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Negotiating control:

Patients' experiences of unsuccessful Weight Loss Surgery.

Jane Ogden, Sian Avenell and Gemma Ellis

Department of Psychology, University of Surrey.

Address for correspondence:

Jane Ogden

Professor in Health Psychology

Department of Psychology

University of Surrey

Guildford

Surrey

GU2 7XH, UK

Tel: 01483 686929

Email: J.Ogden@surrey.ac.uk

Failed weight loss surgery

Abstract

Interviews were carried out with 10 men and women who had undergone weight loss surgery up to 10 years ago and felt that it had failed. 7 had had a further successful procedure. Data were analysed using Interpretative Phenomenological Analysis (IPA). Weight regain following surgery was explained in terms of either the mechanics of the operation or with participants describing ways to 'cheat' as food continued to be used for emotional regulation. All also spoke of how surgery neglected their mind. Following the second successful surgery, participants described changes in both their eating behaviour and cognitions emphasising how their mind had been brought 'in gear' through the investment of two invasive procedures. Transcending all accounts was the mind / body relationship and the issue of control with attributions for both failed and successful surgery shifting from the self to the surgical mechanism as participants negotiated the pathway between self blame and responsibility and utilised conflicting frameworks in which the mind and body were either divided or united. Whereas failed surgery is characterised by a battle for control, successful surgery involves handing control over to their restricted stomachs or considering WLS as a tool to be worked with.

Introduction

In 1991 the National Institutes of Health Consensus Development Conference 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. This continues to be recommended by the National Institute of Clinical Excellence (NICE, 2009) and is supported by much recent research (Sjostrom, Nabro and Sjostrom, 2007; Bond et al, 2006; Elfhag & Rossner, 2005).

The laparoscopic gastric banding (LAGB) and the laparoscopic Roux-en-Y gastric bypass are the most widely used procedures for obesity in the US and Europe (Nguyen *et al* 2006; Tice et al, 2008) and both come under the umbrella term of Weight Loss Surgery (WLS). These 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* 2002).

Although WLS is still considered the treatment of choice for morbidly obese individuals (NICE; 2009) and is currently one of the most frequently performed procedures in the US and Europe (Nguyen *et al* 2005), questions have been raised about the long-term durability of weight loss, particularly at 18 -24 months post surgery when research indicates that a substantial proportion of individuals begin to regain lost weight (Bocchieri *et al*, 2002; Buchwald *et al* 2004, Larsen *et al* 2004; Sjostrom et al, 2007; Picot et al, 2009). In particular, Herpertz *et al* (2004) carried out a review of the literature and reported that 30% of patients regain weight post surgery and Magro *et al* (2008) found that some weight regain was observed in approximately

50% of patients (46% within 24 months and 63.6% within 48 months). In addition, Muller *et al* (2008) compared LAGB to bypass and reported that over a 3 year period 30% of all clients operated with LAGB had the band removed and were converted to a bypass procedure due to poor weight loss.

In response 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. For example, research indicates that economic status, class, mental health difficulties and personality characteristics do not predict postoperative weight loss (Latner *et al* 2004, Larsen *et al* 2004) whereas van Hout *et al* (2005) concluded that younger individuals and those with earlier obesity onset tend to show better outcomes post surgery. Further, Colles *et al* (2008) found the strongest predictors of weight loss by 12 months following LAGB included a higher baseline BMI, lower rating of subjective hunger, high quality of life related to physical functioning and leisure activities.

Many studies have also focused on preoperative psychopathology, particularly depression or personality disorder. Such studies, however, 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 (Wolfe and Terry, 2006). Other research, however, suggests that the greater the weight reduction, the greater the improvements in coping ability, distress levels and mood disorders (Ryden *et al*, 2003).

Some studies have also addressed the role of eating behaviour in terms of post operative food intake and pre operative bingeing and emotional eating (eg. Saunders

1999; Odom et al, 2009). For example, studies indicate that that poorer weight loss is associated with difficulties complying with post operative eating guidelines (Rusch & Andris 2007) and research indicates that individuals continue to have ‘maladaptive and psychologically distressing eating behaviour’ post WLS (Niego *et al*, p356, 2007). Similarly, Walfish (2004) concluded that 40% of individuals seeking WLS would identify themselves as ‘emotional eaters’ and Saunders (2004) reported that for some people difficulties adjusting to the restrictions of surgery left individuals *more* likely to over eat post surgery and to show ‘grazing’ behaviour. In contrast, however, Rusch and Andris (2007) suggested that emotional eating is reduced post WLS as eating high-fat food leads to the negative consequence of nausea or vomiting and Fischer *et al* (2007) found that emotional eating was not predictive of surgical outcome at 8 months.

To conclude, although WLS seems to be the most effective treatment for obesity there remains variability in patient outcomes with some patients showing less than optimal weight loss (eg. Picot et al, 2009). To understand this variability research has focused on pre surgical predictors of weight loss maintenance which has often produced contradictory results. Furthermore, it assumes that outcomes are a result of factors that exist prior to surgery rather than emerging in response to the ways in which an individual adjusts to their surgery. In addition the vast majority of studies have used quantitative measures selected by the researchers which does not allow for the heterogeneity of individual responses meaning that the individual’s experience is only partially understood (Bocchieri *et al*, 2002). A recent study explored patients’ experiences of successful WLS using a qualitative approach and concluded that alongside generalised improvements in self esteem and well being associated with weight loss, success was experienced in terms of a reduction in hunger and a decrease

the preoccupation with food (Ogden et al, 2006). In addition, the authors described the paradox of control whereby by taking away choice over what and how much could be eaten, and by handing over control to the physical limitations imposed by the restricted stomach capacity, participants paradoxically reported feeling liberated and more in control of both their eating behaviour and life in general. The present study aimed to adopt a similar perspective, but to explore patients' experiences of WLS that was deemed unsuccessful. Further, as approximately 30% of individuals need two forms of surgery to achieve sufficient weight loss (Muller *et al* 2008) the present study included a sub sample of those who had experienced failed surgery followed by a more successful procedure.

Method

Design

The present study used a qualitative design with in depth interviews.

Participants

Ten participants (8 female and two male) were recruited from a London based obesity clinic (n=4) and a patient support group (WLSinfo, n=6) if they had undergone WLS and felt that it had not been successful. Of these, 5 had had a second successful procedure and 2 had had a revision operation. The first procedures were: LAGB=7; Gastric Bypass=1; Roux-en-Y=2. The second procedures were: Gastric Bypass=3; Sleeve Gastrectomy=2; pouch revision=2. One patient was currently awaiting a further Gastric Bypass. All primary procedures had taken place between 1 and 10 years ago. Weight loss following WLS was defined as unsuccessful if weight had either been re-gained post surgery, if weight loss was not deemed sufficient by the participant or weight loss had been minimal enough to warrant further WLS. Nine

participants had had their procedures through the NHS whilst one had attended a private hospital and at the time of the first operation all participants had an initial BMI of at least 40 or 35 with co morbidities. Participants ranged in age from 38-56 and nine participants defined themselves as white British and one as black British/Caribbean (See Table 1 for further details).

-insert table 1 about here -

Development of semi-structured interview

A semi-structured interview was developed through conversations with clinicians and researchers in the field, with patients and through the existing literature. 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).

Procedure

Participants at the hospital were identified through the database by the consultant and sent an information sheet and consent form. A mutually convenient time was then arranged and face to face interviews were conducted at the clinic in a private consultation room. For the support group sample an advert and information sheet were placed on the website and interested participants were contacted via email. Telephone interviews were carried out due to the geographical spread of the participants. Interviews lasted between 40 to 90 minutes and were audio-recorded and transcribed verbatim. All identifying information was anonymised and participants were given a pseudonym. Approval was obtained from the NHS Local Research Ethics Committee and the University Ethics Committee.

Data analysis

The data was analysed using Interpretative Phenomenological Analysis (IPA) which explores how participants view the phenomena under investigation (Smith & Osborn, 2003). 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. IPA is thus considered particularly useful when one is concerned with complexity (Smith and Osborne, 2003). An idiographic approach to analysis was used, beginning with particular examples and slowly working up to more general categorisation or theory. A master table of themes was created with 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 and to check for credibility the themes were discussed between the researchers (SA, GE) and with a qualitative methods group held at the University.

Results

All participants described a good initial weight loss after the 1st WLS of between 42 lbs-154 lbs 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 described how the weight started '*to creep up on you*' or as Val said '*it was like someone had just pulled the zip up and it stopped dead*'. Those who had proceeded to a second WLS described how this has resulted in weight loss that so far had been maintained. Participants described the failure of the first WLS surgery in terms of four processes: i) the operation failed ii) cheating the band iii) emotional regulation iv) the neglected mind. In contrast, the second WLS

was described in terms of i) a changed mind set and ii) changed eating behaviour. Transcending these themes was the relationship between the mind and body and issues of control. In particular, participants described how WLS treated the body but not the mind and struggled with notions of control attributing responsibility for failure to a number of sources including professionals, the surgical mechanism itself and themselves. These themes and subthemes will now be described and illustrated with exemplar quotes.

1. Failed weight loss surgery

All participants experienced failed WLS and described how both they and others struggled to make sense of this using terms such as ‘unlucky’, ‘a mystery’ and ‘flummoxed’. They then provided explanations as to why the surgery failed which at times emphasised the operation, but at others highlighted either their own behaviour or the failure of health professionals. For many, their accounts of failure were confused and conflicting as participants drew upon a number of different and often opposing attributions.

i) The operation failed

Several participants explained their weight regain in terms of the operation itself and the failure of the surgery to offer sufficient control and restriction over what and how much they ate.

‘Erm the band is clearly in there not doing very much’ (Robert).

“I didn’t really have any restriction... The band wasn’t doing anything.”

(Emma)

Participants expressed disappointment that the operation hadn't been as effective as they had expected and how they had wanted to be able to rely upon their newly restricted stomach to limit their food intake:

'Int: What happened when you first had the band put in?'

Pam: It was up to its 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)

This expectation then led participants to ask for added surgical support through having the band 'inflated':

'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).

Participants therefore wanted to hand over control to their newly restricted stomach capacity and understood their failed weight loss in terms of the failure of the operation. This desire for external imposed control upon their eating was also illustrated by Pam's description of how she would like her eating to be managed:

'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).

By emphasising how the operation had failed participants illustrated both their desire for an external solution to their problem and their need to attribute this failure to something beyond their control.

ii) Cheating the operation

Alongside accounts blaming the operation, participants also described the ways they found to eat more than they knew they should. These internal and external attributions for failure were not mutually exclusive and most participants fluctuated between these different perspectives. For some this process of eating too much was about pushing boundaries and rebelling. As Laura said:

“I was really depressed about not having to eat initially. That really, really got to me. So much so that I rebelled and tried to eat stuff that I used to eat.”

(Laura).

Similarly, Hannah described her reaction to the limits imposed by the surgery:

“Its human nature to push boundaries and see where the boundaries actually are but it has surprised me... maybe because I feel ill when I eat sweet things that you really don't want to take the risk.” (Hannah)

The use of ‘rebellion’ and ‘pushing boundaries’ illustrate an almost adolescent reaction to the surgery with participants wanting control to be taken away but yet simultaneously resenting and reacting against this when it happens.

For many, the process of eating more came gradually as they learned how to increase their capacity for food. As Ruth said:

“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...I would rather have meat because I could taste it more and I felt a bit more satisfied” (Ruth).

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.

For some participants adjusting to the smaller portions and the different types of food post surgery was an extremely difficult transition and they described a number of strategies to help them eat more.

“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 ...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.

“They say that you mustn’t drink in-between eating because it causes a flush but I would drink during eating...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” (Ruth).

Physically Ruth couldn't eat more without flushing the food through the band which theoretically should signal fullness. But psychologically Ruth described still being hungry. There is a sense of injustice by the new limits imposed by the band and need to 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 consuming highly calorific liquid drinks or 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" (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.

Martin also described overeating but was keen to emphasise that this wasn't cheating whilst at the same time using this term in his explanation:

"I could eat a whole packet of biscuits, now even. And I know that's wrong and that I'll feel shit afterwards but I still do that... If you eat the right things, the restriction doesn't affect it... I'm not consciously cheating... But I know that there are certain foods that can go down." (Martin)

Participants therefore found ways to eat more after weight loss surgery but their use of childlike terms such as ‘cheating’, ‘rebellling’ and ‘getting round’ the intervention suggest an ambivalence both about having their food intake limited and about their own reactions to this which they recognise are destructive in the longer term to their goal of weight loss.

iii) Emotional regulation

The failure of WLS was further explained in terms of emotional eating and the ways in which food continued to be used to 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 to manage their moods. For Dawn chocolate had become synonymous with comfort. Similarly, Emma said:

“I’ve been very aware that food has become an emotional crutch, if you like... I eat my emotions. It drives me mad and I know that I do it but it’s very hard to stop.” (Emma)

Most participants described external pressures leading to food continuing to be used to self-regulate emotions despite the restrictions now enforced by their operation.

‘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).

Some just described periods of lowered mood which resulted in the need to use food again to manage their emotions:

"After I saw my...third consultant and he told me to go on Reductil, that was an all time low for me and I turned back to chocolate which I'd given up for the band and gained about three stone." (Emma)

Others however described how they used other unhealthy ways to manage their emotions and for some this included drinking more alcohol:

"I did start to substitute alcohol for food. But that got worse later on... I became an alcoholic... Post surgery, I definitely transferred to alcohol 'cos I couldn't eat... It was easier and easier to drink to fulfil the need in me."
(Martin)

Food remained an emotional support after surgery and generated a tension between the need to conform and eat less and the need to satisfy emotional needs.

iv) Neglected mind

Participants explained how although the body was treated through surgery the mind was neglected and understood as separate and unimportant by the health professionals or the context in which surgery took place.

"Most doctors, even now, won't recognise that over-eating and issues linked to obesity are a mental health problem. It can be emotional... But they don't

acknowledge it ...To lose weight, you need to look at the bigger picture. What happens with the body, what happens with the mind.” (Emma)

Hannah argued that the medical profession should recognise this at an earlier stage before waiting for the patient to become morbidly obese, in order to provide help as quick as possible:

“I had the same psychological issues that somebody at 20 stone has; I was having that at like 13/14 stone and I think that’s what the medical profession need to take into account. It’s as debilitating being a 14 stone overweight female.” (Hannah).

Dawn also felt frustrated by her experiences of care and the absence of any psychological support:

‘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. ... this (obesity) isn’t really recognised as a mental health problem, that it is’ (Dawn).

Similarly, Robert explained how those working in WLS are skilled in the physical element of care regarding the body but neglect the psychological support that may be needed.

‘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).

The failure of WLS was therefore understood in terms of a number of processes which were both contradictory and complementary as participants struggled with opposing attributions for their weight regain which highlighted tensions between the need to conform and lose weight and the need to meet their more immediate emotional needs. In particular, whilst some accounts emphasised the failure of the surgery or health professionals and located blame outside of the self, other accounts from the same participants highlighted the role of their own behaviour and the persistent need to regulate emotions using food. This struggle between different attributions of failure reflected a parallel struggle between notions of control and blame and participants seemed to be trying to understand both how they could learn from their experiences and to regain control over their weight in the future. It also reflected conflicting notions of the mind and body with either the body failing to control the mind or the mind failing to exert control over the body.

2. Successful WLS

Seven of the participants then described their second WLS which had been more successful and had produced better weight loss. This second surgery seemed to enable a change in eating behaviour and a shift in 'mind set' and participants spoke about getting their minds 'in gear' and a bringing together of both the mind and body in order to produce change. This was sometimes accompanied by feelings of '*failure*' (Ruth) or '*guilt*' (Dawn) concerning the first operation. All participants expressed great satisfaction in their success and had high expectations that their success would continue even though some were still in the relatively recent post operative period. There were no obvious signs of pessimism or helplessness even though they had experienced failure in the past.

i) Changed eating behaviour

For many, the second operation resulted in changed eating behaviour. Some described this process as a consequence of a more restrictive bypass rather than a band and attributed their subsequent weight loss maintenance to a more effective procedure. For example as Hannah and Laura said:

“The biggest difference with the bypass is that I don’t feel hungry so there’s not the frustration that there was with my band...I cannot eat a large quantity of food at any one time. So it’s done what it’s supposed to of done.” (Hannah)

Similarly, Ruth described a reduction in her food intake and the impact of the side effects of overeating:

‘...with the bypass you can’t get anything more into your stomach... 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...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).

This restriction made some feel more in control:

“To a certain extent before the surgery, you have the control about what happens to your weight. You either dieted yourself to try and lose the weight or keep it level or you thought ‘what the hell’ and ate what you liked and put the weight on. Afterwards, that control was taken away from you.” (Val)

Participants also described how the operation changed how they felt about food. Sometimes this was just a reduction in hunger but for others it had also changed the importance that food held for them:

“Before it was this wonderful thing that tasted nice and made me feel good; very much a comforting and joyous thing and now it’s just a pain in the arse, it really is. And it doesn’t give me the satisfaction that is use too...I definitely think that the surgery has altered how my brain processes food, even just the very fact of eating.” (Laura)

From this perspective successful weight loss was understood in terms of the impact of the surgery and the impact of their newly restricted stomach upon their desire to eat and the role of food in their lives. Participants believed that they had had control over their food intake taken away and this was mostly met with relief and satisfaction.

Others, however, attributed their weight loss success to an increased level of internal control that produced significant changes in eating behaviours. Many no longer described trying to ‘*get round*’ or ‘*cheat*’ the surgical mechanism but illustrated how they tried to work in harmony with the operation using it as a tool to aid success. This seemed to happen through being more aware of bodily signals, a shift in thinking and a shift in the perceived location of control from the operation to their selves.

‘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).

As a result of Robert's journey through two operations, surgery is now understood as a 'tool' and an 'aid' to weight loss. He now has a 'fight against weight' and has decided that his actions could cause problems 'if I'm not careful', again positioning himself as in control. This understanding around his own responsibility and self control has produced an interesting behavioural change in that he explains that since the second surgery he tries to stop eating before it 'hurts' in order to avoid 'pushing the boundaries'. Following failed surgery participants described techniques such as 'flushing', 'grazing' and chewing food to a 'pulp' to allow greater consumption that would stretch the boundary of the stomach. For Robert, this previous experience seems to have made him aware of boundaries both metaphorically and physically within his stomach.

This finds further reflection in Robert's account of his own changes in behaviour when asked what now stops him from grazing:

'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'. (Robert).

The behavioural change described (no grazing) is centred around both a fear physical 'damage' to his stomach and a fear of re-establishing old eating behaviours which may cause the stomach to grow. It also reflects a sense of investment as Robert recognises that he has now had two painful operations and wishes to do justice to his efforts by not eating in the way he did after the first procedure. And for some, this change in thinking had been facilitated by improved care by health professionals:

“Things might be a bit different now. The whole team there seems to be geared towards making sure you get the whole psychoanalyst bit as well and everything to make it a lot easier.” (Val).

Successful weight loss following the second surgery was therefore understood in terms of changes in food intake. For some this was conceptualised as a reaction to a more drastic restricting operation and for others it reflected a sense that their own internal control mechanisms had been enhanced.

ii) Changed mind set

The weight loss following the second procedure was also described in association with a changed mind set.

‘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 with the words ‘naughty’ and ‘cheating’ suggest an almost childlike quality to his previous behaviours. His previous experience with the first operation, however, has produced a shift in his ‘mind set’ and 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’ which implies an active rather than a passive role and a role that is ongoing. It also demonstrates an increased confidence in his ability to make a difference and create change.

In a similar vein, other participants expressed 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, for her, the two operations had pushed her along this recovery path. Furthermore, like others she emphasises the role of individual responsibility for being in the right mind set with a mind that is ready to engage.

Ruth brings many aspects of this theme together in this example and illustrates how the journey through two operations helped her to change her mind set:

‘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.

Accordingly, participants understand their weight loss following the second operation in terms of changed eating behaviour. For some this is conceptualised as a direct response to a more restrictive surgical procedure which imposes control upon what they eat. For others, however this change is described in terms of shifts in personal control, brought about by an accumulation of evidence across the two operations. The process of changes is therefore seen as a journey with the failure of the first procedure providing impetus and energy for the second procedure to succeed. This is further described in accounts of a changed mind set which emphasised a bringing together of mind and body and a recognition that the operation is a tool that needs to be worked with if it is going to work.

Conclusion

The present qualitative study aimed to explore participants' understanding of unsuccessful WLS and the requirement for a further operation. The results showed that failed weight loss was understood either in terms of the inadequacy of the procedure or as a result of the individual's own behaviour with participants describing 'cheating' and continuing to eat for emotional reasons. This finds reflection in existing literature illustrating how patients graze post surgery and feel the need to test the limits of their operation (Saunders, 2004; Zilstra, 2009). Similar forms of rebellion are also reported by dieters in response to the limitations imposed by their attempts to eat less (Herman and Polivy, 1984; Ogden and Wardle, 1991).

Furthermore, it illustrates how emotional eating can persist after surgery and indicates that the continued use of food for emotional regulation may contribute to weight regain (Saunders, 2004; Niego et al, 2007; Rusch and Andris, 2007). All participants also described how they felt that although surgery addressed their body it neglected their mind which concurs with recent NICE guidelines calling for psychological support pre and post WLS (NICE, 2009).

In contrast, the subsequent successful procedure was conceptualised in terms of changed eating behaviour and a changed mind set. For some, changes in food intake were attributed to the greater restriction imposed by the new procedure and an associated reduction in hunger and preoccupation with food as eating became more function than pleasure which finds reflection in an earlier qualitative study of successful WLS (Ogden et al, 2006). For others however, changes in how they ate were considered a response to a changed cognitive set and a recognition that the operation wasn't all controlling but a tool that needed to be worked alongside.

Cognitive dissonance theory and the role of investment (Totman, 1987) may help explain why two operations were needed to produce these changes in both cognitions and behaviour. Totman (1987) argued that individual investment in terms of factors such as time, money, pain and inconvenience influence the perceived effect of any given intervention in a similar way to a placebo effect and that individuals need to justify their behaviour (ie having the intervention) as a means to see themselves as rational and in control. In the case of WLS, a second more intrusive operation increases the level of investment and thus increases the need for a justification (ie. it worked) in order to prevent a state of high dissonance and guilt. Accordingly, following two operations the individual has to see that their investment was justified by making the operation effective.

Participants' accounts therefore provide insights into their experiences of both failed and subsequent successful surgery. Transcending the key emerging themes was a recurrent emphasis on the mind / body split and issues of control. Following the first failed procedure participants' explanations ranged from the operation to either their own behaviour or that of health professionals with many holding these conflicting attributions simultaneously. These narratives varied both in terms of whom or what was responsible for failure and the perceived location of control over body weight. Furthermore they reflected a dualistic model of the self with the mind and body being conceptualised as separate and discrete forums for self management. Research exploring successful surgery highlighted a paradox of control whereby participants were able to hand over control to the restriction of their stomach thus feeling paradoxically liberated by having their personal choice taken away (Ogden et al, 2006). The results from the present study indicate that such a phenomenon is not apparent when surgery fails as participants struggle to understand where control is located. Furthermore, failure is characterised by a model of the self whereby the mind and body remain separate with participants feeling that although their body is managed their mind is neglected. In contrast, subsequent success is characterised by a clearer model and a unified sense of the self. In particular, for some, success is attributed to the surgical mechanism as participants clearly show the paradox of control and hand over control to their newly restrictive stomach (Ogden et al, 2006). From this perspective the physical capacity of the stomach is given predominance in their explanation and considered to be able to control their mind. For others however, weight loss at this time is associated with renewed internal control and a belief that the mind and body must interact if the operation is to be a success. Failure is therefore associated with unclear attributions for control and a divided self, whereas

success reflects a clearer model of control and a mind and body which have been integrated.

To conclude, although WLS is the current treatment of choice, there remains much variability in patient outcomes. The present study aimed to explore patients' experiences of failed surgery. The results showed that participants struggled with multiple explanations of weight gain after the first surgery with explanations of control shifting between the self, to others and the surgical mechanism itself. Food continued to be used to self-regulate emotions and participants described 'cheating' the surgical mechanism. Successful weight loss following the second surgery was understood as a 'bringing together of the mind and body' and changes in both eating behaviour and cognitions. Furthermore, the effort involved in having two operations seemed to represent an investment which needed to be justified through behaviour change and subsequent weight loss maintenance. Failure is therefore characterised by a struggle to attribute control and responsibility and a sense of a divided mind and body. Success, in contrast, involves clearer attributions of control to either the surgical mechanism or the self and a sense that either the body can drive the mind or that the mind and body can work together. Ideally, all patients should show both weight loss and weight loss maintenance after surgery. The present study indicates that such success could be facilitated either by encouraging patients to hand over control to their restricted stomachs or to consider weight loss surgery as a tool that needs to be worked with. This could be encouraged through improved psychological support pre and post surgery and a change in culture that no longer neglects the mind for the sake of unilateral changes in the body.

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Table 1 – Participant’s Demographics

Name	Sex	Age	Ethnic	BMI pre 1 st WLS	Time since 1 st WLS (mnths)	Time between 1 st and 2 nd WLS (mnths)	BMI Before 2 nd WLS	BMI Now	Time since 2 nd WLS (mnths)	WLS history
Ruth	F	51	Black British/ Caribbean	53	66	48	57	39	18	Band / bypass
Jane	F	50	White/ British	64	54	18	56	41	36	Band / bypass
Pam	F	56	White/ British	67	42	18	68	35	24	Band / bypass
Dawn	F	56	White/ British	46	120	84	41	34	36	Band / sleeve
Robert	M	52	White/ British	55	42	18	48	28	24	Band / sleeve
Emma	F	38	White/British	54	30			49		Band/Awaiting bypass
Martin	M	49	White / British	64	89	89		34		Roux en Y bypass/ pouch revision
Hannah	F	48	White/British	36	48	40	37	26	8	Band / Bypass
Laura	F	42	White/British	63	12			41		Bypass

Val	F	55	White/British	78	54			49		Roux
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