a lack of support and understanding. However control was also placed in the band itself. _Erm the band is clearly in there not doing very much_ (Robert).

_Int: What happened when you first had the band put in?_

_Pam: It was up to it's maximum capacity with fluid and I was still eating. You know I put on erm, I was still hungry it wasn't doing anything at all. (Pam)_

Pam had anticipated that the band would control two central elements to weight loss, her eating behaviour and her level of subjective hunger. This control is understood as
external from herself. There is a sense of disappointment in the band as it is unable to fulfil this function.

*I went regularly to get the band inflated so that I would, have more constriction or less constriction, to try and boost the weight loss (Jane).*

For Jane some level of control is placed in the intervention and the level of constriction it instils to prevent food intake and *‘boost’* weight loss. All participants had expected the band to serve some controlling function with regards to food intake but when it *‘failed’* to do so some participants searched for other sources of external control.

*I’ve always said to my husband that if I won the pools, I would have a live-in person to do my cooking, give me a diet plan, at home and do me breakfast, dinner and tea on the table that would be easier (Pam).*

Some participants had anticipated that the health professionals as well as the band would act as a gate keeping function regarding food intake.

*I mean I was expecting to be summoned by the dietician and for her to look through and give me a telling off and this that and the other....if you are straying off the path what you want is someone to slap you back again (Robert).*

However for some WLS allowed a temporary sense of perceived internal control while unfortunately appearing to simultaneously increase dysfunctional eating patterns.

*And even when the problem erupted with the vomiting and being sick I quite enjoyed it because I thought at least I was losing the weight. And food wasn’t an issue, I didn’t want, because I knew that the food was making me sick I just walked past it, ....it was so*
odd you know how differently I felt because I knew that I couldn’t eat it. ......it made me feel different because I was in control. It was like, to me food is a disease, it is like an alcoholic drink is a disease or a drug addict it is a disease and a disease you can’t control a disease it controls you. And I feel that the food or the effect of the food on me, controls me. But when I lost the weight and I got the feeling ‘YUCK I can’t eat that’ to me I was in control and I felt much better about myself you know and life was care free so you know I was enjoying it and life was a real buzz (Dawn)

Here Dawn describes vomiting because her band was too tight. This negative physical consequence is perceived as enjoyable by Dawn because firstly she felt she was losing weight and secondly it produced some form of perceived control over food. In a simple behavioural model food became associated with a negative physical consequence, vomiting, and therefore food became easier to avoid. For Dawn food normally controls her. This feeling of being controlled is felt so strongly that she associated it with a ‘disease’ or a drug addiction where the person is positioned as powerless ‘you can’t control a disease it controls you’. During this time of vomiting there was a sense of control over food. This perceived control in one area (food) filters into other areas of Dawn’s life in a powerful way. It affected how she felt about herself and her life in general. ‘Care free’ implies a weight has been lifted both physically and metaphorically.

In summary of theme one, participants struggled with multiple explanations of weight gain after the first surgery with explanations of control shifting from the self, to others and the surgical mechanism itself. Food continued to be used to self-regulate emotions but in an altered way because of the new band restrictions. Participants described ‘cheating’ the surgical mechanism in a number of ways in order to overeat.
3.3 Theme 2. The bringing together of the mind and body

All participants experienced having one unsuccessful WLS in terms of weight loss followed by a second more intrusive surgery that produced better weight loss. This second surgery seemed to enable a shift in ‘mind set’. Participants spoke about getting their minds ‘in gear’ and a bringing together of both the mind and body in order to produce change. Responsibility seemed to be shifted from the medical intervention (WLS) and placed with the self and others (usually health professionals). This seemed to enable some degree of behavioural change which positively impacted upon weight loss however this was sometimes accompanied by feelings of ‘failure’ (Ruth) or ‘guilt’ (Dawn).

All participants spoke about the mind being neglected by the process of WLS. Participants explained that the body was treated through the surgery but that the mind was mistakenly understood as separate and unimportant by the health professionals or the context in which surgery took place.

3.3.1 A shift in ‘mind set’

A number of participants described a shifting mind set from the first to the second surgery.

*With the band I knew I could cheat it, I knew cheating it was wrong and it was really naughty to do that but I did it on occasions and that is why the weight stayed stable. So I’ve already got myself into a mind set that it is not the be all and end all of an operation that is going to solve my weight problems I’m still going to have to work at it* (Robert)

In a cause and effect model Robert describes how deliberately ‘cheating’ the band led to no further weight loss. In his description the words ‘naughty’ and
‘cheating’ suggest an almost childlike quality to his previous behaviours. This experience has produced a shift in his ‘mind set’. He no longer places control with the operation as it is not the operation that will ‘solve’ his difficulties with weight. Responsibility and effort is now placed with himself ‘I’m still going to have to work at it’. ‘Work at it’ implies an active rather than a passive role and a role that is ongoing. It also demonstrates an increased confidence in his own ability to make a difference and create change. Participants express a need to be ready for this change.

You know if you can have the help to go into the line of recovery and control rather into the line of slipping back. There is some point that where in your mind set you have to be ready for that, you have to be ready, it is like when they say oh alcoholics they are not ready to engage in therapy, and think it is probably the same with people that over eat (Dawn).

Dawn uses a recovery model to aid her understanding around weight gain post surgery and at which point an intervention would be helpful in order to gain control. Like the other participants she draws attention to the individual responsibility with regards to being in the right mind set. The mind needs to be ready to engage. The mind is given priority post-surgery by participants. Over eating is viewed in the same way as over drinking. By comparing over eating to alcoholic addiction Dawn is both challenging the conceptualization and therefore the treatment of obesity and emphasizing how serious the difficulties she experiences are.

3.3.2 Changed Eating behaviours

For some participants increased weight loss following the second operation was understood as resulting from an increased internal level of control that produced
significant changes in eating behaviours. Others felt that the second surgery had limited their ability to ‘cheat’ and thus enabled weight loss.

...with the by-pass you can’t get anything more into your stomach, do you know what I mean ?, erm how can I say this I can eat and then I am full and that is it, there is nothing more that you can do. And if you do eat it packs up. Also the other thing is the side effects. Let me see for instance fruit, I love melon but if I eat too much melon which you can easily do chop, chop, chop and then you have awful diarrhoea and is diarrhoea to a point when I can’t hold it, I’ve had about four accidents (Ruth).

Ruth described strong physical cues that she had overeaten. The food either ‘packs up’ inside or it causes diarrhoea. In contrast to her experience with the band of a slow creep up over time and then a sudden realisation one day of her over consumption she now is recognising and responding to strong negative and immediate physical consequences enabling her to change her own behaviour.

With regards to the second surgery participants are no longer describing ways to ‘get round’ or ‘cheat’ the surgical mechanism in order to eat more. Interestingly they now try and work in harmony with the operation using it as a tool to aid success. This seems to happen through being more aware of bodily signals, a shift in thinking and a shift in where control is now placed.

I wouldn’t even expect the bypass operation be the be all and end all of it. You’ve still got to, use it as a tool to aid you in your fight against weight. So I’m always going to have that problem of weight, always, always. And if I’m not careful, I could potentially go back to where I was. Erm, and that’s the same for everybody not just me....... I tend to try and stop before it hurts because then I am not pushing the boundaries (Robert).
Perhaps as a result of Robert's journey of WLS, surgery is now understood by Robert as a 'tool' that is going to 'aid' weight loss but not produce change alone. A 'tool' needs an operator in order to enable it to effectively function. Robert has become the operator. He now appears to be able to have a 'fight against weight' and describes this as an ongoing process. He decides that his actions could cause problems 'if I'm not careful' again positioning himself as in control. This understanding around his own responsibility and control over his weight has produced an interesting behavioural change. Robert explains that since the second surgery he tries to stop eating before it 'hurts' in order to avoid 'pushing the boundaries'. In the first theme participants describe techniques such as 'flushing', 'grazing' and chewing food to a 'pulp' to allow greater consumption that would stretch the boundary of the stomach. This previous experience seems to have made him aware of boundaries both metaphorically and physically within his stomach.

Pam; I eat a little bit of chocolate but don't pig out on it whereas before I'd think nothing of having a family bar of chocolate in one meal and now I can eat a family bar a week. Isn't that bad? (Pam).

Pam describes a significant behavioural change in her eating habits since the second surgery. By explaining she previously would 'think nothing' of eating a family bar of chocolate suggests a shift in her thinking and subsequent changes in her behaviour.

Robert: I don't graze in between. Erm, and consequently lost...... Ten or eleven stone...... I could if I wanted to (graze)

Int: You could,. What stops you grazing?

Robert: the amount of pain, the operations performed. Don't want to do any damage, don't particularly want the stomach to enlarge anymore which it
can do. I mean I could go back to the way I was by just eating a bit more each day and getting the stomach grow naturally.

The behavioural change described (no grazing) seems to occur for two reasons; one is centred around fear of physical 'damage' to his stomach and the other is about a fear of re-establishing old eating behaviours which cause the stomach to grow. Participants continue to demonstrate a shift in thinking and behaviours which is linked to weight loss.

For many participants the physical and psychological cost and level of personal investment of having two operations needed to be rewarded by successful and maintained weight loss.

*As long as I maintain that (weight loss), it was worth it. Everything was worth it* (Robert).

### 3.3.3 The forgotten mind

Many participants expressed how the body but not the mind was treated through WLS. For some this was directly linked to an unsuccessful experience regarding both losing weight and adjusting to weight loss.

*There's been nobody to just sort of talk about the emotional side of it, nobody at all. It's quite amazing really to think that hasn't, and maybe that would have helped during this time,, thinking about it, it probably would have helped quite a lot. .....It's not really an option and I think the only time you really get therapy as such is if you've got a mental health problem and this (obesity) isn't really recognised as a mental health problem, that it is* (Dawn).

Dawn explains that she feels the 'emotional side' of the surgery process is neglected and this may have aided her with the band. Perhaps because of Dawn's job within the
mental health area obesity for her is easy understood as a mental health difficulty. To her this framework of understanding matches her experiences. Dawn explains that how obesity or over eating is conceptualized impacts the support offered.

Some participants explain how the health professionals are skilled in the physical element of care regarding the body but neglect the psychological support that may be needed. For some this was the most difficult part of their experience.

we’re going to cut you open, we know how to cut you open, we know how to solve all that problem side of things, we get all that done and you get on with it'. And that for me was the worse bit about it (Robert).

Ruth brings many aspects of theme 2 together in this example.

Because as I said I stopped losing weight and started to slowly slowly creep up again I felt a bit of a failure because I suppose really if I had been supported I would not have put all my effort into THE BAND cos it has to come from you as well. I now know this but it has taken all those years to find it out, psychologically and physically it has to come from you, you got to put exercise into place you got to get your mind in gear about it and be prepared for the changes but all this I had to do on my own, you know and find out as I said through the failure of the band. (Ruth)

For Ruth the ‘failure of the band’ has enabled her to reflect on her own of responsibility or role with regards weight loss. The ‘failure’ has shifted from being placed with ‘THE BAND’ to understanding her own role in the process. She brings both the mind and the body together ‘psychologically and physically’ in order to produce change. She explains that her mind has to be ‘in gear’ (ready for movement) and prepared for change. Suggesting a physical change (weight loss) is unable to occur without the other ‘the mind’ being able to adhere to dietary changes and physical exercise. Tensions still remain regarding where responsibility should lie. As in the previous themes responsibility/control shifted between the individual and the lack of a support system.
In summary, following the second surgery, participants understood successful weight loss as a ‘bringing together of the mind and body’ and they explained how the process of WLS tended to treat the body but silence the self.

3.4 Theme 3: Adjusting to a new self

All participants spoke about the reduction of weight impacting how they viewed themselves (both externally and internally) and how others viewed or reacted to them. Most participants held complex emotions regarding weight loss with both positive and negative elements which could at times cause tensions in how they felt, behaved and understood themselves and others. Some reported weight loss created an increase in confidence and a new identity which at times causing tensions between an old and new self.

3.4.1 Adjusting to a new external appearance.

Following the second surgery some participants spoke of a struggle between accepting a changed external appearance when their internal perception of themselves, physically and emotionally, remaining unchanged. *I feel so funny, I feel weird (Ruth).* For example this created a sense of leading a ‘double life’ for Dawn where others’ perceptions of her external appearance and inner state did not match her own.

*I just feel sometimes, you know, I’m a fat blob who really has got erm, not a lot of control over her life, but I’m living a double life. You know, that, when I go to work, it’s like when I said to my boss, the other day, I said, ’I’m really not feeling too good at the moment’, she said, ’but you look so wonderful I would never, ever have dreamt that you’re not feeling up to it’ and I said, ‘well I’m telling you now, I’m not’ (Dawn).*
Such conflicting emotions and tensions regarding a new external appearance and an unaltered inner state led some participants to hold fragmented identities of themselves as they struggled to understand who they now were.

One thing I said to my GP a few months ago was everybody takes care of the physical but nobody takes care of, there's a fat man inside this thin body. I've been fat for 53, 52 years erm the mental side of it is, nobody's actually dealt with that and I suppose that goes back to what's support have you had. None. All done myself (Robert).

Robert explains that from a medical point of view 'everybody' has taken care of him but with regards to psychological care 'nobody' has done this. This 'nobody' may perhaps refer to himself as well as health professionals. Externally he is thin but internally he still feels like the person he was before the weight loss. His mind is yet to catch up with his dramatic altered physical appearance. He explains the length of time that he has been 'fat' to emphasis the level of adjustment that is needed to shift from one state to the other. Having no support with this transition or changing identity has meant that he has had to do it himself. 'All done myself' implies that the difficulty is resolved however the rest of the quote describes it as an ongoing process. Participants struggle to abandon old identities of the obese self for new identities and this manifested itself in different ways. For Ruth her large coat that she continued to wear represented her old self that she knew and understood as 'safe'.

I just feel safer sometimes wearing my old clothes.... wearing my bigger clothes like for instance I had this jacket for years and years and for years when I did it up it would be just a squeeze to get it up the zip now I can do it up and it is flowing around me, do you know what I mean, it's really loose. So I know I have lost really a lot of weight and everyone tells me that as well, and all this it is just I don't appreciate it, I don't feel excited about it, you know. (Ruth)
Ruth continuing to wear her old clothes seems to serve two functions. Firstly emotionally her old, bigger clothes have the ability to make her feel safe and secondly wearing them acts as a physical reminder of the weight she has lost. The external cue of wearing her old clothes and other people telling her she has lost weight are two ways that Ruth knows she has lost a lot of weight. However she struggles to adjust and perhaps therefore ‘appreciate’ her new appearance.

### 3.4.2 A shifting identity

Following weight loss most participants described not recognizing themselves in the mirror or on a photograph or not being recognized by friends. For some this created tension and was a difficult experience to comprehend or verbalise.

*And the fact that I’ve got my suit on, I’m this skinny geezer, stood there, talking to my nephew and I didn’t recognise me (in a Photograph). And it’s, you know, that, the impact, the mental impact of that could potentially be quite devastating for some people........ I still, I get up in the morning go into the bathroom and look in the mirror and think ‘My God’ and that is it ‘My God’ no other justification, ‘what the hell?*

For others not being recognised was an opportunity to embrace a new identity separate from the stigma and discrimination that many of the participants had experienced while being obese. Throughout the account social comparisons are used to highlighted participant’s desire to be ‘normal’ or the ‘same as others’.

*Pam: I feel more like other people now. I mean I felt like a freak before because I was so big, I mean there are not many people that are sort of your size out there is there? You know I just felt freakish.*

*Int: How have others reacted?*
Pam: Well my friend walked straight past me when I saw her (laugh). She walked straight past me in the street and she said to me ‘that if you hadn’t have called me back I wouldn’t have known you.’ Yeah, it’s nice

Not being ‘known’ was described as a positive experience for Pam. She was able to distance herself from her old identity of being overweight and feeling different from others; ‘freakish’. For other participants it allowed a sense of liberation and freedom from being seen as ‘just fat’ (Jane).

Jane: Amazing boost to my confidence and belief in myself which I never had before... I always felt, erm, right from when I was a child, I would never be any good because I was always fat. And that’s all anybody ever saw in me. Now, yes I am big but a lot women my age are a similar sort of size and they don’t view me, that’s not the first thing they see about me now.....I think people are quite disrespectful towards people that are obese and people don’t see me as the ‘fat person’. They see me as the teacher, the provider or whatever, now instead.

Since losing weight Jane describes an increase in confidence. She no longer sees herself as ‘fat’ but instead uses the word ‘big’ and therefore appears able to challenge a long held belief about her abilities. She uses social comparison in order to understand her new size and what is perhaps acceptable within society and to herself. Later in the interview Jane does express a desire to lose more weight suggesting that there is an ongoing tension about what is a ‘good enough’ weight loss ‘Whilst, I would like to lose some more’ (Jane). However she does appear to separate herself from people with obesity and explains that she now has a new identity. Through her evaluation others are presented as unable to hold two concepts of being both ‘fat’ and a ‘teacher’ for example. For Jane when she was ‘Fat’ that is all others could see.
3.4.3 Adjusting to attention from others

Adjusting to how others responded could at times cause anxiety. Participants reported simultaneously enjoying and disliking the new attention. Ruth comments on being unsure of how to cope with others comments.

*People start to comment on you, start to say 'corr you lost of weight'. How do you cope with that? Yes it was what I wanted, it didn't I just couldn't cope with it (Ruth).*

Ruth describes being in a difficult position of getting what she wanted (weight loss) but then not knowing how to cope with the consequences (people's comments).

*Int: So how did it make you feel having people comment?*

*Ruth: It was new it was new, it made me feel good sometimes but a bit nervous, you know, because it sort of put me in the limelight. I mean you are in the limelight anyway before people say 'you're a big girl' but it puts you even more of a limelight. All eyes are on you just to see how much weight ...and people say 'oh I might have that surgery myself' and things like that*

*Int: How did that feel, being in the limelight?*

*Ruth: Personally I did not like it. Inwardly I was glad that people did notice but outwardly I felt uncomfortable .... But it was like there was this change and people pointing at me even more you know, it's difficult.*

Ruth explains that her experience of being in the 'limelight' was not new due to her previous big size however the 'limelight' is now experienced as different 'it was new it was new' and more intensely 'even more of a limelight'. Since WLS Ruth seems to be perceiving an added pressure 'all eyes are on you' to see how she does or does not succeed. In fact she perceives her own success or not, as influencing other people's decisions about their own future. Ruth tries to understand how she can feel both 'glad'
and 'uncomfortable' at the same time and she does this by splitting her emotions into 'outwardly' uncomfortable and 'inwardly' glad. She speaks about this change in others reactions and perhaps in her own ability to cope with it as 'difficult'.

*And people say bloody, you look good you know and compliments and everything else. I suppose that's a plus side. But again I'm not that, I'm not that vain effectively.* (Robert).

For Robert being physically complimented is a new experience and it brings into question his own vanity. Vanity, for Robert, does not fit with a traditional discourse of masculinity and he therefore struggles with this new emphasis on appearance.

### 3.4.4 Struggling with excess skin

Some participants describe difficult decisions about whether to have further operations in the form of plastic surgery to help reduce excess skin after weight loss. This would involve a number of major painful operations. Participants described folds of excess skin causing a number of negative physical consequences such as sweatiness, sores, boils and blisters. Accompanying these physical difficulties was a power imbalance with participants having to demonstrate to the surgeons that the excess skin was causing enough medical difficulties to warrant removal. In addition there was some ambivalence regarding plastic surgery, with some participants struggling with the resulting 'abomination' (Robert) of cuts and scars versus being able to buy clothes 'off the peg' (Jane). Removing excess skin and buying clothes 'off the peg' seemed to represent reaching 'normality' for a number of participants. While others still felt their appearance was 'not right' as they continued to struggle with their new self.

*And then I start to be critical of the rest of me now, you know, it's silly. Because there are other operations, there is fat around the thighs that I could potentially have*
removed there is flab under the arms............ I'm not overly concerned with looking nice but I am a bit concerned about looking in the mirror and it not being right and that is where I come from. Not whether it looks nice or not it's whether it looks right and my upper body doesn't look right to my lower body. (Robert).

Some participants remained unhappy with aspects of their appearance and spoke about hiding or covering excess skin or scars from surgery. However plastic surgery was seen by some as important way of improving appearance. Here Pam talks about needing plastic surgery on her breasts and stomach.

I've still got quite a big tum, I'm not really bothered about my lumps and bumps on my legs and arms and everything and I've got back wounds (from surgery) but I'm not bothered about that because you can always keep them covered but your stomach and your boobs, you can't, you can't. So that's when I think things will be much better (Pam).

3.4.5 Was it worth it?

Struggling with the adjustment issues seemed to lead some participants to question the surgery 'at what cost?' (Ruth) and whether the perceived benefits around health and appearance had been enough to outweigh the investment in terms of effort, pain, and time. As discussed earlier this level of investment could be used at times as a way of maintaining weight loss but at other points was questioned.

Erm but then I look down at my body and think was it worth it? And there's all sorts of things going on in my mind which obviously I can't remember some of them but it just hits me occasionally and I find myself, all the pain and the suffering, was worth it? Just for the flat tummy but then I've got to take in account obviously the impact on my health and all that sort of thing as well. (Robert).
For others previous expectations that the surgery would increase their confidence and happiness were less straightforward than anticipated. The act of surgery itself increases a sense of isolation and not being understood. WLS in these cases appears to perpetuate rather than decrease existing vulnerabilities. This is summarized in the below quote.

And, and, as I said, I can't talk about it at work, I can't be open about it. I feel that talking about the weight loss surgery to other people, other people that don't understand. To me would be, seen as making me look vulnerable and that's what I don't want. I don't want people to think I'm vulnerable. But obviously I am vulnerable and I, you know in this particular situation, I would admit that to you. But I wouldn't admit it to anyone else. So I do feel quite vulnerable. (Dawn)

Others questioned why they were not happy despite a significant weight loss.

But the thing is right Gemma, is that the end product is that I'm supposed to be happy about this, I am supposed to be happy that I've lost 9 stone, I'm supposed to be happy I was size 32 and now I'm a size 22, I'm supposed to be happy that I can get trousers and sit on the bus and sit on the seat and do all sort of things, but I'm not happy (crying). (Ruth).

Part of Ruth's unhappiness seems to arise out of an evaluation of how she is supposed to feel or perhaps expected to feel following such a significant reduction in her size. She communicates how easy it is to attribute happiness to measurable outcomes such as being able to sit on the bus or buy smaller clothes but for Ruth this is not producing happiness.
In summary of theme 3, following dramatic weight loss, participants struggled to adjust to a new appearance and a new self. Weight loss produced a number of difficulties and vulnerabilities that could produce tensions between an old and new self in terms of appearance, identity and the reactions of others. For some participants, an increased sense of vulnerability and struggling to adjust led to a cost/benefit analysis of WLS.
4.0 Discussion

The qualitative study aimed to explore participants' understanding of unsuccessful Weight Loss Surgery (WLS) and the requirement of a further form of WLS. The analysis found that participants struggled with multiple explanations of weight gain after the first surgery and they understood successful weight loss following the second surgery as a 'bringing together of the mind and body' however they continued to struggle with 'adjusting to a new self' following weight loss.

Transcending all these themes were issues of control and a mind/body split. Control was initially described as being sought externally from the gastric band and health professionals. At times the band did allow a perceived sense of internal control e.g. vomiting reducing the desire to eat, however this control could be understood as increasing dysfunctional eating patterns. The use of language throughout the first theme is particularly interesting with the inclusion of evocative terms such as 'lucky' and 'cheat'. One term suggests a lack of control with regards to the surgery whereas the other suggests deliberate action. The level of control instilled by the band was disappointing for participants and further surgery was required. A shifting focus from the body to the mind enabled an increased sense of control following the second surgery. Although control did continue to be shifted internally and externally participants described a process of 'getting the mind in gear' which produced behavioural changes. Finally the mind struggled to keep up with a dramatic physical change following weight loss as individuals described trying to adjust to a new self. Weight loss appeared to cause a number of tensions between an old and new self in terms of appearance, identity and the reactions of others. For some participants an increased sense of vulnerability led to a cost/benefit analysis of WLS.

These findings will be examined in relation to the literature and their clinical implications will be discussed. A critique of the study will also be presented with further possible research being considered.
4.1 Theme 1; Struggling with multiple explanations of ‘unsuccessful’ weight loss.

All participants describe an initial good weight loss of 3 to 4 stone followed by a plateau at an unsatisfactory level and then for some participants a process of regaining weight with LABG. Such findings support the idea of a ‘honeymoon’ period of weight loss (Niego et al. 2007) post surgery with weight particularly starting to be regained around 18-24 months after surgery (Buchwald et al. 2004, Larsen et al. 2004). The findings would support the assertion that the first 2 years after surgery should be considered an ‘interim’ (Torgerson & Stostrom 2001) rather than a measure of outcome.

Weight gain after surgery was described as a gradual ‘creep-up’ that at the time appeared unconscious to the individual followed by a sudden realisation of the amount they could now consume. The stomach area had stretched over time to accommodate more food which is consistent with Zijlstra et al.’s (2009) findings of the stomach slowly increasing its capacity. At other points, participants described a conscious element to their behaviour as they found ‘ways around the band’ or to ‘cheat’ the band such as through ‘grazing’ (continuously eating small amounts over time) or flushing food through the band in order to eat more (by drinking while eating) or chewing food to a ‘pulp’ (in order to fit more in) or replacing meals with high calorific substitutes such as chocolate. Such findings add to the literature, with Saunders (2004) reporting individuals ‘grazed’ post WLS and Zijlstra (2009) finding that participants ‘tested the limits’ of the band with what they could eat, how much they could eat and how often.

Participants described doing the above behaviours in order to produce some form of satisfaction or comfort usually in response to an emotional need (distress, loneliness, stress) rather than physiological hunger. Such findings extend Walfish’s (2004) research that 40% of individuals identify themselves as ‘emotional eaters’ before surgery. The present findings suggest that for these participants’ ‘emotional’ eating continues post-surgery. It has been suggested that eating in response to emotions is reduced post WLS as eating high-fat food leads to the negative consequence of nausea or vomiting (Rusch & Andris 2007). However the present findings suggest that WLS
can lead to more and different forms of maladaptive eating behaviour as participants struggle to adjust to the restrictive nature of the band. This supports Saunders' (2004) findings that adjusting to the restrictions of surgery left individuals more likely to overeat post surgery. The findings are concurrent with Niego et al (2007) who found some individuals continued to have maladaptive eating behaviours that could cause psychologically distress post WLS. It supports Niego et al (2007) conclusions that WLS should not be considered a ‘cure’ for pre-existing eating pathology. For these participants overeating continues to be used as an important affect regulation strategy in response to negative affect often caused by stressful life events.

Binge eating was not assessed according to clinical standards for this study but the breakdown of control of eating described by participants was a frequent theme. This supports the concept that binge eating should not necessarily be defined by the amount of food consumed but instead by the subjective loss of control over eating (Saunders 2004, Niego et al, 2007). The results are in accordance with Saunders (2004) who found that grazing post WLS could often be accompanied by feelings of a loss of control.

Interestingly however, participants described that their sense of control would fluctuate at different times post surgery, perhaps helping to explain the previous conflicting research. At times control was sought from the band but instead of increasing a sense of control for the individual, as Ogden et al (2006) found, over time these participants describe disappointment in the surgery mechanism itself. Participants tended to hold an external locus of control with regards to eating behaviour with control often being placed with health professionals and the band itself. This supports findings that an external locus of control is associated with difficulties maintaining weight loss (Holt et al 2001, Teixeria et al 2005). The band failed to enforce the level of control the individual had hoped. Such disappointment with WLS is in contrast to the majority of studies highlighting client satisfaction (Ogden et al 2006) but is concurrent with recent research highlighting disappointment post surgery (Zijlstra et al 2009).

At some points participants described ‘deliberate’ strategies that ignored the limits of the band and the imposed limits by the advice given by health professionals. This suggests a more complex relationship with the intervention which could at times cause a ‘rebellion’ against its restrictions. This seems to match Ogden and Wardle’s (1991) model of over eating that suggests that the ‘what the hell effect’ (Herman and Polivy
1984) is not a passive process but a reactive reaction against self-imposed food restrictions. The food restriction with these participants is not always self-imposed but imposed by the mechanism of the band, health professionals and perhaps social pressures of acceptability. This is concurrent with Stice (2001) findings that social pressures and discrepancy between the thin ideal and actual weight can be linked to overeating. In addition, it links to Thorsby’s (2007) findings that individuals that had WLS refused to accept a common discourse of ‘fatness’ as an ‘embodied moral failure’ with some ambivalence towards the ‘war of obesity’ in spite undergoing one of the most radical interventions. This led to complicated and contradictory understandings with regards to the origins of their own obesity (Thorsby, 2007). How the individuals place themselves within this context and are positioned by others may help explain the struggle for understanding why WLS was ‘unsuccessful’. Explanations shift from the self, to others, to the medical intervention to a defended position of ‘unlucky’.

4.2 Theme 2. The bringing together of the mind and body

All participants experienced having one unsuccessful WLS in terms of weight loss followed by requiring a second surgery that produced better weight loss. The second more intrusive operation seemed to enable some participants to reflect on their own role with regards to the first operation. Participants describe a change in ‘mind set’ through a bringing together of the mind and body.

Some participants placed their relationship with food within an addiction model to communicate the difficulties they had, particularly in relation to the level of control over eating. This enabled the conceptualization of obesity to start to be challenged. The literature is also starting to understand over eating in this way with Walfish (2004) suggesting that a relapse prevention programme for drinking and gambling could be adapted for this population.

The common sense model (Leventhal et al 1998) may help explain participants’ shifting understandings. The model highlights that the duration and failure of a symptom (obesity) to respond to treatment (first surgery) will raise questions for the individual about the cause of the difficulty which will in turn activate communication and care
seeking. After the second surgery the role of the mind in determining behavioural changes is prioritised by individuals.

All participants spoke about the mind being neglected by the process of WLS and that this may account for insufficient weight loss with the first surgery. Western culture endorses a mind-body dualism which creates a sharp distinction between the mind and the body (Yardley 1999). The medical culture of WLS seems to promote the treatment of the body and the silencing of the self. Yardley (1999) writes how unfortunately the dualist conceptualisation of illness encourages 'self-handicapping behaviour' (Yardley, 1999 p42) with a model of illness regulation where the scientific 'expert' takes responsibility of defining and managing the illnesses. The individual is often placed in a position of 'passive bewilderment' (Yardley, 1999 p43) meaning the difficulty is not simply found in the mind or body but is a product of contemporary circumstance.

Therefore the socio-cultural context of care has implications for how obesity is treated and individuals are likely to respond. Bates et al (1997) found in clients suffering with chronic pain that dominant discourses around mind-body dualism could contribute to a client's sense of isolation with their experiences being misunderstood and pathologised if a medical intervention was unsuccessful. Similarly the participants in this study explain a sense of isolation and being misunderstood and interestingly take a position of pathologising overeating in order to understand their difficulties and create change.

After the second surgery an internal locus of control seems to be described and as such there is an increased confidence to maintain healthy behaviour. This is concurrent with Teixeria et al's (2005) review and supports Zijlstra et al's (2006) study that suggests that WLS strongly changes individuals' self-efficacy beliefs about their capability to regulate eating behaviour. For these participants it is the second operation that appears to produce the same shift in cognitions. An increase in self-efficacy beliefs is accompanied by more positive eating behaviours and increased activities. Participants also report responding to physiological hunger rather than cognitive control and thus appear to decrease overeating. This is in concordance with Herman and Polivy's (1984) 'boundary model of overeating'.

The cognitive dissonance theory (Totman 1976, 1987) may help explain why for these participants two operations are needed to produce these changes. Totman argues that individual investment in the intervention in terms of time, money, pain and
inconvenience influence the perceived effect in a similar way to a placebo effect. For low dissonance to occur the individual needs to justify their behaviour (a second operation) and the individual needs to see themselves as rational and in control. A second more intrusive operation increases the level of investment and thus could be argued to increase the level of justification (it worked) in order to prevent a state of high dissonance and guilt.

4.3 Theme 3: Adjusting to a new self

The third theme supports Bocchieri et al (2002b) study that weight loss following surgery is not always experienced as unequivocally positive and can in fact cause a number of tensions. With regards to adjusting to dramatic weight loss participants described 'not looking 'right’ or 'normal’. There were also conflicting emotions around not being recognised by others and at times not recognizing themselves. In addition there were mixed emotions with regards to being in the 'limelight’ following WLS and difficulties coping with new intense attention and social pressures. In concordance with Bocchieri et al (2002b) some participants described adjusting to a new self which involved a shifting identity which was sometimes deemed positive but could also cause tensions between an old and new self.

Almost all studies asking about outcome report a general satisfaction post surgery (Wolfe & Terry, 2006) and an increase in quality of life and self-esteem (Ogden 2004). The present study suggests that dramatic weight loss involves a process of adjustment for some individuals that may be important to weight loss maintenance. As with Bocchieri et al (2002b) study significant changes in appearance, behaviours and the reactions of others left participants unsure of whom they now were. A mind-body dualism or split remained (Yardley 1999). The body had dramatically changed but the mind struggled to adjust meaning that participants described discrepancies regarding how they saw themselves physically and how they were now seen by others.

Bocchieri et al (2002b) found that participants spoke of a re-birth or a transformation that involved significant life changes, becoming visible to a world in which they had once felt insignificant and a new sense of freedom in a new body. Similarly participants
spoke of an identity shifting from one that was defined by their size, ‘fat person’ to a new identity that was significant within society and respected; a ‘teacher, a provider’. The findings also support previous research that tends to find that occupational status improves post WLS (Herpertz et al 2003). Participants linked their changing work roles to an increase of confidence which was entwined with their appearance being considered more socially acceptable.

For some participants losing weight increased a sense of vulnerability and old now oversized clothes were used to offer a sense of safety and a connection to the old self. This extends Bocchieri et al’s (2002b) findings that losing weight can increase a sense of vulnerability and that previous weight could be understood as having a self-esteem-preserving function. They found that as weight was lost, participants were forced to consider internal rather than external factors to explain their limitations. In the present study a new appearance could create increased social opportunities which could at times create anxiety. This was particularly the case for one participant that was in the process of considering interactions with the opposite sex following weight loss. The present study extends findings by suggesting how some participants may cope with this increased sense of vulnerability by hiding their new appearance. This is in line with authors who found that some individuals did not have sufficient coping strategies to adjust to a new body/image after WLS (Delin et al 1995).

With regards to adjusting to a new appearance excess skin was a difficulty that was discussed by participants. Few studies acknowledge the difficulties of excess skin and the impact this has on the individual (Bocchieri et al, 2002a). Participants described the physical and psychological consequences of having excess skin. Some participants described that when they looked in the mirror and saw a large body before WLS this appeared more ‘normal’ or ‘right’ than a thinner body with folds of sagging skin. This is concurrent with Bocchieri et al (2002b) who found that some participants became more conscious of the excess skin following weight loss than they had been about being obese. In addition in the present study participants described an interesting power imbalance between themselves and the medical team. Participants needed to demonstrate the medical limitation of having excess skin (rather than the psychological impact) in order to have the skin removed. Again the process seems to promote the treatment of the body but the silencing of the self (Yardley 1999).
The link between body satisfaction / adjustment to a new appearance and the maintenance of healthy behaviours was not fully explored in this study. However the cost/benefit analysis that participants describe continuing to go through suggests that the cost of the surgery and the limits of the new life style and satisfaction with new appearance and associated benefits are linked. This fits with Byrne et al’s (2003) findings that satisfaction with body shape is linked to increased weight maintenance behaviours. As Bocchieri et al (2002a) suggests individuals that felt disappointed by the effects of weight loss would have little justification to adhere to a dietary regime. Within this study it appears that participants were caught in a cost/benefit analysis of WLS. They were attempting to maintain healthy behaviours in order to sustain a new self. This new self could paradoxically increase a sense of vulnerabilities. It therefore seems important that individuals are supported through this process. The findings support Kinzl et al (2002) who found that individuals were interested in psychological support post surgery regarding eating behaviour and self-esteem as a consequence of weight loss. Participants in this study spoke about needing a greater emphasis on the mind with more support from health professionals with regards to adjusting to new eating restrictions and a new self.

4.4 Conclusion

In conclusion it was found that participants struggled with multiple explanations of weight gain after the first surgery with explanations of control shifting from the self, to others and the surgical mechanism itself. Food continued to be used to self-regulate emotions but in an altered way because of the restrictive nature of the surgery. Participants described ‘cheating’ the surgical mechanism in order to overeat and for some participants WLS increased dysfunctional eating behaviours. Following the second surgery, participants understood successful weight loss as a ‘bringing together of the mind and body’ and they explained how the process of WLS tended to treat the body but silence the self endorsing a mind-body dualism (Yardley 1999). In order to produce behavioural change, participants described the mind being ‘in gear’ with participants seemingly acquiring more self-efficacy in their ability to control eating.
behaviours (Zijlstra et al 2006). Such shifts in cognitions can be understood using the
common sense model (Leventhal et al 1998) and theories of cognitive dissonance
(Totman 1976, 1987). Following dramatic weight loss, participants struggled to adjust
to a new appearance. Weight loss appeared to cause a number of tensions between an
old and new self.

4.5 Clinical Implications

As with previous research (Kinzl et al, 2002; Greenburg et al, 2005; Zijstra et al, 2009)
the findings of this study support the need for psychological intervention for clients as
they adjust to new postoperative demands. The findings highlight two particular areas
where support would be beneficial. Firstly in adjusting to the new restrictions that
surgery places on eating behaviour and secondly in adjusting to a new self once weight
has been lost.

Adjusting to the new eating restrictions.

Two vulnerable points post WLS were identified. The first was when the ‘honeymoon’
period of weight loss stopped and participant’s weight plateaued or started to be
regained. A second vulnerable point was moving from soft food to solid food where a
trial and error process could produce distressing vomiting and increase dysfunctional
eating behaviours. Information and support in the form of individual or group sessions
seems particularly pressing at these times so that individual’s needs are addressed in a
person centred manner and the self is not silenced.

The study did demonstrate that WLS seemed to help some participants recognise when
they were eating in response to unpleasant emotions however WLS did not always
enable individuals to cope with or alter this. Participants were left with no mechanism
or strategies to replace ‘emotional’ eating. Weight loss maintenance after WLS may be
improved by postoperative guidance/interventions aimed at improving self-regulation
cognitions and encouraging alternative coping strategies (Zijlstra et al 2009).
In support of Saunders’ (2004) findings the current study calls into question whether BE should be defined by the amount consumed or a subjective loss of control over eating, particularly after WLS. Again learning to identify emotions which trigger uncontrolled eating and developing alternative strategies may enhance weight maintenance and decrease levels of distress. The NICE (2004) guidelines recommend Cognitive Behavioural Therapy (CBT) for Binge Eating Disorder (BED). Research also demonstrates that Cognitive Therapy can increase the use of adaptive coping strategies for clients with BED and other eating disorders (Bloks et al 2001). Such interventions appear promising but would need to be adapted for this population post WLS.

In addition individuals may benefit from interventions which focus on depression/anxiety and improving self-esteem as these have been linked to better weight maintenance. Increasing a sense of self-efficacy appears to be particularly important. Interventions that focus on the individual’s own role and cognitive-behavioural guidance aimed at helping with stress, emotions and physical problems to prevent relapse would be beneficial (Zijlstra et al 2009). However interventions will need to be aware of an important balance for as Sogg and Mori (2009) write, ‘while it is important for individuals to take responsibility for changing behaviours over which they do have some control it is equally important that they do not subject themselves to a cycle of self-blame and discouragement’ (Sogg and Mori p373, 2009).

Adjusting to a new self.

The study identified a number of difficulties in adjusting to a new appearance post surgery. The ability to adjust successfully to a new self may be a determinant of long-term successful surgical outcome (Bocchieri et al, 2002a). The findings suggest that support is needed around negotiating new social situations and new roles within relationships. Adapted social skills, training aimed at increasing confidence and self-esteem may be an appropriate intervention for some individuals. Body image work and dealing with excess skin both practically and emotionally could also be beneficial.
4.6 Methodological Issues and Future Research Implications

The sample of the study can not be understood to be representative of the wider population of individuals that had WLS or required two forms of WLS. The aim of the study and the methodology chosen was to establish an in-depth/rich understanding of individuals’ experiences rather than achieve a representative sample. Generalising beyond these individuals needs to occur with caution as the conclusions drawn involve the researcher’s interpretations of the individual meaning making. However Smith & Osborn (2003) write that themes within one’s sample could be relevant to individuals from analogous populations. The results of this study contribute to and enrich understanding around how individuals that have ‘unsuccessful’ WLS and require further surgery understand and adjust to this process.

When the participants lost more weight after the second operation they seemed to have acquired more self-efficacy in their ability to control eating behaviours (Zijlstra et al 2006). However the lasting changes in self-regulation cognitions after the second surgery are questionable. They appear to be related to weight loss in previous studies (Zijlstra et al 2006). If individuals stop losing weight or even regain weight after the second surgery it is when these self-regulation cognitions may become more important to maintain the successful outcome. Further research is needed to demonstrate whether weight loss maintenance after WLS may be improved by postoperative cognitive-behavioural guidance aimed at improving self-regulation cognitions. In addition the findings continue to highlight the need for longitudinal research (Niego et al 2007).

A value of this study is to alter perceptions within the obesity research field and place an emphasis on understanding people’s experiences post surgery. There should be less focus on what variables predict postoperative weight outcome and instead a focus on improving postoperative guidelines and psychological interventions (Zijstra et al 2009). In addition this is the first study that focuses on individuals that have needed two forms of WLS. If weight regain is observed in approximately 50% of individuals following surgery (Magro et al, 2008) and 30% of individuals have two forms of WLS (Muller et al, 2008) the effectiveness of WLS alone needs to be questioned. The cost of two
surgical procedures financially and to the individual needs to be better understood. The potential benefits of psychological intervention after the first surgical procedure need to be researched further. Randomised controlled trials of different interventions post WLS are needed. The field needs consistent standardised measures pre and post WLS (Niego et al 2007) and a clear definition of ‘success’ (van Hout et al 2005) to allow a cross-comparison of results.

In addition further research understanding the social and cultural context that surgery takes place in would be useful. Interviewing health professionals on their experiences of caring for morbidly obese individuals pre and post surgery would enrich the knowledge base and increase understanding of the possible pressures and organisational limitations that they are under and how these may impact individuals’ experiences of care.

4.7 Final Reflection

Throughout writing this research I have been conscious of the dominant discourse around an ‘obesity epidemic’, responsibility for weight being placed with the individual and that achieving significant weight loss is the best outcome (Thorsby 2007). It is worth acknowledging that some individuals might opt to be obese rather than undergo the process of WLS.

The treatment of the body and the silencing of the self has been a particularly powerful theme through this work. I am aware that my training in psychology is likely to have drawn me to this area. Nevertheless, a lack of opportunity for individuals to process their experiences or seek psychologically informed support has been surprising. I plan to feedback the findings to the participants and disseminate the results to the obesity clinic.
5.0 References


6.1 Appendix 1: Participant Information Sheet
Participant Information Sheet

We would like to invite you to take part in a research study investigating individual's experiences of weight-loss surgery. In particular we are interested in people that have had difficulties after surgery and may have regained weight or perhaps needed a second of operations (e.g. band surgery to bypass surgery).

This information sheet is to explain why the research is being carried out and what it would involve for you if you decide to take part.

Please take the time to read the following information carefully and feel free to talk to others about the study if you wish.

If any information is not clear or you have any questions please do feel free to contact us. (Our contact details are included at the end)

What is the purpose of the study?

The research is being conducted to explore people's experiences after weight loss surgery. In particular we are interested in how people feel they did not lose enough weight or regained weight after surgery. How do these people feel? What are their experiences?

These are important questions which we hope you can help us understand through being involved in the project.

Why have I been invited?

Individuals that have had surgery and have then required a second surgery have been sent this information sheet in order to invite them for an interview to explore their experiences. It is expected that 5-10 participants will be needed to take part in this study.

Do I have to take part?

It is up to you to decide. We will describe the study and go through this information sheet, which we will then give to you. We will then ask you to sign a consent form to show you have agreed to take part. You are free to withdraw at any time, without giving a reason.

What will happen if I take part?

If you decide to take part you will be asked to attend an interview with the female researcher (Gemma Ellis) which will last about one hour at a time and date which is convenient for you. During this interview you will be asked questions about your experiences before and since surgery. The interview will take place in a confidential setting at your usual obesity Clinic or Hospital. The interview will be audio taped and the information recorded will be confidential. You will also be asked to complete a
demographic information questionnaire i.e. asking you about your age, work qualifications etc.

**Will my participation in the study be confidential?**

All information collected during the study is confidential. If you decide to take part only the researcher will have access to your name and contact details. The audio-taped interviews and transcripts of your interview will be stored securely and only accessible to the researchers involved in the study. All tapes and transcripts will remain anonymous and will be kept for the required 5 year period before being destroyed.

If you tell the researcher something that makes her concerned about your or a service user's safety or well-being they will have a duty of care to share this information and it will no longer be confidential. However if the researcher has any concerns she will discuss them with you first.

**What are the possible disadvantages and risks of taking part?**

If we have concerns about your safety or well being we have a duty of care to share this information however this will be discussed with you before any action is taken.

It is possible that participants may have questions or feel the need to discuss issues relating to their surgery or weight in more detail after taking part in this research. Completing the interview may have an emotional impact on participants as they reflect on their experience. The researcher will be available after the interview if participants wish to discuss any issues that may cause distress.

**What are the possible benefits of taking part?**

We cannot promise that the study will help you, although you may find it valuable to have time to discuss your experiences after surgery. It is hoped that the information we get from this study will help inform and therefore improve services.

**What will happen if I don’t want to carry on with the study?**

You can choose to withdraw from the study at any time. If you choose to do this your data (i.e. from the interview) will be destroyed and no longer included in the study.

**What if there is a problem?**

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions (contact details at bottom of page). If you remain unhappy and wish to complain formally, you can do this through the NHS Complaints Procedure. Details can be obtained from the NHS website www.nhs.uk

**What will happen to the results?**
A report of the results will be written for the University of Surrey and will also be written up for publication in a scientific journal. Participants will not be identified in the report or publication and a brief summary of the results will be made available to you upon request.

Who is organising and funding the research?

Research Team

Investigator

Gemma Ellis, Trainee Clinical Psychologist, University of Surrey

Supervisor

Professor Jane Ogden, Health Psychologist, University of Surrey

Our contact consultant at the xxxxxxxx Hospital is XXXXXXXX.

Who has reviewed this study?

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee to protect your safety, rights, wellbeing and dignity. This study has been reviewed and given favourable opinion by Kings College Hospital Research Ethics Committee.

Who should I contact for further information?

If you have any questions about the study, would like to participate, or wish to request a summary of results please do not hesitate to contact Gemma Ellis at XXXXXXX, or Professor Jane Ogden at XXXXXXX.
6.2 Appendix 2: Interview Schedule
Interview Schedule

Introduction

My name is Gemma Ellis and I am a trainee clinical psychologist at Surrey University. Thank you for agreeing to take part in the research.

Today I will be asking you some questions about your experiences of weight loss surgery.

I will anonymise your interview so I hope you will feel free to speak openly to me. Please feel free to ask me any questions at any point throughout the interview today.

Surgery

Could you give me a brief history of your original weight gain?

How did you decide to have the first surgery?

How did you feel after the surgery?

Prompt – physically, emotionally, and mentally.

How were things after the band?

Prompt – work, interests, relationships, eating

Why do you think that you stopped losing weight/regained weight with the band?

How did you decide to have a second surgery?

How did you find the second surgery?

How did you lose weight/gain weight following the second surgery?

Effect on the self

How would you describe yourself as a person?

Prompt – what sort of person are you? most important characteristics?

Has having surgery made a difference to how you see yourself?
Prompt – if so, how would you see yourself now as compared to before surgery? How would you say you have changed?

What about the way other people see you?

Prompt - colleagues, family friends?

On a day to day basic how do you deal with eating now?

Do you think about the future much?

Thank you very much for participating in this research.
6.3 Appendix 3: Consent Form
Consent Form for Research Participants

Participant Identification Number for this research: 

Name of Researcher: Gemma Ellis

Please initial box

I have read and understand the participant information sheet dated .......... (version 1). I have had the opportunity to consider the information and ask questions. My questions have been answered satisfactorily.

I understand that my participation is voluntary and that I am free to withdraw at any time. I do not have to give any reason for withdrawing from the study. There will be no negative consequences for me if I decide to withdraw.

I understand that data collected as part of this research project will be treated confidentially. I understand that the results will be published but I will not be identifiable.

I consent to participate in the above study.

I consent to being audiotaped during the interview

I understand that these audiotapes will be transcribed and will then be kept in a secure place. Both the tapes and transcripts will be destroyed after analysis.

Name of participant Date Signature
6.4 Appendix 4: Demographic form
Participant Demographic Form

ID

The following questions ask you some personal details about yourself. You do not have to answer these questions if you do not wish to. Any responses that you do give will be kept strictly confidential. Completed questionnaires will only be seen by the researchers involved in the study.

ARE YOU? Male □ Female □

HOW OLD ARE YOU? __________

WHAT IS YOUR CURRENT OCCUPATION?

Employed □ Unemployed □ Student □

Please specify occupation ____________________________

DATE OF FIRST SURGERY:
DATE OF ADDITIONAL SURGERY:

BMI BEFORE 1ST SURGERY

BMI AFTER 1ST SURGERY

BMI BEFORE 2ND SURGERY
### CURRENT BMI

#### HOW WOULD YOU DEFINE YOUR ETHNICITY?

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>White - British</td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>White - Irish</td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>White - Any other White Background</td>
<td></td>
</tr>
<tr>
<td>D</td>
<td>Mixed – White and Black Caribbean</td>
<td></td>
</tr>
<tr>
<td>E</td>
<td>Mixed – White and Black African</td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>Mixed – White and Asian</td>
<td></td>
</tr>
<tr>
<td>G</td>
<td>Mixed – Any other mixed background</td>
<td></td>
</tr>
<tr>
<td>H</td>
<td>Asian or Asian British – Indian</td>
<td></td>
</tr>
<tr>
<td>J</td>
<td>Asian or Asian British – Pakistani</td>
<td></td>
</tr>
<tr>
<td>K</td>
<td>Asian or Asian British – Bangladeshi</td>
<td></td>
</tr>
<tr>
<td>L</td>
<td>Asian or Asian British – Any other Asian Background</td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>Black or Black British – Caribbean</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>Black or Black British – African</td>
<td></td>
</tr>
<tr>
<td>P</td>
<td>Black or Black British – Any other Black background</td>
<td></td>
</tr>
<tr>
<td>R</td>
<td>Other ethnic groups – Chinese</td>
<td></td>
</tr>
<tr>
<td>S</td>
<td>Other ethnic groups – Any other ethnic group</td>
<td></td>
</tr>
</tbody>
</table>
6.5 Appendix 5: Debriefing Letter
Debriefing Letter

Thank you very much for participating in our research. The aim of this research was to explore people’s experiences after obesity surgery. In particular how people feel if it is necessary to have the procedure reversed or if they view the surgery as unsuccessful.

The research is being conducted by a Trainee Clinical Psychologists and a Health Psychologist based at the University of Surrey and ethical approval has been sought through King’s College Hospital.

This study will not include your name of any other identifying characteristics and the research did not use any form of deception.

If after taking part in this research you have any questions or concerns about the subjects we discussed please feel free to contact Gemma Ellis at XXXXXXXXX, or via the Department of Psychology, xxxxx, or Professor Jane Ogden at XXXXXXXXX.

You may also request a copy of the research findings once the project is completed.

Thank you for your participation in this research.
6.6 Appendix 6: Ethical Approval Documentation

Original Ethical approval for Professor Jane Ogden Research

Original R&D approval

Ethical approval for amendments

Evidence of amendments notification to R&D.

University of Surrey Ethical Approval
Dear Dr. Ogden,

Re: LREC Protocol No. 09-03-170
A cross-sectional study of changes in psychological and behavioural factors following surgery for morbid obesity

Thank you for your letter dated 29 September 2003 in response to our queries. I am happy to provide approval on ethical grounds. The following documents were received:

- GP Letter
- Patient Consent Form

The conditions of approval are set out below:

- You do not undertake this research until approval has been given by the relevant NHS Trust. Without Trust approval, ethical approval is void.

- You do not deviate from, or make changes to, the protocol without prior written approval from this Research Ethics Committee, except where necessary to eliminate immediate hazards to research participants or when the change involves only logistical or administrative aspects of the research. In such cases, the REC should be informed within seven days of the implementation of the change.

- You complete and return the standard progress report form to the REC one year from the date on this letter and thereafter on an annual basis. This form should also be used to notify the REC when your research is completed and in this case should be sent to this REC within three months of completion.
• If you decide to terminate this research prematurely, you send a report to this REC within 15 days indicating the reason for early termination.

• You advise the REC of any unusual or unexpected results that raise questions about the safety of the research.

Please quote LREC Protocol No.08-03-170 in all future correspondence relating to this study.

[Redacted] is compliant with ICH GCP guidelines

Yours sincerely

[Signature]
Dear Dr Ogden,

14 August 2003

RE: 03DK13 A cross sectional study of changes of psychological and behavioural factors following surgery for morbid obesity

Thank you for submitting this protocol to the R&D Committee for review. In general the committee were happy with the study but would like you to submit a version taking into account the reviewer's comments enclosed for Chairman's Action. The committee were also concerned that the time, which had elapsed since the surgery, might affect patients' perceptions and felt that the phrase "in the past year" did not describe the timescale with acceptable accuracy.

Kind Regards

[Signature]

Research Manager
Directorate of Research and Development
Ethical approval for amendments

27th of November 2008.

Professor Jane Ogden,
Department of Psychology,
University of Surrey,
Guilford,
Surrey,
GU2 7XH.

Dear Professor Ogden,

Study title: A cross sectional study of changes in psychological and behavioural factors following surgery for morbid obesity
REC reference: 08-03-179
Amendment number: 2
Amendment date: 28/08/08

The above amendment was reviewed at the meeting of the Sub-Committee of the REC held on the 27th of November 2008.

Ethical opinion

The members of the Committee present, Doctor Jewitt and the Reverend Rushton, gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

Approved documents

The documents reviewed and approved at the meeting were:

<table>
<thead>
<tr>
<th>Document</th>
<th>Version</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Notice of Substantial Amendment (non-CTIMPs)</td>
<td>Oct 2005</td>
<td>01 July 2008</td>
</tr>
<tr>
<td>List of changes to Protocol</td>
<td>1</td>
<td>29/08/08</td>
</tr>
<tr>
<td>Patient Information Sheet</td>
<td>1</td>
<td>29/08/08</td>
</tr>
<tr>
<td>Consent Form</td>
<td>1</td>
<td>29/08/08</td>
</tr>
<tr>
<td>Interview Schedule</td>
<td>1</td>
<td>29/08/08</td>
</tr>
</tbody>
</table>

R&D approval

All investigators and research collaborators in the NHS should notify the R&D office for the relevant NHS care organisation of this amendment and check whether it affects R&D approval of the research.

Statement of compliance

This Research Ethics Committee is an advisory committee to London Strategic Health Authority
The National Research Ethics Service (NRES) represents the NRES Directorate within the National Patient Safety Agency and Research Ethics Committees in England

228
The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

07/H0808/193: Please quote this number on all correspondence

Yours sincerely,

Chris Ward,
Assistant Committee Co-ordinator.

E-mail: chris.ward@kch.nhs.uk
Evidence of amendments notification to R&D

Directorate of
RESEARCH &
DEVELOPMENT

Professor Jane Ogden
Department of Psychology
University of Surrey
Guildford
Surrey
GU2 7XH

Date: 29th May 2009

Acknowledgement of Amendment

R&D: 03DE13
Title: A cross sectional study of changes in psychological and behavioural factors following surgery for morbid obesity
REC Number: 08-03-170

Dear Professor Ogden

Thank you for submitting your recent amendments. I can confirm that these do not change the terms of your R&D Approval. I have also extended the project end date to 31/12/09 as stated in your notice of amendment to the REC.

Yours sincerely

Wendy Fisher
Research and Development Manager (non-commercial)
Research and Development Department
Kings College Hospital NHS Trust
First Floor Jennie Lee House, 34 Love Walk
London SE5 8AD

R&DRegistration@kch.nhs.uk
Dear Gemma

Reference: 289-PSY-08
Title of Project: A cross sectional study of changes in psychological and behavioural factors following surgery for morbid obesity.

Thank you for your submission of the above proposal.

The Faculty of Arts and Human Sciences Ethics Committee has given favourable ethical opinion.

If there are any significant changes to this proposal you may need to consider requesting scrutiny by the Faculty Ethics Committee.

Yours sincerely

[Signature]

Dr Adrian Coyle
6.7 Appendix 7: Transcript to Illustrate the Process of Analysis
G: So to start with for the interview, if you could just tell me, give me a brief history of your original weight gain?

B: Okay. Erm, about 15-20 years ago, I had a DVT. Erm, I've always, ermm, since the age of 14, been, ermm, quite heavy and been on a couple of doctor controlled diets in those days. Erm, using possibly amphetamines as ermm, ermm as a pill to help me lose weight or dospan, whatever it was that they gave. Didn't really pay much attention at the time. Erm, the diet pills worked, ermm, but then I put the weight back on and I'd always hovered around 16, 17 stone until I had this, ermm, this DVT.

Erm, back when I was about 33, so that's some 20 odd years ago. Erm, it's actually 20 years this year and ermm, I was advised to give up smoking which I did, ermm, immediately after coming out of hospital but substituted smoking with tons of chocolate and stuff like that. Erm, consequently weight ballooned up to around 22 stone, ermm, of which really didn't bother me. Erm, I was concerned a little bit but ermm, it didn't really stop me doing the things I was doing at the time so I didn't think much of it. And, ermm, I had a major life threat in 2001 whereby I lost my large bowel, total colectomy. And, ermm, the upshot of that was that I'd actually got down to 19 stone when I came out of the hospital, ermm, which wasn't a surprise because like, they take 35 feet of intestine out of you plus all the other bit and also I wasn't eating obviously at the time so the weight loss was good and I felt really good. Erm, but afterwards, ermm, because food transits through the body very quickly I was feeling hungry too often and I stuffed myself stupid most days. I've always enjoyed food and ermm I went up to just under 30 stone. Erm, my doctor, ermm, had, at the time, I'd had the, it's a bit difficult coza lot when around then. At the time I had the, errr, life threat, we put that down to, I was on some diet pills, ermm, Zenacol. Erm, and we believe that, they now don't give them if you've got Diverticulitis which I had, ermm, and that's what flared my Diverticulitis up which caused my bowel to explode and that was the end of it really. So at that time, I was obviously concerned about the weight was on these, ermm, Zenacol tablets and the weight loss was going good. Erm, but then, ermm, as I said, the Diverticulitis, ermm, flared up, lost my large bowel, come into hospital, ermm, came out of hospital at 19 stone, ermm and the next year, 2 years, I put on up to nearly 30 stone from 19.

G: Oh gosh, in a 2 year period, and why do you think...
B: Well, it's because the food transits through the body...basically I was feeling hungry all the time and food, immediately I ate it, erm, because I think you store two and half days worth. I'm not sure the full mechanics of it but I was only storing about a day's worth before it was moving...so it was moving through quickly, I was feeling hungry, I just stuffed myself stupid.

G: And were you noticing the weight coming on?

B: Oh yeah. I mean I went from, erm, a thirty, thirty eight inch waist to a sixty two inch waist. Erm, the impact upon my health was tremendous, erm, the large bowl operation had fired off a thing called Fibromyalgia which I've got. Erm, which is basically chronic pain, chronic fatigue syndrome, muscle stiffness, loads of other issues as well. And, err, that was one of the reasons why I went to my doctor in the first instances, erm, to talk to him about the weight as it was increasing from the 19 stone mark and we tried, there was a new pill out that was supposed to be a lot safer than Zenacol, can't remember what it was called, erm, reduced, I think. Yup. Went on those. Really didn't do any good and my doctor was sort of advocating, erm, stomach banding and I said, don't be silly, I mean, you know, I've got a big scar down my stomach and I don't want to go through any operations. Erm, health was taking a real turn for the worst really, I was finding it difficult to manage throughout the day. Difficult to walk, difficult to do anything. Erm, in the end I gave in. Spoke to my doctor, erm, got me referred, erm, but then was told I couldn't have the operations because RB hospital don't fund it. Went to war with RB, took a year, got them to fund the operation. Then set about finding a NHS doctor that does the banding operation within London coz I didn't want to travel out of London. Found Mr M, here, came down and a preliminary appointment. He said the band was the wrong operation for me at the time and advocated that we do a full stomach bypass. But as an interim method as an urgency, we'd do the banding because obviously my off??? was failing. Erm, and then afterwords look at after six months, eight months or so look at the full bypass.

G: So, was that, that sounds like it was discussed, you were always going to the band and then the full bypass?

B: Yes
G: Was there ever a time when you were going to see how the band goes?

B: Yes, it was see how the band goes but he was suspect, because it was the wrong mechanism for the controlling all my weight. Erm, I think his concerns were because I was heavy, a reasonable chance of the next operation succeeding as well. So in January, February 2006, yeah, January, February 2006, I came in here, had the band fitted and erm, spend three or four days here and then went home. Erm and then in the period of three or four months, lost about four stone which was good but then, erm, family life and pressure, work pressures as well. I managed to cheat the band a couple of times and it was, I stayed stable at four stone loss. Erm, had a follow up appointment with Mr M.

G: Oh, just before, what would be really interesting is to hear about how you managed to cheat the band?

B: Well the fact of the matter is, all the band does and that's why initially I suppose why Mr M. reckoned it was probably the wrong operation for me was that all the band does is just sections off your stomach, erm, to a little pouch which is supposedly supposed to tell the brain you've had enough. Effectively, it never did. What it did was hurt like hell when it was full.

G: Oh, okay. What kind of feeling was that then?

B: Just a very heavy, hard pain in the middle of the chest. Erm and nausea. Think I was sick a couple of times towards the end of the band with it. And I found that if I chewed the food tremendously to a pulp I could actually get more of it, erm, quite frequently. Had the band adjusted at a certain point to quickly so I couldn't, erm. And at that point, stayed stable. It still wasn't enough weight loss for me to feel good about myself, and to carry on and to manage on a day to day basis.

G: So you had dropped from 30 stone to about 26.

B: Yeah, yeah. Absolutely right, about 25, 26 stone. Erm, still too much.
G: And what kind of things could you eat when you were on
the band?

B: I could eat...I actually ate anything I felt like eating even
though the dietician was advocating rabbit food and stuff like
that and my, em, my philosophy behind it was that, I’m going
to eat a little bit of it so I might as well eat what I like. Em, the...
calorie input, I mean it was a miniscule amount of food to be
honest. And as I say, four stone straight away was quite a good
loss.

G: And why do you think you didn’t carry on losing because as
you say that four stone was a good loss. Why do think it didn’t
carry on losing?

B: I suppose because I ate up to what the band would allow
me to eat up to and that was not the amount of food that was
going to cause continual weight loss over, over that period of
time.

G: Okay.

B: Erm, effectively the band really was useless apart from doing
the initial surge. And I’d done a lot of research on the subject
anyway. There’s probably one very good website on the web
today that goes into everything. And consequently got some
friends who’ve had the same operations and their bands have
not done them any favours either so....

G: Hmm, yeah.

B: The band works to a certain extent. I suppose if you’re just
overweight, the band’s probably a good idea.

G: Okay.

B: But if you’re, you’re hugely obese, I mean, effectively the
operation that certainly Mr M. advocates and certainly the
websites and research advocates is the full stomach bypass.
Em, I reluctantly looked at that and said, no I don’t want it and
fought it for a little while and then decided em, because my
health was really quite bad that I’ve got to do something. Em,
the band is clearly in there, not really doing very much.

G: Hmm, Did you start to put on weight with the band?

B: I was bouncing a little bit but it wasn’t a massive amount to
be honest with you. maybe two or three pounds here and there
you know. Em, but it would come off again. Because what
would happen was, erm, I'd obviously eat a bit too quickly sometimes and that would then. I'd throw that back and then I wouldn't fancy eating for maybe half a day, maybe a day.

Erm, and as I say my health was quite bad. I was in and out of hospital quite frequently. Erm, with, I was coughing up blood. At some points, I was taken in over a few days for that. Erm, so the weight was sort of fairly stable. Anyway, I decided then to come and talk to Mr M. and we had a discussion, he was going to do the full bypass and I was scheduled for that in, on June 2007.

G: So you tried the band, so was it about a year then?

B: Yes. Band was in for a year.

G: Mmm. And what kind of, erm, you...

B: Consequently, also, I must tell you about the band as well which, erm, probably set me against the band is that they put the port the wrong way round so they couldn't actually adjust the band for there visits which didn't help. They were sticking needles in my chest to try and get into the port, err, and then they erm, I mean I'm not good with needles or anything as regards knives and stuff and then they came in under a local anaesthetic, they cut my chest open, turned the port round and stitched me back up which really frightened the crap out of me.

G: Oh god.

B: Excuse my terminology.

G: Yeah.

B: And, erm, really, by that time, the band was, I was thinking more about I've got this piece of plastic in me with tube and a metal port and I really wasn't comfortable. Although, had I needed to keep it in there, it wouldn't have been an issue. It just wasn't comfortable. And the weight wasn't coming off which was the prime objective of having this band inside.

G: Err, you're not comfortable, err, physically wasn't make you feel comfortable?

B: No, no, I just wasn't mentally comfortable with it in there. Physically, it wasn't really, you couldn't really tell apart from just maybe pressing on the chest you could feel the band, the port.

G: Yeah.
B: So I wasn't that bothered. I mean it was just a mental, a mental thing more than anything else. Erm, so we had a discussion, he was going to do the full bypass in June 2007. I came in, err, went down for the operation. Was down there for quite a long time, more than the time they stated. When I came back, err, it said they couldn't do the full bypass because there was so much damage inside lesions and stuff from all my operations like my large bowel removal and the previous banding operation that they just, it was not good for them to try so they did the next one back from a total err, a total stomach bypass. They did a sleeve gastrectomy which is basically a bypass but without moving tubes, the duodenum and all that business, the bowel tubes and all that. Erm, and that night I wasn't very well and the next day I had to back for an emergency op because the staple lining was sealed properly so err, went back for that. Erm, came out of that, was in hospital quite a few weeks, I think. When I was discharged, I was discharged, one of wounds wasn't healed so I to put on a wound bag on and I was leaking pus and stuff and I had a, I had a, erm, plural effusion as well which is fluid on the lung.

G: Gosh, yes.

B: They tried at outpatients to remove fluid with a needle through me back. Didn't work and the hole in my tummy and puss coming out took three months to heal and in that time, I was in and out of hospital three or four times with episodes around the wound and severe pain inside which amounted to my gall bladder had failed or packed up. There was large gallstones forming. One had obviously got stuck in a bar duct or something and I to come in, in October 2007 and have my gall bladder removed.

G: Gosh.

B: But they couldn't do that keyhole. They had to open me up fully because of so much damage and afterwards they said it was right to have done that because they would have a had right big problem doing it keyhole, Erm, so consequently, got over all that and... August 2008 I had my plastic surgery... I had the stomach flap taken away which was another 5 kilos of spare skin.

G: So okay, so before the plastic surgery, was there about a year with the sleeve?

B: Yeah, that's about it yeah.
G: And how did you find the sleeve?

B: Great, no problem. I mean, basically, I can't eat. Erm, again I adopted the philosophy, I eat what I want, I can only eat five mouthfuls, job done. I don't graze in between. Erm, and consequently lost. I'm now 15 stone, ten stone, ten or eleven stone. Don't graze.

G: So you lost ten, eleven stone. And that was in a year, in a year time. And it was interesting that you said that you didn't, you don't graze?

B: I could if I wanted to.

G: You could, okay. What stops you grazing?

B: Err, the amount of pain, the operations performed. Don't want to do any damage, don't particularly want the stomach to enlarge anymore which it can do. [I]m not sure. I didn't go back to the way I was by just eating a bit more each day and getting the stomach grow naturally. Erm, don't particularly want to split the staple lining if that's possible, I've obviously got at least that. Whether it's possible, I don't know. I don't think it is but just don't want to even think about it. Erm, that's it really.

G: So it sounds like it's a thought of more operations that stops you grazing?

B: Yeah.

G: Have you had any support at all around your operations? Advice or...

B: No, not really. I mean, that is pretty poor to be honest. Erm, a lot of the operations, erm, a lot of what they've done and everything else is only sort of, I found out myself, nobody's really talked about what operation I'm going to have, just briefly but been very little support for me really to be honest. To be frank about it. Erm, and if it wasn't for my pushy nature, I doubt really we'd be at this stage in my life anyway.

G: What about the after, aftercare after an operation?

B: Erm.

G: I mean when you go back home kind of thing.
B: Pretty abysmal really. District nurses failed to turn up on several occasions. Erm, the, I mean the service is poor to be honest but that's probably specific to the area I live in. Erm, probably specific for whatever reason... lack of staff, I don't know. All I know is that prior when I had my large bowel removed, the district nurses, the follow up and everything else was just tremendous. District nurse was there every day, making sure things were right. My doctor was looking after me. My doctor looked after me now more so. I get my regular checks here and that's it really, nothing else. No guidance, nothing.

G: And what about the dietician, you mentioned the dietician with the band?

B: Seen her twice. Not seen her at all afterwards. I don't think I've seen her since I've had my er, my sleeve gastrectomy, not that I probably need to. But had I been perhaps of a different frame of mind, a different person entirely, erm, maybe it would have done.

G: So what kind of things do you eat? If you could talk me through a day now, what kind of things can you eat with your sleeve?

B: Erm, well, I normally start in the morning with a cup of tea. Erm, gets me woken up and then I have another cup of tea with either erm, two crumpets or two slices of toast, buttered toast. That sees me until I get into work and then I have a cup-a-soup, er, just to put something in my tummy because I still feel hungry and I still feel empty. I used to suffer with hypoglycaemia so I need to obviously make sure that I balance what sugar take in and everything else otherwise I get zero sugar and have an episode.

G: Right.

B: Erm, lunchtimes, depends how I feel. Erm, I go out and I normally buy a sandwich and a soft drink of which I can only eat half of a sandwich as it is two slices of bread with a filling and I can only eat half of that before I feel full and then I finish the drink throughout the rest of the afternoon. And I go home in the evening and I top that up with a couple of little pieces that big, er, couple of little spring rolls or some mashed potato and maybe a chicken nugget or two if I'm feeling hungry with a soft drink. Erm, that's about it really. That's entire food. On occasions, I go out to eat with family and friends. I pick off their plates and I eat and I eat what I want till my stomach tells me eat and eat what

Social adjustment

Eating out

Out with family and friends

Pick up their plates and I eat and I eat what I want till my stomach tells me
G: Okay, so has that happened at all?

B: Since the sleeve vagotomy, I have actually been sick. I've come close once a year. Erm, but I haven't actually been sick and I'm trying obviously not to make myself sick because it's pushing really hard if you do. So basically that's it. It's not difficult, erm, I'm on extra supplement pills to give me extra vitamins I'm missing. Erm, I'm due to come up again for another blood check soon and they will tell me what vitamins I'm missing or whatever. Then, we'll adjust it. Erm probably don't eat the right foods according to the dietician but my erm, my philosophy is that I've lost fifteen stone from start to finish. I don't intend to be putting tons of it back so I'll go on the way I'm going on.

G: And just from what you said, going out for a meal, would you order yourself a meal?

B: No, no. We make it plain to restaurants that I can't eat. Erm, I can only eat five mouthfuls so therefore all you're going to give me is an empty plate, knife and fork and I'll pick up off either my wife's, my kids' or friend's plates or whatever. Five or six mouthfuls in most restaurants we go in, I accept that fact.

G: And how does that make you feel?

B: Sometimes a little despondent, because I enjoy food. Erm, and one thing I said to my GP a few months ago was everybody takes care of the physical but nobody takes care of there's a fat man inside this thin body. I've been fat for 33, 32 years; erm, the mental side of this, nobody's actually dealt with that and I suppose that goes back to what's support have you had. None. I don't think the medical profession ever deal with it.

G: And just from what you said, going out for a meal, would you order yourself a meal?

B: No, no. We make it plain to restaurants that I can't eat. Erm, I can only eat five mouthfuls so therefore all you're going to give me is an empty plate, knife and fork and I'll pick up off either my wife's, my kids' or friend's plates or whatever.

G: And how does that make you feel?

B: Sometimes a little despondent, because I enjoy food. Erm, and one thing I said to my GP a few months ago was everybody takes care of the physical but nobody takes care of there's a fat man inside this thin body. I've been fat for 33, 32 years; erm, the mental side of this, nobody's actually dealt with that and I suppose that goes back to what's support have you had. None. I don't think the medical profession ever deal with it.

G: And just from what you said, going out for a meal, would you order yourself a meal?

B: No, no. We make it plain to restaurants that I can't eat. Erm, I can only eat five mouthfuls so therefore all you're going to give me is an empty plate, knife and fork and I'll pick up off either my wife's, my kids' or friend's plates or whatever.

G: And how does that make you feel?

B: Sometimes a little despondent, because I enjoy food. Erm, and one thing I said to my GP a few months ago was everybody takes care of the physical but nobody takes care of there's a fat man inside this thin body. I've been fat for 33, 32 years; erm, the mental side of this, nobody's actually dealt with that and I suppose that goes back to what's support have you had. None. I don't think the medical profession ever deal with it.

G: And just from what you said, going out for a meal, would you order yourself a meal?

B: No, no. We make it plain to restaurants that I can't eat. Erm, I can only eat five mouthfuls so therefore all you're going to give me is an empty plate, knife and fork and I'll pick up off either my wife's, my kids' or friend's plates or whatever.

G: And how does that make you feel?

B: Sometimes a little despondent, because I enjoy food. Erm, and one thing I said to my GP a few months ago was everybody takes care of the physical but nobody takes care of there's a fat man inside this thin body. I've been fat for 33, 32 years; erm, the mental side of this, nobody's actually dealt with that and I suppose that goes back to what's support have you had. None. I don't think the medical profession ever deal with it.

G: And just from what you said, going out for a meal, would you order yourself a meal?

B: No, no. We make it plain to restaurants that I can't eat. Erm, I can only eat five mouthfuls so therefore all you're going to give me is an empty plate, knife and fork and I'll pick up off either my wife's, my kids' or friend's plates or whatever.

G: And how does that make you feel?

B: Sometimes a little despondent, because I enjoy food. Erm, and one thing I said to my GP a few months ago was everybody takes care of the physical but nobody takes care of there's a fat man inside this thin body. I've been fat for 33, 32 years; erm, the mental side of this, nobody's actually dealt with that and I suppose that goes back to what's support have you had. None. I don't think the medical profession ever deal with it.

G: And just from what you said, going out for a meal, would you order yourself a meal?

B: No, no. We make it plain to restaurants that I can't eat. Erm, I can only eat five mouthfuls so therefore all you're going to give me is an empty plate, knife and fork and I'll pick up off either my wife's, my kids' or friend's plates or whatever.

G: And how does that make you feel?

B: Sometimes a little despondent, because I enjoy food. Erm, and one thing I said to my GP a few months ago was everybody takes care of the physical but nobody takes care of there's a fat man inside this thin body. I've been fat for 33, 32 years; erm, the mental side of this, nobody's actually dealt with that and I suppose that goes back to what's support have you had. None. I don't think the medical profession ever deal with it.
education. Ern, she's 15 and half stone and she's only 14 years old.

G: Right.

B: So she's probably going be down this route and I would like to see better support in place than what I've had. I'm pretty strong minded, pretty focused, know what I want. She may not necessarily be like that and I know friends of mine and people I've spoken to as I've met them here and outside that have had this operation or are going for the operation, some are weak-willed, some aren't weak willed and other stuff. So not only do they need to get the operation sorted which they have and they're making leaps and bounds in the technology to do that but they also need to think about the person and that's currently not taken care of.

G: Because as you've said, you know, you described a fat man in a thin body. Can you tell me a little bit more about that?

What you mean?

B: Well it's a case of going and look in the mirror for day... and I've got a flat tummy. Now I've never had a flat tummy. Ern, I've got some scars there which are diminishing very quickly so all the power to the plastic surgeons. They've done a blinding job but there's obviously still a lot of excess skin and fat up here which I'm going to talk to him about today. I don't particularly want to go for another operation because it's going to be another major plastic surgery but I may need to, because it doesn't look right whereas before being fat doesn't look right but I've grown up with it, that's... you know, when I look in the mirror, I've got this fat man looking back at me and I'm happy, I was happy with that. Wasn't happy, wasn't happy towards the end because thirty stone, if you saw what I see in the morning it just wasn't pleasant. Ern and of course it, the knock on effect of that is hygiene, sweat sores, sweat boils, blood boils, erm... all sorts of issues plus compounding on what I've already got as illnesses. Ern, so it's difficult. Ern, and it's just the fact that also going into a shop and buying clothes, I mean I was saying to a guy today, I rode motorbikes 26 years ago, I took up just after the band operation again, I gave up for 20 years and I wouldn't never ever in those days bought leather to ride on the bike... and I would never ever envisage myself in leathers but I've got a set of leathers because I took one look at my body and I...
I thought, well, yeah it isn't that bad. It's not going to look too unreasonable in a set of leathers, we'll buy em. Em but then I look down at my body and think was it worth it? And there's all sorts of things going on in my mind which obviously I can't remember some of them but it just hits me occasionally and I find myself, all the pain and the suffering, was worth it? Just for the flat tummy but then I've got to take into account obviously the impact on my health and all that sort of thing as well. There's not a lot of pressure on my internal organs which there was when I was thirty stone. This that and the other. So it's just if it would have been nice to maybe get this all out as we're properly discussing it, probably would have nice to have done this eight, you know, a year, well, nine months ago, eight months ago with somebody and somebody say well, you know, yeah, you're right to consider that or no, forget about it, do this. So that side of things has been very tax really and maybe would have helped me a little but maybe help somebody else a lot more than me and make the operation successful coz a woman, I'm a parent governor at school, there's a woman there she's overweight and she's had the, she came in and the sleevevesentectomy straight away. She lost three or four stone and then she's stopped losing with it because she grazes through the day because she hasn't got the right state of mind. I believe she's either just been in or she's in at the moment having the full bypass.

G: Right

B: But if she doesn't change the way she thinks about it, I suspect she's not going to be losing tons and tons of weight like everybody else.

G: So how do you think you've managed to change the way you think about it?

B: Em, I just think, it's a unique set of circumstances whereby I've got this Fibromyalgia in the background which I was hoping was going to go easier for me with a lot less weight on my limbs and bones and joints and stuff but it hasn't. Plus also a lot less weight has enabled me to walk up the road without losing my breath, without feeling feint, without feeling dizzy and everything else. Em, and a lot it is just aware now that I can actually do things that normal human beings do like walk up the road without actually feeling feint, without actually, you know so therefore that's helping me and plus also because I'm actually quite a strong personality anyway, I think I've
succeeded. But as I say, I'm just concerned for people following me that aren't. That don't get maybe the help and aren't as resound maybe as I am.

G: And when you wonder with yourself, is it, was it worth it. And you told me a bit about why it is worth it because you mentioned some physical health benefits. What...do you know what goes through your mind about why it might not be worth, why it might not have been worth it?

B: Well, the only thing that has gone through my mind that says it might not be worth it, is just the actual pain and suffering that I've gone through. Er, everything else has to be a plus. It's got to be.

G: And what about the, the, sorry I cut you off about the plastic surgery. Can you tell me a bit about that? Or how you came to that decision?

B: Er, I wasn't going to have it done because I'm not that. I'm not that naive. Not naive, what's the word I'm looking for. I don't care. You know, I'm not going on beaches looking at babes so babes aren't going to be looking so I'm not that bothered you know. Er, but I thought about it because it was being mentioned that once you get stabilised in your weight, you get to this set weight, we'll talk about plastic surgery and I'm like, yeah, yeah, yeah, okay. In the early days, I was saying, yeah, we won't even go there. Towards the end of it, I've got this. It's going to get a bit graphic now but I've got this flap of skin and excess long term fat in it which folds and obviously it gets sweaty, it gets sore, there's blood boils, blisters. Er, the maintenance of it is quite a lot plus soreness and the pain from the blisters and the mess and it smells so it was just a. it was I suppose one morning I woke up and I thought you know if they chop that away, I'm not going to have all that issue. I can get on and do something else. And I'm thinking about clothes as well because clothes aren't designed with this big flap in front at that point in time. I wouldn't be able to wear these trousers and stuff. I still have to, err, bear in mind I'm still a plus 44/46 waist with this flap. Er, I'm now a 38 so it was a conscientious decision to say well, I've done so much so far, I might as well just go and finish and complete the job, err and reap the results of that, being able to go and buy clothes, a, cheaply because you can get them off the peg, b, they fit and don't look horrendous. I don't particularly look a bad sight and what if I put a bathing costume on, I don't look that bad. Err,
even though I'm not there, you know, my time's up for that sort of lark, malarkey, it isn't too bad so I don't know, it was the decision at the time. Erm, and you could ask me was the right
decision, the jury's still out, suppose so, I'm certainly feeling better because of it, I feel...normally on a day to day basis,
better about it. Sometimes, I look at myself and think am I an
abomination of being cut about but it's just one of those things
you know.

G: And you feel better, what kind...can you tell me a bit more
about how you know you're feeling better? I mean, do...

B: Difficult question innit.

G: Yeah, like, have you noticed anything?

B: No, well, I notice the comments people make...I mean friends
that I've known for years and years and years have actually
walked passed me. Some of them, I ain't seen for a while, have
only seen me prior to the operation, have actually walked
passed me. And totally, totally missed me. And people say
bloody you look good you know and compliments and
everything else. I suppose that's a plus side. But again I'm not
that, I'm not that vain effectively. I mean, oh yeah, oh yeah,
due to the operation, yeah, I feel a bit better but mainly did it
for my health and that's all I did it for. Erm, the fact that I do
look good I suppose is a bonus and it is, it does. I suppose it
does please me in the end but it wasn't the moving factor, it
wasn't the big, deciding factor, erm that I look good to get
thing done. It was for the health side of things and as long as I
maintain that, it was worth it. Everything was worth it.

G: And how do you plan to maintain it?

B: Hmmm, difficult question. I suppose you could liken it to
somebody that's just come off the alcohol. And they'll always
want a drink and I'll always want to stuff down a chocolate bar
and stuff. Erm, and on occasions I do! What the heck, you
know.... But I've just got to make sure I don't stuff down two,
three, four or five or graze. Should I do that, then obviously
things are going to, erm, are going to happen. I've put a few
pounds on recently but that's because I've been a bit lethargic
recently due to my inability to move to due the Fibromyalgia
but that will go in the summer, erm, like everybody in the winter,
you tend to put on a little bit anyway, erm, but I don't intend to,
erm, physically put on tons of weight again. Erm, so it is just a
case of carry on as is. And see what happens in a year's time.
two years, five years, ten years. Who knows what's round the
corner.

G: So, it's interesting you've compared it to like, like a drink, like an alcoholic. So that's how you feel about food?

B: Oh yeah, I mean it's like gambling isn't it. There's gambling, alcohol, food, drugs, I mean it's all the same. It's an obsession. Food is an obsession. Food is an obsession with my daughter and I clearly see that now. She can't, you know, when my younger daughter has something to eat, she wants something to eat. Why does she want something to eat? Because the taste sensations, she enjoys food, she enjoys the fact that she feels extremely full.

G: Is that the same experience as you?

B: And that's where I come from. Huh, you know! Err, I suppose I've got a little bit of an excuse because I come from era whereby my parents used to say you ain't leaving the table until you've finished what's on your plate. Err, that nowadays is not the given that people, that parents do and I certainly don't advocate that with my kids. But, I blame my parents a little bit for my overweight but also there's, it's now been proven to a certain extent that it's controlled by your genes and if you've got the wrong set of genes, err, you're going to be obese or you're going to be overweight anyway, err and the sooner they recognise and get that out before baby's born, the better it's going to be for us all but until that happens, I suppose the stomach operations are probably going to be the best thing. Pills certainly are a waste of time. Dieting certainly is a major waste of time because you yo-yo diet and that's the way it goes and always will do. Everybody knows who's been on a diet, yo-yos up and down, up and down. People lose lots of weight and you put it all back on. Been there, done that and I've got a t-shirt for it.

G: And why do you think the weight goes back on after the you've lost it?

B: Because what you tend to do is you go and say, oh it won't hurt if I have this packet of crisps, you know, I fancy this packet of crisps. I haven't had crisps for months and months and months and you have a packet and you think, aw, that's really rice, I'll have another packet tomorrow. And you do. You cheat a bit further, you cheat a bit further and it's slowly, slowly...
increases and it creeps up on you and the next minute, you’re on the scales and back, being overweight.

G: And I mean, it sounds like, you’re very reflective and you can see how that’s, that could creep up. Did you know that, when you had the band? Did you know, did you have...

B: Yeah, I felt guilty when I pushed it. Felt extremely guilty. But it didn’t matter. Er, again it’s like alcohol, you know, you want to drink, you want to drink, and I wanted a bit of good and I was going to have a bit of food. Especially when you walk into a place like a restaurant for argument’s sake and you smell, the smells, I’ve gotta taste that, one mouthful’s not enough, I’ll have another one.

G: And did you notice times when you were eating more than other times? Is there was a pattern to that?

B: Erm, comfort eating was still around. I still comfort eat. And suppose to a certain extent, I do now. Erm, I just make sure when I comfort eat. I only eat the five mouthfuls because that’s all I can eat but it’s of something that I really want to eat not just something to give me sustenance and that’s why I’ve taken the route of I’ll eat what I want but I will only eat a small amount of it so that the, erm, sorry, the plastic surgery wounds are still sore, slightly, very slightly. So, erm, and I’ve got no fat on my bones so the bones stick in.

G: Oh gosh...if you want to have a walk around...

B: No, no, I’m alright. It’s...what people don’t take into account is that I had all that padding so I could sit for hours on end and not get a problem. Now, I’ve got bone sticking in what’s left of flesh round there and it hurts. So, this is the fat man inside you still syndrome. But where was I? Erm, so I expect it’s still. I mean the operation is not the be all and end all of it, I wouldn’t even expect the bypass operation be the be all and end all of it. You’ve still got to, erm, use it as a tool to aid you in your fight against weight. So I’m always going to have that problem of weight, always, always. And if I’m not careful, I could potentially go back to where I was. Erm, and that’s the same for everybody not just me.

G: So you were kind of talking about using food as a comfort?

B: Yeah, I mean I still do if I have a bad day, you know, I go home, erm and instead of having, erm, a mundane meal which
I know I'm supposed to have; I'll maybe say to, I'll have that because I like the taste of it and just eat that because it's nice but I can't eat a tremendous amount of it because it hurts and at the point of hurting I stop. I tend to try and stop before it hurts because then I am not pushing the boundaries...... but that's it really.

G: How do you come to that that...

B: Awarenesses, I think is the word you are looking for

G: Yeah

B: Umm it's difficult, you, well it is not difficult it all comes down to your psyche and stuff like that. I think what you have to take into account. At the end of the day because I've always been in work that uses analytical decision making and stuff like that I'm always looking at problems and solving problems and everything else, I tend to look at things in that sort of way so with the band I know I could cheat it, I knew cheating it was wrong and it was really naughty to do that but I did it on occasions and that is why the weight stayed stable. So I've already got myself into a mind set that it is not the be all and end all of an operation that is going to solve my weight problems I'm still going to have to work at it. Umm effectively all the research I did that come through as well, the Doctor sort of muted it, MR M, sort muted it that it is not a be all or end all, it is not a given that it does resolve the issue of weight and that you don't have to work at it. So it is just setting myself into a mind set umm of which I've done. And the proof of the pudding is that I sit before you half the man I was effectively.

G: And what about other people, you mentioned your children and your partner. What do they feel about your story?

B: My wife is extremely supportive, she is overweight as well she says she could never go through what I've gone through just to control weight. And I must admit as I said in the early stages of the interview it was a big decision to do that. Primarily for somebody to cut you open to do something just to control weight is quite an awkward concept but at the end of the day the knock on effect of health and everything else it was reasons for doing that. So as I say the wife is extremely supportive I mean she is always saying you look good and thing and that, and I can't believe it and the family are exactly the same. My oldest daughter is probably struggling but she has got her own issues and her own problems but she is probably struggling as
well thinking about because her weight is bad and I've said to
her look the issue is that you are likely to be go down the same
route that I've gone down if you are not very careful. And I'd
rather that you controlled your weight now and get into a
regime that you are going to take with for the rest of your life
rather than have to resort to surgical methods to get it down.

And she is in agreement cos obviously saw all the pain I went
through. she saw me dragged away from home several times in
an ambulance when I was brought back here because the
wounds were leaking or because the thorn, I was having a
big problem. So that upset her tremendously but it hasn't
stopped her eating so we are still working on her. My other
daughter is very supportive, my 12 year old, she thinks it is
brilliant that her Dad is now this sort of slim person and that he
has worked very hard to get there and the rest of the family are
extremely supportive as well so within the family it is good new
and that helps.

G: Because you said that you are half the man in size and I
wondered how it is for people to experience that?

I think the wife is over the, I mean she does. One of the things
that I'm not, it difficult now because you are going into
marriage and stuff. Even though I'm married and I've got a life
partner and Marriage is for life as far as I am concerned, I'm
sort of old school, my wife is, we are married and that there
is to it I don't necessary see it. Like my Dad, my Dad never did
share things with my Mum of the personal nature I don't discuss
how I feel sometime, my wife can sometimes see sometimes
that I'm not feeling well and she pop in but I don't necessarily
discuss all the ins and outs of how I feel, what I'm doing and this
and that and the other and she sometimes finds this quiet
daunting. And I suspect that it probably would be if I was in her
position but that is what I've always been, we've have been
married for 25 years she is aware of that. She pleased that I've
lost the weight because obviously I am going to be around a
lot longer than I probably was going to be with all the weight.
She is pleased for me because I'm actually doing more things
that I want to do now because the weight has gone. That's it
really she is very supportive. But she wouldn't go through it even
though she is over weight. Obviously it was a big decision for
me but obviously for her she is aware it is not the right decision
or she is scared.

G: And how and how do you feel about that?
B: I'm of the opinion in my wife case that she does what she needs to do. She is big enough and older enough to make her own decisions emr so that that. In my daughters case I've obviously got to try and help her because I am responsible for her, I'm her guardian I brought her into this world, I tend to make sure that she stays in the world as long as possible. I mean we are probably going to have to look after her until we die anyway because she is dysprastic she is sort of educationally re, retarded a bit so we are going to have to look after her for the rest of our life and that is not a problem, I'm pleased we have got her because we struggled we went through IVF, we lost four in the womb so we've got 2 kids and we are pleased about that. Not pleased about her weight but that is for her to take care of with a little help from us. Em I was hoping she was going to see my experiences as more positive that she actually has done it is only through the fact that I've had a few episodes because things haven't gone right that she has seen that it may be a bit more to it that there should have been and that is pro what has put her off if she ever decides to go that route. So that is that, that is where I'm coming to with that.

G: What about support?

B: I think the support aspect has certainly been wanting, not from the physical side of things from the side of things of the operation the doctors doing the operation the support I've re inside the hospital has been absolutely fine. It is the support for argument sake from the dietician I meant I was expecting to be summoned by the dietician and for her to look through and give me a telling off and this that and the other. I said the support within the community the district nurse coming in after hospital was perhaps a little bit poorer this time.

G: Have you seen any other health professionals?

B: No, basically it is all down to my GP he manages my health and I go and talk to him if I got any issues.

G: And er... would it, would it have been helpful to see the dietician more do you think? You said you were expecting a telling off?

B: In my case, probably not, because I've never been one for dieticians, emr because I suppose I've always carried with me even on the pill controlled diets and everything else. Em, that
really, you just need to reduce the amount of food that
you take in, and even when I've been on Kano-controlled
diets I've always tended to look at the foods that I enjoy eating
even though they're not on the diet, it's a verbatim, I won't go
near them. Why I turn round I say well, today, I'm going to
eat that. I know that's X amount of calories, I'll compensate for
that either side of it on meals and take in the prerequisite
amount of calories for the day and then maybe don't eat so
much the next day and then come back online and eat the
right amount of calories the day after so I've always tried to
balance that. Erm: dieticians tend to look a bit more black
and white... You will eat these proper foods; these are foods you
can eat, these are foods you can't eat and everything else.
And there are reasons for inbetween. And that has always
been a bit too regimental for me and it's probably why I failed
mostly on diets and pill controlled diets. My own fault but it's
just that philosophy I've carried through. But the for argument's
sake, the last operation I've had which is the
steevagastrectomy, that mechanism in place is actually quite a
powerful tool and is helping me to use my own philosophy to
manage my weight along successfully whereas with the
pills the only pill that was perhaps a little bit successful was
zenacol because obviously you ate fat, it dumped it, believe
me, it dumped it. Sometimes it was very awkward.

G: And have you had any, err, I suppose, aw, 2 questions
coming out of my head. But err, I suppose, the same with the
band in that err, you described the pills weren't successful, the
band, but the sleeve seems to be more successful. You said it
was a useful tool. Is that because of what you said earlier
because it, err, tells you when you're full and you just don't
want to push it or...

B: Yeah. I mean effectively what the sleeve does is just reduces
your stomach size by four fifths so if you bear in mind that I've
now lost four fifths of my eating ability, the first thing that, Sarbin
led to believe is that what happens is that when you eat food,
your stomach expands, that sends a message to the brain to
say you're full. Well I don't think that's ever been the case with
me. Even when I was eating and eating and eating, I could
eat so much food which would be unbelievable and the only
thing that would happen is I would get a pain obviously where
it's expanding beyond the point of non pain if you like. I've
never ever been to, had a sequence that says to me you can
stop eating because you're full, ever, that I can ever remember

---

251
in my entire life so whether there's a malfunction in the
mechanics inside or not, don't know, don't care. All I know is,
the fact that once I go I start to eat now, four or five mouthfuls
of food, if it was soup, I could probably fake ten mouthfuls, or a
cup of tea, four or five mouthfuls and yet I can feel it's full and it
doesn't hurt, it just, it nags. It's just a semblance maybe of a
little bit of pain in there and I'll say okay, fair enough, that's my
message to stop and I'll stop.

B: Yeah. Well yes and no. Well, I got the same thing with the
band, erm, but I knew once the food had filtered through from
the little pocket to the big stomach, I could then fill the little
pocket again. And sometimes I did that. Effectively, I suppose I
could do the same with the sleeve. The sleeve doesn't have the only
thing is that because it's my whole stomach that's one fifth the
size it was, it takes a little bit more time to empty than the band
sack did. I mean the band sack would empty within twenty,
three minutes into the stomach itself. Whereas the sleeved
area, the sleeved off area of real stomach, obviously has to
transit through what it does to convert it into waste matter and
then go into the bowel and that takes just a little bit longer. So
therefore when it says you've had enough, that's enough is
just through a little bit longer. By that time, I've preoccupied
myself and moved away from the thought of food as well and
gotten into the fact I'm doing, I'm busy, I don't need to eat.

B: Not particularly, it's about the same. Had I adhered to what
the band was doing, which was put the food in my mouth until
your pouch had filled up, eat no more but that wasn't the case.
I would munch the food down so that it would dribble through
and go through the banded area, the banded off area
quicker, munch a bit more. Sometimes I got it right but most of the time I got it right and I was
made myself ill right but most of the time I got it right and I was
actually taking on board more food than I really should have
done. Weight wasn't rocketing back but I wasn't losing any
and the idea was to come down to some manageable weight
and that wasn't occurring and that's what made me take the
step after discussions and some deep thought about it.
G: Yeah, yeah, that's clear. Very clear.

B: But I mean, I can't get over to you enough, that these operations, any one of them are not the be all and end all of it. They're a tool to help you do the job with. And if people think which some people do and I've heard people talk about it when I've been sat outside and there's been fifteen of us queuing to get in and see Mr M, erm, that this operation is going to have, it's the miracle that everybody's been looking for. It ain't, you've got to work at it.

G: Did you know that before you had the operation?

B: I'd had inclinations of it. I was told a couple of times by Mr M. But it also comes out very strong from the research I did on the web, that you do have to manage, erm, so I was aware of it, yes. I don't think people are made aware enough, some people.

G: And I suppose is it different to be aware of something and then actually something being a reality I suppose?

B: Yeah. Because you don't know the reality. I mean, potentially you could, erm, I mean what the dietician advocates I believe with the sleevegastrectomy, is that you serve yourself up a regular, what she or he would call, a regular sized meal and it's going to take you between twenty and forty minutes to eat that whereas a normal person would eat that within ten minutes because of the quantity but because it's going to fill you up, it could take you up to forty minutes to eat it. I chose to discard the fact that's supposed to be the proper food that I'm eating and it's going to take me forty minutes to eat it. I chose to discard the fact that's supposed to be the proper food that I'm eating and it's going to take me forty minutes to eat. I'll eat whatever I fancy and then when I fill, i.e. Within the first five to six mouthfuls, stop, walk away and that's the way I've chosen to manage it. And that for me is successful. For somebody else, it might not be. But I've got a trade off. I enjoy the taste, the sensation of that food, why not have the five mouthfuls rather than the bland food that I'm not going to enjoy. And since the operation I've found that my taste has gone, I've lost my taste, I need to highly season stuff, erm, to get any satisfaction out of it whatsoever. So I need to chuck tons of pepper on, lots of stuff to give it a kick to satisfy me as well. Whether that's just me, mentally wise or whatever, a perception, I don't know but that's what's happened to me and in my case, it works. Somebody else might be different and this is why I say, we need more support than the operation
and the dietician and there isn't any and I don't think there's plans for any.

G: What do you think that support should...

B: Some form of psychology mix, who knows...don't know.

G: That's difficult for me to say because I don't like them sort of people. I've never liked that sort of practice and I really clam up when that happens but in these particular circumstances as I said to you before, one of things that comes to the front is I've got a fat man in a thin body as a saying which would denote really I should, should need that sort of help. So that's, I don't know.

B: Erm, yeah, it was phrase, my daughter had a coming of age party and there was a photographer going round and photographed and there was a photograph of me talking to my nephew and we looked through these photographs and I've gone who's that talking to Mark and my wife's gone, that's you, you silly so-and-so! They weren't the exact words but I won't. And I've gone, you're joking and I've looked it and thought, bloody hell, literally, no other words to describe it. And the fact that I've got my suit on, this skinny geezer stood there, talking to my nephew and I didn't recognise me. And it's, you know, that, the impact, the mental impact of that could potentially be quite devastating for some people. Me? Well, I find it quite amusing now. At the time, I was taken a back. I mean I was. Oh, oh my god! You know.

G: Can anything prepare you for that?

B: No, well don't know. Nothing has prepared me for it (pause) nothing prepared me for it... And I still, I mean we are a year on, 6 months on since the plastic surgery and I still, I get up in the morning and I go into the bathroom and I look in the mirror and think 'My God' and that is it 'My God' no other justification, no other what the hell you know. And then I start to be critical of the rest of me now, you know; it's silly, because there are other operations, there is fat around the thighs that I could potentially have removed there is fat under the arms, which isn't too bad as it goes the only issue that I've got is that there is a bit of upper body flab which I was saying to my wife 'no more excess skin'.
operations' but I'm thinking you know it doesn't look nice. Not that I want to be, how can I put it, I'm not overly concerned
with looking nice but I am a bit concerned about looking in the mirror and it not being right and that is where I come from. Not whether it looks nice or not it's whether it looks right and my upper body doesn't look right to my lower body because of the plastic surgery so potentially there is potential I might go for a second operation but not this year. I've been at this job for 2 years and had 1 year off.

G: Before the surgery did anyone talk to you about the excess skin?

B: Yes yes, there was obviously hints at that there could be a potential of excess skin, the research on the web proves that and actually on sky there was several American show showing obese people having operation and there was a couple of them in there having the final tidy up operations like the plastic surgery and stuff. So there is enough out there to let you know but not necessary to let it sink in at that time. The more daunting side of it is that when you come round to actually saying 'yeah ok I'm going to go for the plastic surgery' is actually talking to the plastic surgery people, finding out what they are going to do, whether they are in fact going to do anything because they don't necessary have to do it because I'm assuming there is a set criteria that will allow them to operate under NHS plastic surgery or not. As there was with the banding operation because you have to be above a certain BMI or else it was a no goer. I obviously fell into the criteria to have the bottom part of it done and we will see tonight whether I fall into the criteria for the top part.

G: If I see something else I want to ask about.

B: And then I will take the decision of whether, if I'm allowed when and if I'm actually going to go ahead with it. So erm it is very hit and miss erm process and erm people don't, like I didn't in the early days, don't know were to go what to do and a lot of that information could be disseminated by your GP in the first instance as guidance and then for erm more NHS people to be doing the operation cos currently in this area, for the whole of London I think this is the only NHS hospital that does it, although I'm lead to believe that XXXXX starting up I'm not sure, which pushes these guys here which like a cattle market and obviously you are not getting the emr customer care that you are perhaps entitled too ... I don't know, Erm I'm not knocking
what I've had cos I've had a result, it’s been reasonable good. I’ve been looked after so that is all that matters but if you want things to go smoothly you want more support you need to disseminate information to those that are in need of. You need clearly defined plans, clearly defined routes to go. Err with the various operation not just ‘we’ll do this and then we will follow it up with this’ err don’t know. That is for you guys to decide you decision maker, the policy makers. But from my point of view that is the way I see it.

G: Yes and it’s about getting people points of views and people experiences.

(Work - time off work)

G: Is there anything else that you want to say before we bring the interview to an end?

B: I don’t think so. I mean the important things are that the surgeries were done there were a few complications in my cause. The only thing as I say that was a big a big issue to me was this fact that you treat the physical but the mental nobody done anything about and if that is taken on board and something is done about that I reckon that will probably aid in future in future operations for people and help them along.

G: And how do you think ‘mental’ side will help?

B: Err I just think that it will err just take off all the rough edges off everything. I mean basically what you gotta taken into account is certainly if we go back to when I had the band, I was told what the band was, I was told what it was going to do right, I was given the date to come into hospital, come into hospital wake up I've got a band fitted, right, go home ‘this is what you can do, this is what you can’t do’, this and the other and that is it and I’m left. So I've got this band in me and I go along in my own means and get the thing done. So it is a case of err, and I know why it wasn’t done it’s because there is not enough money around to do it with. The follow up, I think the follow up should have been a bit more frequent, there should have been some guidance, there should have been checks and balance put into place. And again to a certain extend it was the same with the sleeve gastrectomy into hospital, have it done, get over all the bits and pieces of complication ‘there you go get out there and get on with it, come back in 6 months and will just check your blood.’ And
sometimes it gives the impression that it is just a machine that is working and going through the motions and nobody takes into account that there is a human being at the end of it all. And we have depersonalised everything and that's my own complaint about it all. It's 'we're going to cut you open, we know how to cut you open, we know how to solve all that problem side of things, we get all that done and you get on with it'. And that for me was the worse bit about it. It's 'we've going to cut you open, we know how to cut you open, we know how to solve all that problem side of things, we get all that done and you get on with it'. And that for me was the worse bit about it.

G: Mmmmm

B: And if you were for arguments sake going to ask me to score my overall experience in the past 2 years out of ten I'd probably say erhm 7, 7 ½. Purely because erhm support has been a little bit lacking as regards to you know 'fat man thin'.

G: Ten being the top and one being the bottom?

B: Yeah, yeah oh yeah and that's it really

G: And what would have made it a ten?

B: Erm probably a bit more psychological support I think, a bit more in the early days, closer monitoring but I guess as I said to you before I think that is not done because of lack of resources and fund and stuff. Erm what possibility wouldn't go a miss come to thinking about it was that when I was on Zenacol you had a hot line you could call 24/7 because Zenacol obviously, I don't know whether you know the effect of Zenacol, dumps the fat, it can cause people some anxiety, in fact it caused me some anxiety when I had a couple of episodes with it. And I could have if I want to rang up and got support with it. I suppose in hindsight if I was feeling a bit low I could have rang up NHS direct and said to them look I've just had this operation I'm feeling a bit this that and the other and they could have maybe been a bit of supportive. I think that support should have come from here. Haven't been able to. Maybe there should be a 24 hour by 7 contact number that you could ring up and say 'I felt this today, this didn't help, is it a problem, do I need to come into hospital or can I just carry on and get some advice'. I think it is the support behind it all that is lacking. Had we had in place something like that then you be up around the ten mark I believe.

G: Do you think that would have had an impact on the band?
Oh yeah definitely. Cos one of the things is it was 6 months between visits with the band. It was 3 months in the early days while they were trying to adjust it but then 6 months. Well in 6 months you can get up to a lot of things, do a lot of things and if you are straying off the path what you want is someone to slap you back again. I mean AA meetings are every day and then you've got a support partner I believe, I mean I don't know too much about it, but you got a support partner you can ring up 24/7. You know 'I feel like a drink. No, don't have a drink I'll come out.' 'I feel like a ham sandwich.' 'No don't have a ham sandwich I'll come out.' Yeah.

I mean I'm flippant about it but it would have been nice you know in those day to perhaps have that sort of support. Especially when you know that somebody has been messing about with your inside and you get a pain or a twinge or something. It would be nice at that time to phone someone up and say 'is it anything to worry about or whatever' rather than just leave it and know that you are likely to forget before your next appointment or when you get to your next appointment you are not going to have time, you mention it but you get 'well that is part of the course' and that's it. You know and somebody at the end of the phone might say will it perhaps knitting together and there is this causing it and if it becomes an issue and it gets consistent go to your doctor or whatever. So it is that form of support behind it. For fear of repeating myself it is very well done the operation and your out next one in, your out next one in and it's a production line. And that in the case of human beings is not going to work really erm and I personally reckon that you've got quiet a few failures with operations and people not actually losing weight because purely and simply that, no support mechanism behind it all.

G: Mmm, Well thank you very much it has been really helpful to hear your experience. I'll stop recording unless there is anything else.

B: I haven't got anything else.
Log of Research Experience
### Research Log

<table>
<thead>
<tr>
<th></th>
<th>Research Activity</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Formulating and testing hypotheses and research questions</td>
<td>✓</td>
</tr>
<tr>
<td>2</td>
<td>Carrying out a structured literature search using information technology and literature search tools</td>
<td>✓</td>
</tr>
<tr>
<td>3</td>
<td>Critically reviewing relevant literature and evaluating research methods</td>
<td>✓</td>
</tr>
<tr>
<td>4</td>
<td>Formulating specific research questions</td>
<td>✓</td>
</tr>
<tr>
<td>5</td>
<td>Writing brief research proposals</td>
<td>✓</td>
</tr>
<tr>
<td>6</td>
<td>Writing detailed research proposals/protocols</td>
<td>✓</td>
</tr>
<tr>
<td>7</td>
<td>Considering issues related to ethical practice in research, including issues of diversity, and structuring plans accordingly</td>
<td>✓</td>
</tr>
<tr>
<td>8</td>
<td>Obtaining approval from a research ethics committee</td>
<td>✓</td>
</tr>
<tr>
<td>9</td>
<td>Obtaining appropriate supervision for research</td>
<td>✓</td>
</tr>
<tr>
<td>10</td>
<td>Obtaining appropriate collaboration for research</td>
<td>✓</td>
</tr>
<tr>
<td>11</td>
<td>Collecting data from research participants</td>
<td>✓</td>
</tr>
<tr>
<td>12</td>
<td>Choosing appropriate design for research questions</td>
<td>✓</td>
</tr>
<tr>
<td>13</td>
<td>Writing patient information and consent forms</td>
<td>✓</td>
</tr>
<tr>
<td>14</td>
<td>Devising and administering questionnaires</td>
<td>✓</td>
</tr>
<tr>
<td>15</td>
<td>Negotiating access to study participants in applied NHS settings</td>
<td>✓</td>
</tr>
<tr>
<td>16</td>
<td>Setting up a data file</td>
<td>✓</td>
</tr>
<tr>
<td>17</td>
<td>Conducting statistical analyses</td>
<td>✓</td>
</tr>
<tr>
<td>18</td>
<td>Choosing appropriate statistical analyses</td>
<td>✓</td>
</tr>
<tr>
<td>19</td>
<td>Preparing quantitative data for analysis</td>
<td>✓</td>
</tr>
<tr>
<td>20</td>
<td>Choosing appropriate quantitative data analysis</td>
<td>✓</td>
</tr>
<tr>
<td>21</td>
<td>Summarising results in figures and tables</td>
<td>✓</td>
</tr>
<tr>
<td>22</td>
<td>Conducting semi-structured interviews</td>
<td>✓</td>
</tr>
<tr>
<td>23</td>
<td>Transcribing and analysing interview data using qualitative methods</td>
<td>✓</td>
</tr>
<tr>
<td>24</td>
<td>Choosing appropriate qualitative analyses</td>
<td>✓</td>
</tr>
<tr>
<td>25</td>
<td>Interpreting results from quantitative and qualitative data analysis</td>
<td>✓</td>
</tr>
<tr>
<td>26</td>
<td>Presenting research findings in a variety of contexts</td>
<td>✓</td>
</tr>
<tr>
<td>27</td>
<td>Producing a written report on a research project</td>
<td>✓</td>
</tr>
<tr>
<td>28</td>
<td>Defending own research decisions and analyses</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Submitting research reports for publication in peer-reviewed journals or edited book</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>----------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>30</td>
<td>Applying research findings to clinical practice</td>
<td></td>
</tr>
</tbody>
</table>