# Life After Bariatric Surgery: Men's Perspectives on Self-concept, Intimate Relationships, and Social Support

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Darren Depriest Moore

ABSTRACT

The objective of this dissertation was to explore the experiences and perspectives of men who have had bariatric surgery. The researcher specifically explored life after bariatric surgery, with a focus on men's perspectives of self-concept, intimate relationships, and social support. Phenomenology was utilized and the researcher conducted 60-90 minute interviews with men who, had bariatric surgery in the previous five years, were over the age of 25, were at least six months post-surgery at the time of the study, had been in at least one intimate or committed relationship after surgery, and resided in the United States. Symbolic interactionism and family systems theory were used to guide the study. Five themes emerged in the study which included: (1) a shift in identity construction; (2) enhanced relationship experiences; (3) increased intimacy; (4) fluidity of informal social supports; and (5) mental health services. The study included a rich description of the phenomenon, critical analysis, a discussion of the theoretical model, and discussion of clinical implications for marriage and family therapists.

## DEDICATION

I would like to dedicate my dissertation to my mother, Delphine Marie Elizabeth Moore. I know life has not always been easy for you or for me, but you have taught me to have faith, to believe in God, to trust the Lord, to be persistent, to strive to do my best, and to never give up. Thank you for showing me that, at the end of the day, regardless of any trials or tribulations one may have in life, with God, all things are possible. As I think back on your life and what you have taught me, I think of the following words by the poet Langston Hughes...Enjoy!

**Mother to Son**

Well, son, I'll tell you:
Life for me ain't been no crystal stair.
It's had tacks in it,
And splinters,
And boards torn up,
And places with no carpet on the floor—
Bare.
But all the time
I'se been a-climbin' on,
And reachin' landin's,
And turnin' corners,
And sometimes goin' in the dark
Where there ain't been no light.
So, boy, don't you turn back.
Don't you set down on the steps.
'Cause you finds it's kinder hard.
Don't you fall now—
For I'se still goin', honey,
I'se still climbin',
And life for me ain't been no crystal stair.

Mommy, I love you and I hope that I have made you proud. Darren Depriest Moore.

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# CHAPTER ONE: INTRODUCTION

Obesity is a public health phenomenon that impacts individuals, couples, and families in America and abroad (James, 2004). While there are a variety of treatment options for individuals who suffer from obesity, bariatric surgery has become widely accepted as the best treatment currently available (Buchwald, 2005). Bariatric surgery was once viewed as an extreme measure used to lose weight. However, with the development of less invasive medical procedures and changes in attitudes toward treatment, more men, women, and even some teens have decided to obtain this procedure (Zeller, Modi, Noll, Long, & Inge, 2009). Traditionally, the scholarly research that has been conducted regarding bariatric surgery to date has been focused on medical outcomes (i.e., significant weight loss and associated co-morbidities) (Santry, Gillen, & Lauderdale, 2005). More recently, there has been an influx in scholarly discussion regarding psychological, psycho-social, and relational aspects of obesity and bariatric surgery (Van Hout, Verschure, & Van Heck, 2005). However, the discussions have been focused exclusively on women, leaving men out of the dialogue. The purpose of this dissertation is to bring men's voices to the center and specifically to explore the post-operative experiences and perspectives of men who have had bariatric surgery. Learning about men's experiences post-bariatric surgery may assist marriage and family therapists and other professionals who may work with this treatment population.

While bariatric surgery is a medical procedure, it is also an individual and family process, that can shape or influence intimate and interpersonal relationships (Greenberg, Perna, Kaplan, & Sullivan, 2005). Within the literature regarding bariatric surgery, a few researchers have suggested that bariatric surgery can negatively impact and cause conflict within couple relationships post-operatively (Hafner, 1991; Hafner & Rogers, 1990). In addition, some

researchers have suggested that individuals struggle post-operatively with adapting to a new life style (Dymek, le Grange, Neven, & Alverdy, 2002). Scholars have found that some individuals experience difficulties making the required behavior modifications necessary to sustain weight loss success (i.e., adapting to a new diet, increasing their level of exercise, altering personal relationships with food) (Hafner, Watts, & Rogers, 1991). However, the research that has been conducted in the area of bariatric surgery regarding psycho-social and relational factors has been extremely limited in scope and more focused on the experiences of women.

Learning about men's post-bariatric surgery experiences may assist mental health professionals in providing services that are tailored specifically for men. In addition, asking men about their experiences within the context of their intimate relationships may assist marriage and family therapists in developing treatment. This topic was examined in order to describe the phenomenology of post-bariatric surgery and, in doing so, equip mental health and medical professionals with insight to develop new strategies and interventions that are focused on men individually, and in context of their romantic relationships.

## Significance of the Study

Marriage and family therapists view obesity from a relational family systems perspective, with a focus on patterns of interaction. More recently, marriage and family therapists have become involved in pre-operative treatment for bariatric surgery (Gaynor & Petro, 2009). Marriage and family therapists specifically assist with assessing individuals for bariatric surgery readiness. Although there are some marriage and family therapists who provide pre-operative counseling, this has not been fully implemented into the bariatric surgery process. Marriage and family therapists also work with men and women post-operatively and assist in helping them adjust to a new lifestyle. However, with the exception of a couple of the American Association

for Marriage and Family Therapy (AAMFT) accredited graduate programs and clinical internships (e.g., East Carolina University, University of Rochester, University of Nebraska, Seattle Pacific University, Mercer University, and University of San Diego), marriage and family therapists have lacked in conducting research, providing educational training, and developing clinical interventions specifically for people seeking bariatric services (Directory of MFT Training Programs 2011).

Research on bariatric surgery is significant because it is the most successful treatment for morbid obesity (Foster et al., 2003). Obesity is an epidemic that impacts individuals and couples within larger family systems. According to Sutton, Murphy, and Raines (2009), "1 in 50 U.S. adults has a BMI [Body Mass Index] of 40 or higher, up from 1 in 2000 in 1986" (p. 299). Many people die every year due to obesity and its associated health issues. According to Mehta and Chang (2009), "obesity is considered a major cause of premature mortality and a potential threat to the long standing secular decline in mortality in the United States" (p. 851). Obesity is also highly correlated with a number of co-morbidities which include but are not limited to obstructive sleep apnea, hypertension, Diabetes Mellitus II, heart disease, and various cancers, among others (Guh et al., 2009; Kim & Popkin, 2006; Mokdad et al., 2003).With the high prevalence of obesity among individuals in America and abroad, it is very important to explore obesity treatment.

Although there has been a substantial amount of funding that has been invested to try to decrease the epidemic of obesity, there has not been enough success (Blumenthal, Hendi, & Marsillo, 2002). Warin, Turner, Moore, and Davies (2008) stated that "despite the intense level of attention directed towards obesity, there has been limited success in addressing the rising rates of this public health phenomenon" (p. 97). Obesity has become one of the major public health

issues in America. The Centers for Disease Control, the National Institutes of Health, the current Surgeon General, and Michelle Obama *herself* have made obesity one of the top priorities of the nation (Benjamin, 2010). If scholars do not conduct research on this epidemic, the rates of obesity will continue to increase. Obesity not only affects individuals, couples, and families in terms of health, but it also affects the larger society. Obesity and its associated co-morbidities cost individual taxpayers and businesses money and is a financial burden for the government (Finkelstein, Ruhm, & Kosa, 2004; Yang & Hall, 2008). Obesity costs taxpayers money due to loss of productivity in the workplace and due to increased medical costs for illness. Obese individuals often require more doctor visits and more prescription drugs, ultimately costing taxpayers more money than non-obese individuals. According to Wyatt, Winters, and Dubbert (2006), obesity costs the average taxpayer $175 per year.

While there has been a plethora of researchers who have explored the topic of bariatric surgery, most of the research traditionally has been focused exclusively on medical outcomes (Stunkard, Stinnett, & Smoller, 1986). Due to the medicalization of obesity, there has been less of an emphasis on the psychological and the relational aspects of this phenomenon. However, as scholarship in the area of obesity research has advanced to include a more systemic perspective, more attention is now being focused on the psychological and psycho-social aspects of obesity. Nevertheless, there is a need for more researchers to focus on exploring the role that the family system, including the couple dyad, plays within the bariatric surgical process.

Including men's experiences and perspectives within the context of their intimate relationships could provide a more systemic view of obesity and bariatric surgery, which may prove to be helpful when thinking about clinical intervention strategies. A systemic perspective links to process as it incorporates relational dynamics over time among and between individual

parts of a system (i.e., the individual and spouse dyad, the individual and doctor relational system, among others). This dissertation situates the post-bariatric experience as a process instead of as an isolated medical procedure. Given the aim of this research is to provide a phenomenological analysis of post-surgical experiences, pre-surgical experiences are included to provide a more holistic context for the analysis.

## Purpose of Study

The overall goal of this dissertation study was to explore men's interpersonal and relational experiences after bariatric surgery. A specific purpose of the study was to develop an understanding of the experiences, processes, and meaning making for men who were in a committed relationship at the time of undergoing bariatric surgery. Through this phenomenological analysis, the researcher also identified how marriage and family therapists could intervene and assist post-bariatric individuals with maximizing their potential for long-term weight loss, support, and successful relationships. The rationale for the research was that there is a lack of research regarding bariatric surgery with men, a lack of research on relational patterns co-occurring with weight loss surgery, a lack qualitative research studies, and the omission of this topic within marriage and family therapy scholarly literature. This dissertation study will contribute to the discourse regarding obesity and bariatric surgery by (a) focusing on men's evolving self-concept; (b) contributing to the view of surgery as a process; (c) including a focus on relational aspects (e.g., intimate relationships; relationship satisfaction; intimacy; social support); (d) utilizing qualitative research methodology; and (e) informing marriage and family therapists, medical professionals, and perhaps, future people seeking bariatric surgery. For this dissertation, *self-concept* was defined as the process by which individuals view themselves in juxtaposition to others (Yahaya & Ramli, 2009). *Relationship satisfaction* was defined as an

individual's subjective experience of a relationship which is understood as the level of personal happiness an individual feels about his or her relationship (Karney & Bradbury, 1995). *Intimacy* was defined as close interpersonal interaction between two individuals which may be of a sexual or emotional nature (Miller & Perlman, 2008). *Social support* was defined as physical, emotional, financial, or spiritual assistance by someone that is within an individual's social network, which may include friends, family, co-workers, and others in the community (Marcoux, Trenkner, & Rosenstock, 1990).

## Research Questions

The grand research question for this dissertation is: "How does the process of bariatric surgery influence men's perceptions of self-concept, intimate relationships, and social support?" The research questions for this study include the following:

1. How does the bariatric surgery process influence men's perceptions of self-concept?
2. How do men perceive dating and relationship satisfaction after weight loss surgery?
3. How do men perceive intimacy after bariatric surgery?
4. How do men perceive social support after their bariatric surgery?
5. How do men perceive the role of a marriage and family therapist during the process of life after bariatric surgery?

The research questions were created to explore the phenomenon of bariatric surgery for men who were in a relationship during the surgical process. The research questions were specifically designed to address the gaps in the literature relating to the post-surgical processes of bariatric surgery for men. This inquiry was developed to provide marriage and family therapists with information that could be used to assist with intervention development and psycho-education for this population. This study was developed to provide mental health and other

professionals with information that *may* be utilized to improve quality of care for individuals who have undergone bariatric surgery. This examination also assisted with generating new ideas about theory, future research questions (both qualitative and quantitative), as well as research designs and methodologies.

**Research Assumptions**

The researcher has the following assumptions about bariatric surgery and the experiences of men who were in a relationship during the surgical process:

1. Men who have undergone bariatric surgery have unique experience that may be fundamentally different than women who have had the surgery (gender is an essentially different experience).
2. Individuals who have surgery experience the process of bariatric surgery differently than their partners who do not have surgery.
3. Examining men's perspectives of their couple relationships may expand how researchers, scholars, and practitioners understand the phenomenon of obesity, bariatric surgery, and weight loss in the family system.
4. Significant weight loss can impact men's relationships both positively and negatively.
5. Bariatric surgery should be viewed systemically, as a process instead of as an individual medical procedure.

**Theoretical Framework**

There are a variety of theoretical frameworks that could be utilized to examine the topic of men's experience of post-bariatric surgery. However, there are two major theories that inform this research study: symbolic interactionism and family systems theory. Symbolic interactionism was selected specifically to serve the purpose of viewing men as individuals with their own

experiences, processes of meaning making, and perceptions. Family systems theory was selected to view men not only as individuals, but also as a part of a couple or family relational system. Additionally, two marriage and family therapy models have been discussed as they demonstrate the clinical application of family systems theory with individuals as it relates to the topics of obesity, weight loss, and bariatric surgery.

**Justification of symbolic interactionism**

Symbolic interactionism was an appropriate framework for this study because of its inherent focus on self, self-concept, and meaning making. The first research question of the dissertation specifically addresses self-concept and how men's self-concept is influenced by the process of surgical intervention. Utilizing symbolic interactionism as a framework assisted the researcher in understanding how the individual self is defined in juxtaposition to external influences. When applying this theory to the bariatric population, one would suggest that the meaning of weight loss is developed through the exchange between the individual, the family system, and the larger society. Klerk and Ampousah (2003) stated that "in symbolic interactionism, individuals acquire identities through social interactions in various social, physical, and biological settings" (p. 1138). Klerk and Ampousah further suggested that the "self develops by getting social feedback from others" (p. 1133). Utilizing symbolic interactionism assisted the researcher in exploring participants' self-concepts including how men view themselves as it relates to the experience of weight loss surgery. Utilizing self-concept allowed the researcher to view individuals who have undergone bariatric surgery in the context of their interactions with the larger society. The section below provides a brief summary for the theory of symbolic interactionism.

**Overview of symbolic interactionism**

Symbolic interactionism is a sociological theory based on the idea that individual behavior is shaped by one's interaction with the environment. Symbolic interactionism is rooted in a social constructionist ideology. Symbolic interactionism was derived from the work of George Herbert Mead and Charles Cooley during the early 1900s. The term symbolic interactionism was developed by Mead's student Herbert Blumer in 1962. The premise of symbolic interactionism is that humans respond toward symbols on the basis of the meaning they develop and impose on the symbols (Birbeck & Drummond, 2006). Blumer (1966) suggested that "symbolic interaction involves interpretation and definition" (p. 537). According to Lynch and McConatha (2006) "much of human behavior is determined not by the objective facts of a situation, but by the meanings people ascribe to it" (p. 89). Lynch and McConatha (2006) further suggested that "what humans define as 'reality' is actually a set of social constructs consisting of symbols that are assigned meaning and acted upon in accordance with these meanings" (p. 89).

One of the concepts of symbolic interactionism germane to this study is meaning making. Symbolic interaction theorists believe that individuals contribute to the meanings shared by the group, while simultaneously taking meanings from the group and incorporating them into their own lives (Kanuff, 2006). According to Shirpak, Matika-Tyndale, and Chinichiam (2007), "people actively engage in the interpretation and creation of symbols as a way of making sense of, assigning meanings to, and communicating about their daily lives and the world in which they live" (p. 116). Symbolic interactionists believe that individuals act towards things based on the meaning they ascribe to them. They also believe that meaning is created through language and symbols. Theorists who subscribe to symbolic interactionism support the belief that meaning is created through interactions between internal and external mechanisms. Therefore, for

individuals, thoughts, feelings, and experiences are channeled through interactions with other people in the environment.

Another relevant concept of symbolic interactionism is "self." The self is defined and maintained through involvement with the environment. The self is not an individual, but is created through social interaction. According to Roe, Joseph, and Middleton (2010), "self gives form to how an individual understands who and what he or she is" (p. 31). Symbolic interactionists believe that individuals learn rules regarding behavior from society. They also believe that people incorporate beliefs from society into their lives (i.e., internalization). Symbolic interaction theorists believe that the construction of reality occurs through the reciprocal relationship between individuals and society. Blumer (1966) also suggested that "the human being may become the object of his own action" (p. 535).

The concept of self-identity is also important to this study. Self-identity is tied to an individual's view of himself and how he perceives himself to be viewed by others. Connected to self-identity is the concept of global self-esteem and self-concept. Rosenberg (as cited in Matsueda, 1992) "argues that the formation of global self-esteem entails three mechanisms: reflected appraisals, social comparison, and self attribution" (p. 1578). Matsueda further suggests that through reflected appraisals, individuals form concepts of themselves based on their beliefs about how they are viewed by others. The term "looking-glass self," originally coined by Cooley, referred to significant other's judgments which are used in the construction of the self (Nurra & Pansu, 2009). Also, symbolic interaction theorists support the notion of "taking on the other" which is the belief that individuals start to view themselves as they are viewed by others (Martin, 2005). Rosenberg (1989) explained that self-concept is "the totality of the individual's thoughts and feelings with reference to the self as object" (p. 34). The above terms (self-identity,

global self-esteem, looking-glass self) are useful as they relate to self-concept (i.e., how men's perceptions, thoughts, and feelings about themselves and their experiences of surgical intervention are mediated by and defined through social interactions with the outside world).

The final relevant concept is socialization. Symbolic interaction theorists support the notion that meaning is not innate, but is created through the process of socialization within culture and society. The family is also viewed as being responsible for contributing to the construction of meaning for individuals. Figuerosa (2008) suggested that symbolic interactionists support the notion that family members assist with defining the meaning of context, and that individual actions in essence are dependent on the meanings defined. Researchers that employ the theory of symbolic interaction focus on examining how individuals construct meaning and how they construct the self in relation to the environment.

**Justification of family systems theory**

Family systems theory was an appropriate theory to utilize in this study because of its overarching focus on wholeness, stability, and change within relational systems. Utilizing family systems theory assisted the researcher with focusing not only on the individual who has undergone bariatric surgery, but also on the context of the individual's couple and family relational system. The theory helps to expand the scope of the study from the individual to the couple processes present after bariatric surgery. The second, third, and fourth research questions relate to relational dynamics post-bariatric surgery. Utilizing a family systems theoretical framework helped the researcher explore how satisfaction, intimacy, and social support are expressed, experienced, and perceived within relationships. By incorporating the concept of wholeness and interdependence, the researcher was able to focus on viewing change systemically. Family systems theory assisted the researcher with zoning in on relational aspects

associated with obesity and weight loss, which may assist with developing sound clinical interventions and may provide implications for future research. The following paragraphs provide a brief summary of family systems theory.

**Overview of family systems theory**

In order to talk about family systems theory, one must engage in a discussion regarding its origins in what is referred to as general systems theory (Moyer, 1994). There are a number of scholars from different disciplines who have made contributions to the development of general systems theory. However, Ludwig Von Bertalanffy (1950, 1951) is known as one of the major contributors. Bertalanffy was a radical in many ways because he developed theoretical perspectives that went against traditional scientific theory. During his time, the sciences were based on a mechanistic and reductionist model. The reductionist model was focused on the belief that complex systems could be fundamentally understood through the examination of individual parts. Bertalanffy (1950, 1951) believed that in order to understand complex systems, one must also pay close attention to the interactions between parts of a system. Bertalanffy believed that there were certain components and laws that were universal within all systems (Poureau & Drack, 2007). These components included wholeness (non-summativity), subsystems, interdependence, boundaries, and feedback, among others. These components have been adapted and transferred into what is referred to as family systems theory.

Family systems theorists view the family as an individual system made up of interconnected parts. These parts interact with each other and ultimately impact and shape the entire system. A system can be composed of smaller systems (i.e., individuals) and can simultaneously be part of a larger system (i.e., the couple dyad or extended family system). Therefore, the same organized entity can be regarded as a system or subsystem depending on the

observer's focus of interest (Nichols, 1984). Family systems theorists also support the notion that there are hierarchical relationships between systems (Kast & Rosenzweig, 1972).

Family systems theorists support the notion of wholeness (non-summativity) in that they believe that the family system is more than the sum of its parts (Lewis, 2005; Ramage & Shipp, 2009). Wholeness is an additive process by which a whole is achieved through the integration of parts (Bortoft, 1996). The two concepts, wholeness and non-summativity, are interchangeable words referring to the idea that the components of a system make up the unique characteristics of the whole. Family systems theorists believe that it is important to examine the interactions between family members. They also believe that it is important to understand the interactions between the family system and the environment. Family systems theorists believe that a change in one part of the system will impact or alter the entire family system (Hurley, 1982). Related to wholeness is the concept of interdependence or circular causality. Family systems theorists support the idea that parts of a system operate in a recursive relationship and are interdependent. These theorists have gone against the traditional scientific view of linear causality. In addition, family systems theorists believe that there are certain patterns that occur within family relationships (i.e., complementary and symmetrical relationships). According to Becvar (1982), "the concept of a system is an invention which is used to describe regularities or redundant patterns we observe between people and their phenomena" (p. 5).

Family systems theorists assert that a family system can be open or closed. The concept of open or closed system relates to the topic of obesity and weight loss surgery in terms of change. A family system that is open would be more welcoming of change within a family system. An open system would experience less negative feedback from the system. A closed system would not be as accepting of change (e.g., weight loss) and would resist it. Closed

systems are associated with entropy, a principle in science (thermodynamics), which suggests that some systems possess a certain degree of dysfunction that eventually leads to disorder. Within closed systems, entropy assists with maintaining a level of equilibrium in the system with little change. In open systems, entropy may occur but the system is able to function through the exchange of input and output. Essentially, open systems are able to function and obtain a degree of steady state through dynamic change.

A family's level of openness is based on the type of boundaries they possess. Salvador Minuchin proposed that problems occur when boundaries are too weak or too strong (Nichols & Schwartz, 2004). Similarly, Murray Bowen incorporated the concept of enmeshment or disengagement (Kerr & Bowen, 1988). Bowen's terms of enmeshment and disengagement relate to Minuchin's weak or strong boundaries as they both deal with an individual's relationship with others and their external environment. According to Bowen, disengagement occurs with an individual as rigid boundaries in place prevent contact with external systems, such as other individuals. Enmeshment occurs when an individual has diffuse boundaries, or is able to access support from external systems, such as other individuals. Enmeshed couples are loving and attentive, while disengaged couples may experience more independence and isolation within their relationship due to the strong boundaries in place. A family that is enmeshed or that has a weak boundary may be less accepting of change within a system. Change would challenge the relational bond between individuals and could contribute to less enmeshment when one loses weight. A family that has strong boundaries may be more accepting of change within a system as individuals may not feel a sense of loyalty to others.

Family systems theorists employ the view of the family as a self-regulating system (cybernetics). The concept of self-regulating systems relates to the topic of obesity as it has to do

with how individuals govern themselves. Each family may have their own rules around obesity and weight loss. Some families may have a rule that requires everyone to be overweight, similar to the sense of loyalty discussed by the Family Firo model (Doherty & Harkaway, 1990). For example, resistance within a family system can be viewed as a way to regulate the system. A family may invite change or resist it based on how they make sense of weight loss and how weight loss fits in with the family's rules.

Self regulation within families is mediated through the interaction among parts with one another and the interaction of the parts with the outside world. Family systems theorists draw from the work of general systems theorists Bertalanffy and mathematician Norbert Wiener (Rosenbleuth & Wiener, 1945). Family systems theorists also draw heavily on the work of Gregory Bateson and Don Jackson. Bateson (1972) believed that destructive patterns of communication are maintained by self-regulating interactions of the family. Don Jackson (1954) is noted for his application of homeostasis to the family system. He believed that individuals within families resist change as a way to maintain stability. Family systems theorists believe that individuals within families seek to maintain stability through positive and negative feedback loops. Negative feedback is where a system's output signals a desire for equilibrium to occur in order to reduce change in a system. Positive feedback is where a system's output signals a shift toward change within systems (Hudson, 2000). Part of the change process includes differentiation among the parts within a system, (Boulding, 1956).

Family systems theorists stress the importance of employing a relational epistemology when examining a phenomenon. While the main phenomenon of interests is the relationships among family members, family systems theorists acknowledge that individuals also have relationships with the outside world. Some family systems theorists maintain that problems exist

within relationships among family members and within relationships that individuals have with the outside world (i.e., Michael White & David Epston, 1990).

Family systems theorists believe that, in order to understand human behavior, one must view it in the context of different levels of systems. Keeney (1983) stated that “the therapist can understand an individual’s experience, only by observing how his social context is punctuated” (p. 27). From a family systems perspective, individuals’ experiences, such as obesity or psychopathology, must be viewed in the context of couple and family relationships. Instead of focusing on individuals who have undergone bariatric surgery as isolated human beings and as clients, a family systems approach would include examining the patterns of interaction that exist between men who have bariatric surgery and other parts of the larger system (i.e., the couple dyad or other family sub-systems). Men who have had bariatric surgery do not exist in a vacuum. They have relationships with their significant partners, children, families of origin, extended families, and peer groups. They also have relationships with nursing staff, medical doctors, marriage and family therapists, and the community at large. Therefore, significant weight loss from bariatric surgery not only alters the lives of the people who have had weight loss surgery, but also the lives of intimate partners, children, and extended family. For the couple dyad, the experience of bariatric surgery includes the individual experiences of the person having the surgery, the individual experiences of the partner, and the recursive interactions between the two.

***Clinical Applications.*** Marriage and family therapists have utilized family systems theory to develop additional theoretical perspectives and understanding regarding obesity and weight loss. Marriage and family therapists have also translated their theoretical perspectives into therapeutic orientations and clinical models. While there is a difference between a theory and a model, all clinical models are guided by a theory. Although there are a variety of marriage and

family therapy models that have incorporated family systems theory when applied to the study of obesity, the most noted models are structural family therapy (Harkaway, 1986) and the Family FIRO Approach (Doherty & Harkaway, 1990). From a structural model perspective, obesity may serve as a stabilizing function for the family system. Obesity, as a symptom, may be used to divert attention away from other issues or problems within the couple relationship. Harkaway (1986) stated that "the consequences of losing weight may thereby become more threatening and unpleasant than the symptom" (p. 201). Harkaway further stated that "attempts to remove the symptom without attending to its place within the system would likely be met with resistance, sabotage, or failure" (p. 201). According to Doherty and Harkaway (1990), "obesity can be viewed in context of three overarching concepts (inclusion, control, intimacy) and can represent loyalty, alliance, boundaries, and security for the family system" (p. 292). Furthermore, Doherty and Harkaway suggested that "sexual jealousy, based on feelings of betrayal, may emerge with weight loss in one partner" (p. 292).

**Theoretical Integration**

Symbolic interactionism and family systems theory were integrated to assist with examining the post-operative experiences of men who have bariatric surgery. Symbolic interaction theory and family systems theory are congruent in that they both have a focus on examining relationships of individuals. While symbolic interaction theory is primarily focused on the individual in the context of the larger society, symbolic interaction theorists also believe that family is a major mechanism for identity development similar to family systems theory. According to Rosenbaum (2009), "all roles are seen to exist in reciprocals, so that in marriage, spouses' views, understandings and expectations of each other have the potential to impact the core sense of self and, consequently, the perceived quality of life that each partner experiences"

(p. 43). Similarly, La Rossa and Reitzes (1993) suggest that the significance which people attribute to symbols forms the basis of human behavior when these symbols are learned from people who are "significant others" with whom they have a relationship, particularly intimate partners in primary groups.

Although family systems theorists traditionally have a focus on the relationships that individuals have with other members of the family or couple system, they also acknowledge the relationships that people have with the larger society. Michael White and David Epston (1990) (narrative therapists) who ascribe to systemic thinking believe that humans govern and evaluate themselves through their social interactions with the larger society. White and Epston (1990) suggested that "in these circumstances, persons will perpetually evaluate their own behavior and engage in operations on themselves to forge themselves as docile bodies" (p. 24). Family systems theorists also focus on viewing the self in the context of social systems. Systems thinkers Sanders and Tom (1989) stated, "indeed, we find it more useful to think of the self as a socially defined unit that arises through, and is maintained and/or modified by, social interaction" (p. 10). In addition, family systems theorists acknowledge that meaning is constructed within interpersonal relationships. According to Yang and Rosenblatt (2007), "a couple relationship is based on meaning—the meaning a couple gives to their relationship, to themselves, to the things they do, to the future, to whatever they talk about" (p. 307).

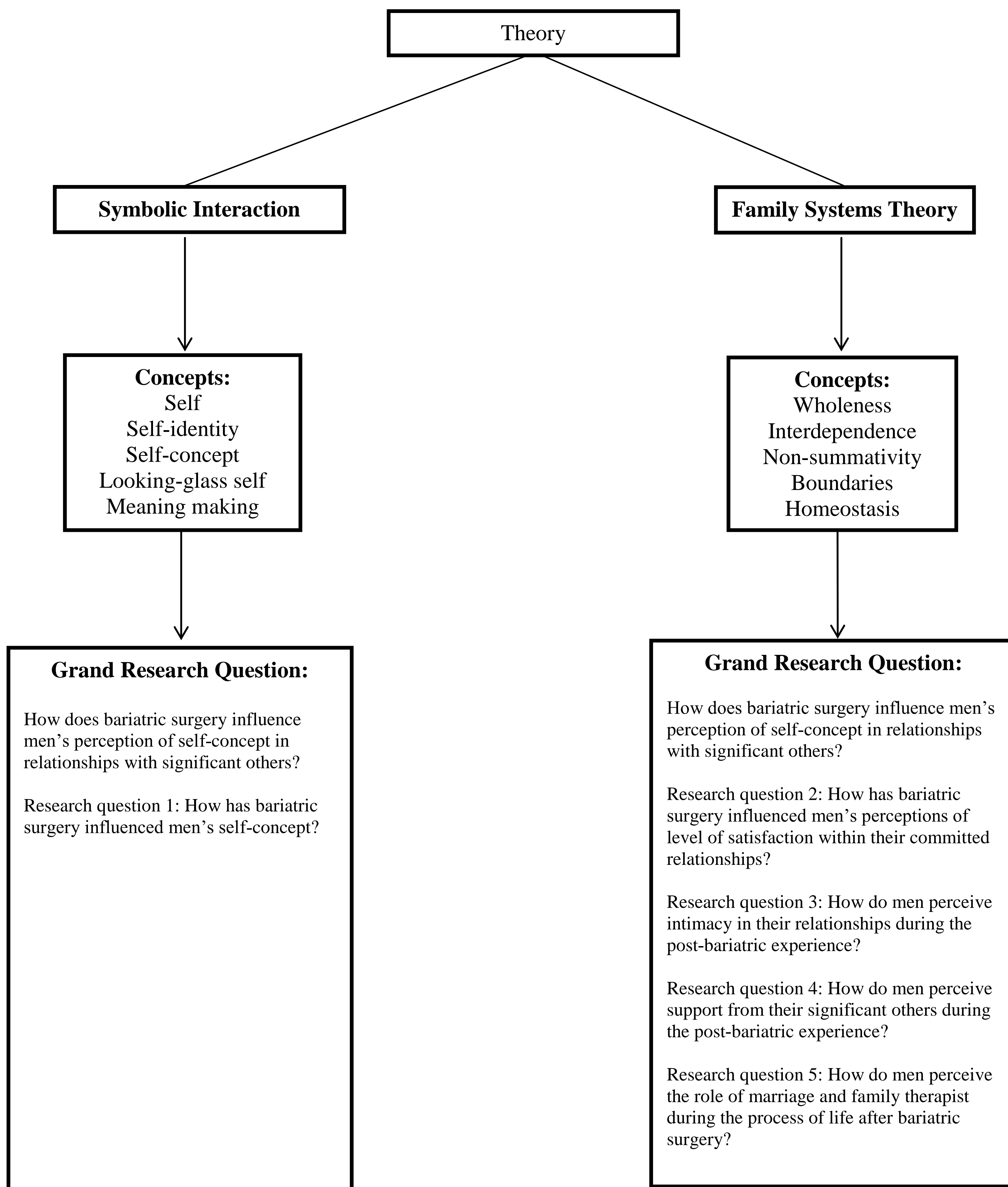
Symbolic interaction theory and family systems theory both account for certain aspects of relational dynamics among individuals and families. However, the extent to which each theory addresses either the individual or family system differs. Symbolic interaction theorists may address family roles but still focus on the individual (Rosenbaum, 2009). Family system theorists may address individuals within the couple dyad, but still focus on the relational dynamics.

Symbolic interaction theory and family systems theory enhance one another and compensate for the other's weaknesses. Symbolic interaction theory and family systems theory work together to provide a balanced perspective, meaning that both the individual and the couple processes are able to be viewed equally. **(See Figure 1 for the Theoretical Diagram).**

This study contributed to scholarly discussions regarding the obesity epidemic (James, 2004). It specifically added the experiences of men to the discussion, which initiated new ways of viewing the obesity epidemic. Through this study, the researcher explored an unchartered territory in order to gain a more in-depth understanding of the phenomenon of bariatric surgery. Through this examination, the researcher learned information that may be helpful in developing strategies to address the obesity epidemic. It is hoped that this research will assist mental health professionals and other professionals with developing treatment for this population, and provide information for individuals, couples, and families who may undergo such a surgical procedure.

**Figure 1**

**Theoretical Diagram**



# CHAPTER TWO: LITERATURE REVIEW

The topic of bariatric surgery within the context of couple relationships is a new area of research. Traditionally, researchers who have examined the topic of bariatric surgery have focused on the person having the surgery as an individual. Research that has included relational aspects of this medical procedure is very limited. Researchers who have investigated bariatric surgery have also focused mainly on medical outcomes. This research study focused exclusively on the post-surgical experience of individuals and their spouses from the perspective of men who had bariatric surgery. However, in order to fully understand this phenomenon, it is important to provide an overview of obesity treatment and to investigate what life was like prior to the surgical intervention. By describing the pre-surgical experience, a frame of reference and context prior to change is established. Reviewing literature regarding the pre-surgical experience provides information regarding the context for people who present for bariatric surgery.

The purpose of this literature review is to provide a synopsis of the current literature to date in this emerging field and the background information needed to understand the topic of bariatric surgery. This chapter includes an overview of obesity from an historical perspective, relevant literature regarding the pre- and post-bariatric surgical experience, an analysis of research that has been conducted with couples who have undergone other surgical procedures, and a critical analysis of the gaps and limitations of the current research.

## Historical Perspective

Within the medical field, obesity has been socially constructed as a chronic disease. Weiss (2004) noted that “a prevalent view in the medical world is that obesity is a medical condition” (p. 288). Therefore, within the medical field the focus has been on weight reduction, with less emphasis on psychological, mental health, and relational aspects. According to the American Obesity Association, obesity is defined as “excess body fat.” Although there are many

ways to measure obesity, calculating Body Mass Index (BMI) is one of the most widely used methods. According to Wray and Deery (2006), "BMI, a height to weight ratio, is often used to measure the medically defined condition of obesity" (p. 230). BMI is used to classify individuals into different weight groups and is used to assess for possible health risks. In order to calculate BMI, one must "divide weight in pounds (lbs) by height in inches (in) squared and multiply by a conversion factor of 703" (CDC, 2011). A person is considered obese if they have a BMI of 30 or higher. A person is considered to be morbidly obese if they have a BMI of 40 or higher. Individuals are considered eligible for bariatric surgery if they have a BMI of 30 with a co-morbidity or a BMI of at least 35 without a co-morbidity.

The main objective of medical professionals who treat obesity is to decrease body fat and to promote and improve health and quality of life. While there have been a number of medical and behavioral interventions developed over the years, bariatric surgery is the most effective. Within the medical field the individual has also been socially constructed as "the patient," (Herzlich & Pierret, 1985). Historically, within the field of medical sociology, individuals have been pathologized and viewed as "sick" and needing to be "healed," (i.e., Brown, 1995). Therefore in the literature, most researchers still refer to individuals who undergo medical procedures including bariatric surgery as "patients." From my own personal perspective, I believe that there are a certain set of negative assumptions inherent in the term "patient" such as "weak, ill, sick." Therefore, I have made a conscious effort to limit referring to individuals as "patients" in my research as a way to refrain from promoting, perpetuating, or privileging the medical field. While I reject the notion of "patient," I also acknowledge that it is used in mainstream medical research. Therefore, the term does appear within the body of my research as it relates to the literature review section.

**Advances in Bariatric Surgery**

The first surgical procedure used to treat obesity was the jejunoileal bypass (Kendrick & Dakin, 2006). The jejunoileal bypass first was conducted at the University of Minnesota in 1950. The main purpose of this procedure was to bypass the small intestine to facilitate malabsorption. However, this procedure proved to be very dangerous and resulted in severe post-operative medical issues. Therefore, other procedures were developed which included the bilopancreatic diversion, the duodenal switch, gastroplasty, gastric bypass, and gastric banding (Kendrick & Dakin, 2006). Another medical procedure, the intragastric balloon, was recently developed to treat obesity but has not completed FDA approval (Genco et al., 2006). The most popular surgical interventions used to treat obesity are the roux-en-**y** gastric bypass and laparoscopic banding (Guller, Klein, & Hagen, 2009). According to Lanyon, Maxwell, Karoly, and Ruehlman (2006), "the Roux-en-Y GBS involves both volume restriction (85% of the stomach is bypassed) and malabsorption (the first 20-30 cm of the duodenum are bypassed) of nutrients" (p. 57). Traditionally the roux-en-y gastric bypass was performed using an "open" procedure requiring the abdomen to be cut open. Risks associated with traditional bariatric surgical procedures include wound infection, leaks, vitamin deficiencies, osteoporosis, gallstones, and mortality, among others (Sansone, McDonald, Wiederman, & Ferreira, 2007). However, new technologies have been created which allow the roux-en-y procedure to be done laparoscopically, which decreases the risks involved.

In the early 1990s, a new medical procedure became available which solely uses restriction as the major mechanism for weight loss. This medical procedure is called laparoscopic gastric banding and is often referred to as the "lap band" (O'Brien & Dixon, 2003). The lap band has gained in popularity due to its low risk in post-surgical complications and its minimally

invasive nature (Spivak, Anwar, Burton, Guerrero, & Onn, 2004). Lap band surgery can be conducted as an outpatient procedure and requires less than a one day stay in a hospital (O'Brien, Dixon, & Brown, 2004). With the gastric banding procedure a silicon ring is placed around the stomach, which can be adjusted to restrict the size of the stomach (Tadross & Le Roux, 2009).

**Mental Health Perspective**

Although obesity has been viewed as a medical issue, mental health professionals have acknowledged the importance of addressing the psychological components of obesity. Mental health professionals have a long history in providing psychological services to treat obesity and associated clinical issues (i.e., depression, self-esteem, negative body image, and eating disorders). Group therapy has been increasingly used in conjunction with other treatment for obesity. Cognitive behavioral therapy is popular due to it being empirically supported (Ramirez & Rosen, 2001). Another group therapy that has been used to treat obesity is the "integrated group psychotherapy model" which includes movement and 'mind/body' work" (Weiss, 2004, p. 289).

Mental health professionals have also become involved in working with individuals who have bariatric surgery, conducting psychological evaluations prior to individuals being approved for surgery (Grothe, Dubbert, & O'jile, 2006). According to Sarwer et al. (2008), "between 20% to 60% of patients have been characterized as suffering from an Axis I psychiatric disorder, the most common were mood and anxiety disorders" (p. 50). Mental health professionals also are involved in treatment post surgery. According to Sarwer et al. (2008), some people experience suboptimal weight loss, complications, residual body dissatisfaction, and substance abuse issues, post bariatric surgery.

However, it is important to note that most studies that have been conducted to date use a sample of women (i.e., Scholtz, Le Roux, & Barlen, 2010). For example, Mahony (2010) conducted a study assessing the sexual abuse and attack histories of individuals presenting for bariatric surgery. In this article, there were 573 participants, which included 419 women (73.12%) and 154 men (26.88%). Furthermore, Di Bello et al. (2008) conducted a study regarding bariatric surgery on early myocardial alterations in adult severely obese subjects with a total sample of 13, which consisted of 11 women and 2 men. In addition, Grilo et al. (2008) conducted a study regarding overvaluation of shape and weight in binge eating disorder and overweight individuals with a total sample of 210 adults, with 160 being women and 50 being men. Other individuals may experience difficulties adjusting to the changes after surgery. Mental health professionals have been involved in conducting individual counseling as well as facilitating support groups to assist with maintaining successful long-term weight loss (Kinzl, 2010; Kinzl, Trefalt, Fiala, & Biebl, 2002). The incorporation of mental health professions into obesity treatment, further suggests the importance of addressing psychological and psycho-social aspects of obesity and weight loss.

**Motivation for Surgery**

There have only been a few researchers who have explored motivations for bariatric surgery. Most of the researchers have reported health concerns as being the primary reason why individuals undergo bariatric surgery. Liberton, Dixon, Laurie, and O’Brien (2004) conducted a study and examined motivations for surgery among a sample of individuals in Australia. This research was retrospective in nature and all of the participants were post-operative. Two hundred and eight individuals, 31 of whom were men, had laparoscopic banding and were administered a short questionnaire which covered areas such as appearance, embarrassment, medical conditions,

health effects, physical fitness, and physical limitation. Participants had already previously completed the Beck Depression Inventory, the appearance orientation and evaluation section of the Multidimensional Body Self-Relations Inventory, and the Medical Outcomes Trust form. In this study over half of the participants (52%, n=108) listed medical conditions and health concerns as the most important reason for having bariatric surgery. However, other reasons such as physical appearance were also reported. Researchers have reported that some individuals undergo bariatric surgery simply to get down to their ideal weight (Fabricatore et al., 2007). Some researchers suggest that obese individuals have unrealistic expectations regarding weight loss (Foster, Wadden, Phelan, Sarwer, & Sanderson, 2001). Medical professionals report that a 10% reduction in body weight is considered ideal (Wadden et al., 2003). However, in a study conducted by Foster, Wadden, Vogt, and Brewer (1997), obese individuals reported that they desired to lose 32% of their excess body weight.

## Life Before Bariatric Surgery

In order to conceptualize what life was like for individuals prior to bariatric surgery, one must review the literature regarding obesity. Prior to bariatric surgery, people encountered a variety of negative consequences related to their obesity status (Farrow & Tarrant, 2009). Farrow and Tarrant conducted a study and evaluated the impact of experiences of weight-based discrimination upon emotional eating, body dissatisfaction, weight-related cognitions, and behaviors among 197 undergraduate students. Participants completed a number of measures regarding weight-based discrimination, emotional eating, and body dissatisfaction, which included a 13-item Dutch Eating Behaviour Questionnaire, a nine-item body dissatisfaction subscale, a social support questionnaire and self-reported height and weight. The authors used a variety of statistical analyses including descriptive statistics, independent t-tests, moderated

regression, and hierarchal regression analysis. The researchers found that discrimination can have a negative impact on psychological well-being, attitudes, and behavior.

While it is true that every person presenting for bariatric surgery may not experience such negative consequences, there has been a number of researchers who have suggested that negative consequences are prevalent among obese individuals and individuals who present for bariatric surgical intervention (Grilo, Masheb, Brody, Burke-Martindale, & Rothschild, 2005; Pain & Wiles, 2006). These negative consequences may impact how individuals may feel about themselves, how they think about themselves, and how they experience the world (i.e., self-concept). These negative consequences may impact a person as it relates to their couple and family relationships (Barbarin & Tirado, 1985). While obesity impacts individuals among a variety of domains, the most significant to the research questions of this study include mental health and self-concept, social stigmatization, intimate relationships, and sexual intimacy.

**Mental Health and Self-Concept**

Obesity is associated with a variety of mental health and psycho-social issues, which interface with how individuals construct self-concept. The mental health and psychosocial issues that have been found to be prevalent among obese populations include but are not limited to depression, bipolar disorder, neurosis, negative body image, eating disorders, and psychological distress related to obesity stigma and weight-based discrimination. The associated mental health and psychosocial issues directly relate to and can significantly influence how individuals view themselves, how individuals assess their self-worth, and how individuals compensate for their beliefs (i.e., negative compensatory behaviors).

Self-concept is an explanatory term used in psychology and other social science fields to describe the process by which individuals view themselves (Bardone-Cone et al., 2010). Self-

concept may include how individuals view themselves in juxtaposition to others (Yahaya & Ramli, 2009). According to Yahaya and Ramli, "Self-concept refers to the totality of a complex, organized, and dynamic system of learned beliefs, attitudes and opinions that each person holds to be true about his or her personal existence" (p. 25). Self-concept influences identity construction, and can include thoughts, beliefs, and feelings, about self-worth, body image, and self-esteem (Clabaugh, Karpinksi, & Griffin, 2008). Self-concept has been discussed by numerous scholars to include Sigmund Freud, William James, George Mead, Charles Cooley, among many others (Epstein, 1973). Self-concept has also been incorporated in clinical settings and has been discussed by therapists such as Carl Rogers (Rogers, 1951). Self-concept has been incorporated into a number of theories such as social comparison theory, self discrepancy theory, gender schema theory, and numerous others (Bem, 1981; Festinger, 1954; Higgins, 1987). While there are numerous definitions for self- concept, most researchers and scholars support the notion that: (a) self-concept involves individuals' perceptions of themselves; (b) self-concept is learned and emerges out of social interaction; (c) self-concept is dynamic and can change over time; (d) self-concept involves self-evaluation and appraisal; (e) self-concept involves the ideal self, perceived self, and the social self; and (f) difficulties may emerge for individuals when there are inconsistencies between ideal self and perceived self (Markus & Kunda, 1986; Shavelson & Bolus, 1982; Sirgy, 1982). Closely associated terms with self-concept include Cooley's looking-glass self, identity, sense of self, self-evaluation, and self-appraisal. The process of developing one's self-concept may involve self-evaluation and internalization.

The topic of self-concept has been discussed within research conducted regarding obese individuals. Researchers have found that shape and weight impact an individuals' self-concept (Geller, Johnston, & Madsen, 1997). Researchers have found that not having a clearly defined

sense of self, may contribute to internalization of societal standards (Vartanian, 2009). Similarly, Blaine (2009) found that "obese people with self-concepts that are organized around appearance dimensions of the self and are overly dependent upon social approval will be vulnerable to criticism, disappointment, and failure" (p. 179).

Chan and Gillick (2009) conducted a qualitative study to explore how overweight individuals construct their identity and whether or not they view their fatness as a disability. The authors interviewed seven participants who self-identified as a "fat" person, which included 5 men and two women. The participants were between the ages 18-64 and had a BMI that was greater than or equal to 30. The researchers used qualitative semi-structured individual interviews to gather their data. Some of the interview questions centered around what 'disability' meant to the participants, if they identified with having a disability, their views on fatness and society's reactions, and whether having a disability identity was viewed as beneficial or detrimental. Data analysis was done by coding the transcriptions. The results showed that the average person does not consider fatness to be a disability; the people who did have a disability identity were not considering fatness into their disability, instead they had issues such as diabetes or arthritis. Also, Klacynski, Goold, and Mudry (2004) conducted a study and examined the relationship between negative stereotypes of obesity, a concept they call the "thin ideal" and the perceptions and beliefs around obesity, weight gain, and self-esteem issues. In the study there were a total of 107 participants (men = 17, women = 90) who were undergraduate students. The authors measured self-esteem, body esteem, causes of obesity, attitudes toward and stereotypes of obesity, thin idealization, control over weight, and verbal ability. In the study, it was found that self-esteem and negative attitudes towards obesity were negatively correlated with one another. Gender and body mass were also found to be associated with body esteem. A key part of

the study was that the authors found a negative correlation between “negative attitudes towards obesity and self-esteem” (p. 307).

In addition, Smeeters, Mussweiler, and Mandel (2010) conducted a three-part study and researched the way in which advertisements that have heavy or thin models affects the well-being, self-concept, and self-esteem of the overweight, normal, and underweight consumer. The authors included a sample of 156 women (undergraduate participants) and explored the psychological implications that can occur when women are exposed to images of thin women in the media. The first study consisted of exposing women to an ad booklet which contained advertisements with pictures of models and filler advertisements. Participants were randomly assigned into groups based on their BMI and were administered the Advertisement Questionnaire, the Picture Comparison Task Assessment and the Twenty Statements Tests. The second part of the study included having students answer the same Advertisement Questionnaire as in study one; they also were given a booklet containing four ads with models. Participants were also given the task to sit in front of a computer monitor and performed a word recognition task. In the third study the researchers looked at the behavioral implications when exposed to advertising models. Authors used ANOVA and a regression analysis to gather their results. Their findings showed that social comparison processes and subsequent self-evaluative and behavioral outcomes are different for individuals differing in their BMI.

**Depression.** Depression has been found to be highly correlated with obesity (Chen, Jiang, & Mao, 2009; Napolitano & Foster, 2008). Chen, Jiang, and Mao conducted a quantitative study in the Department of Epidemiology and Community Medicine at the University of Ottawa. The purpose of the study was to determine the age and sex variations in the associations between obesity and depression. Authors used data from 59,652 adults throughout Canada that

participated in a Canadian Community Health Survey that was administered in 2005. The survey that was used included questions related to health status, healthcare use, and health determinants. Using the scores from the survey, the researchers analyzed the results in regards to depression, utilizing a multi-stage stratified sampling design. The results showed that depression is found in 5.3% of adults living in the provinces that the survey was administered to. Depression was also higher in men than in women according to this study. There was a high increase in depression among people who had issues with obesity or being underweight.

According to the DSM IV-TR (2000), "the essential feature of major depressive disorder is a clinical course that is characterized by one or more major depressive episodes, without a history of manic, mixed, or hypomanic episodes" (p. 369). The mood associated with depression has been described as "depressed, sad, hopeless, discouraged, or down in the dumps" (DSM IV-TR, 2000, p. 349). Dong, Sanchez, and Price (2004) conducted research and examined the relationship between obesity and depression among a total of 1,730 European Americans (558 men, 1,172 women) and 373 African Americans (103 men, 270 women,) segregating extreme obesity and normal weight. The researchers invited participants to complete a self-questionnaire and a structured clinical interview. Data was also collected from members of the participants' families of origin. The measurements used looked at the individual BMI and the history of depression treatment. The researchers ran a logistical regression and found that obesity was positively associated with depression with an OR of 1.81, ($p<0.0001$). The researchers further found that BMI, race, marital status, chronic medical conditions and family history were the predictors of depression for both the genders.

Charles Solow (1977) conducted a study and examined the psychological co-morbidities associated with obesity. He conducted semi-structured interviews with 29 pre-bariatric

individuals from a New Hampshire hospital, and administered a series of psychological exams and questionnaires. Solow found that almost half of the participants had some type of mental health diagnosis. Solow reported that 12 participants were found to be psychologically impaired, including neurosis in five, personality disorder in four, and schizophrenia in three. Alciati et al. (2007) conducted research regarding bariatric surgery and bi-polar spectrum disorder. Alciati and colleagues recruited 83 pre-surgical participants from a hospital in Italy. These researchers used a structured clinical interview, a questionnaire, and a hypomania checklist. The statistical analysis that was used was chi-square and analysis of variance. The investigators found that 89 percent of the participants presented with a bipolar spectrum disorder including Bipolar I, Bipolar II, and hypomania.

**Negative body image.** Although body dissatisfaction does not affect all individuals who struggle with obesity, researchers suggest that body image concerns are prevalent among obese individuals and individuals who present for bariatric surgery. Thompson (1990) stated that "in general, research strongly supports the common sense observation that overweight individuals are unhappy with the way they look" (p. 28). According to Ramirez and Rosen (2001), "compared with normal weight individuals, obese persons overestimate or distort their body size more, are more dissatisfied and preoccupied with their physical appearance, and avoid more social situations because of their appearance concerns" (p. 440). Additionally, Muennig, Jia, Lee, and Lubetkin (2008) found that psychological distress associated with negative body image is a contributing factor of morbidity among obese individuals. The purpose of the study was to see if stress related to negative body image perception was a factor towards the desire to lose weight. The sample of this study included 247,027 participants who were pulled from the Behavioral Risk Factor Surveillance System data set. Authors used random digit dialing to survey

participants and examined the impact of desired body weight, independent of actual body mass index, on the amount of physically and mentally unhealthy days by race, ethnicity and gender. The authors conducted a regression analysis and found the difference between desired and actual body weight to be a stronger predictor than BMI of mental and physical health. The authors concluded that the health effects around obesity may have something to do with the way in which individuals see their bodies.

In a study conducted by Watkins, Christie, and Chally (2008), researchers found that "overweight and obese participants reported significantly higher levels of negative body image when compared to normal and underweight participants" (p. 95). Watkins and colleagues examined the cognitive and affective dimensions of body image of 199 college men. The participants were randomly selected and their body mass index was measured. The researchers utilized a chi-square ANOVA test to determine the difference between four BMI groups which were underweight, normal weight, overweight, and obese. Researchers found that BMI was correlated significantly with negative body image and that BMI is an important factor in locating potential body image disorders in college-aged men. Other researchers have found a high prevalence of body dissatisfaction among obese individuals and have found that when compared to non-obese samples, obese individuals display more concerns regarding their body image (Calvete et al., 2002; Johnstone et al., 2008; Kaplan, 1979). According to Watkins et al. (2008), "body image is the subjective level of contentment with one's appearance and is measured by determining discrepancy between actual and ideal weight and attitudes regarding level of satisfaction with appearance" (p. 95). Bottamini and Ste-Marie (2006) reported that body image "can influence one's thoughts, emotions, and behaviors and may be revealed in attitudinal and perceptual components" (p. 109).

Grilo et al. (2008) conducted a study which explored the prevalence of body image and binge eating among obese individuals. The authors had 210 participants (160 women and 50 men), who were classified as being an overweight binge eater or an overweight non-binge eater. Out of the total number of participants, 165 met the DSM criteria for binge eating and were overweight. The participants were given two eating disorder assessments and a depression scale. The authors used an analysis of variance to compare the two groups. The researchers found that "the BED [Binge Eating Disordered] clinical overvaluation group reported greater shape, weight, and eating concerns than the subclinical overvaluation and overweight comparison groups, whereas the BED subclinical overvaluation group reported greater problems in these areas than the comparison group" (p. 417). Striegel-Moore, Wilson, Wilfley, Elder, and Brownell (1998) also conducted a study which included exploring body image concerns and binge eating in an obese sample. This study consisted of a sample of 392 participants who were categorized into four groups: "BED group (33 women and 20 men), a sub-threshold group (79 women and 40 men), a recurrent overeating group (21 women and 39 men), and a control group (80 women and 80 men)" (p. 27). The authors used a MANCOVA and found a major difference between the binge eating group and the control groups. They found that "compared with controls, the BED group attached significantly greater importance to their weight, expressed more dissatisfaction with weight, and reported a bigger difference between their current and ideal body size" (p. 33).

**Social Stigmatization.** Social stigmatization is a prevalent issue that often impacts the self-concept of obese individuals. Obese individuals are affected psychologically by the discrimination that they face. Obese individuals suffer social consequences related to their obesity status, as they may be subject to public ridicule, weight biases, weight-based discrimination, and stigmatization (Thomas, Hyde, Karunaratne, Herbert, & Komesaroff, 2008).

Social stigmatization may occur for obese individuals within peer groups, couple and family relationships, workplace settings, and within the medical field itself. According to Lewis and Puymbroeck (2008), "anti-fat bias refers to existing negative attitudes towards people perceived as being overweight that often result in discriminatory acts, while obesity stigma is the result if social disapproval tied to such stereotypes" (p. 574).

Researchers have found that obesity stigmatization occurs within work place settings. Swami, Chan, Wong, Furnham, and Tovee (2008) conducted a study and found that obese individuals were least likely to be hired when compared to individuals with a lower body mass index. The authors explored weight-based discrimination using a range of weight categories, as represented by images of real women with known body mass index (BMI). The first part of the study had 30 men who each rated image according to the likelihood of occupational hiring for managerial post. In the second part of the study, they had 28 men and rated the same images for likelihood of helping behavior following a minor accident. Swami et al. 2008 had 30 men who attended an undergraduate institution. The participants were shown images twice to assess for different things. Participants were told there is no wrong or right answer. The results of the study found that "individuals with a slender body weight (BMI = 19–20) were most likely to be hired and helped, while obese (BMI > 30) participants were least likely to be hired and helped" (p. 968). In the same way, obesity stigmatization also occurs within the medical field and negatively impacts individuals who seek treatment (Teachman & Brownell, 2001). Merrill and Grassley (2008) conducted a study on the experience of being an overweight person presenting for treatment. Eight overweight and obese women between the ages of 20 and 60 were recruited from the southern region of the United States. Semi-structured interviews were conducted utilizing phenomenology as the research method which resulted in the finding of four major

themes, "struggling to fit in, feeling not quite human, being dismissed, and refusing to give up" (p. 141). In this study participants reported that they felt blamed for being overweight, felt rejected by medical professionals, and felt that their health concerns related to their weight were dismissed.

Researchers have suggested that social stigmatization negatively impacts the health of obese individuals. Puhl and Heuer (2010) conducted a literature review regarding the stigmatization of obesity and found that "stigmatization of obesity threatens health, generates health disparities, and interferes with effective obesity intervention efforts" (p. 1019). Carels et al. (2009) conducted a study examining the relationships between weight bias and weight loss and found that greater levels of weight bias positively correlated with decreased weight loss for individuals. The authors explored the relationship between weight bias and weight loss treatment outcomes. They researched the relationship between explicit and implicit weight bias and (a) program attrition; (b) weight loss; (c) self-monitoring adherence; (d) daily exercise levels and overall caloric expenditure; (e) daily caloric intake; and (f) daily caloric deficit among overweight/obese treatment-seeking adults. The study consisted of a sample of 46 overweight and obese adults with 93.1% being Caucasian and 89.7% being women. The mean baseline BMI was 36.6 (standard deviation [SD] =7.1). Participants completed an 18-week behavioral weight loss program and were asked to self-monitor and report electronically about their daily energy intake and their level of exercise. Participants were also asked to complete the Obese Persons Trait Survey. The authors found that greater weight bias was associated with "inconsistent self-monitoring, greater caloric intake, lower energy expenditure and exercise, creation of a smaller caloric deficit, higher program attrition, as well as less weight loss during the self-help phase of the stepped-care treatment" (p. 350).

While most research on obesity stigma has been focused on women (i.e., a limited sample size of participants that are men), researchers suggest that men are also impacted by this phenomenon. Hebl and Turchin (2005) conducted a study and examined obesity stigma among men. Over 60 undergraduate students were recruited to participate in this study. Participants were asked to rate 12 photos which consisted of men and women with varying body mass indexes regarding likelihood of employment, success in the workplace, and physical attraction. A 2(participant race) x 2(target race) x 2(target size) x 3(target size) analysis of variance was conducted and researchers found that the larger the man, the less highly the target was rated.

**Obesity and Relationship Satisfaction**

Research regarding obesity and couple relationships is extremely limited (Sobal, 1990). The research that has been done in this area has been focused on relationship quality or marital satisfaction and sexual intimacy and functioning. Some researchers have reported that obese populations present with a high prevalence of marital dissatisfaction prior to surgical intervention (Hafner, Rogers, & Watts, 1990; Sarwer, Wadden, & Fabricatore, 2005). For instance, Sobal, Rauschenbach, and Frongillo (1995) conducted a population study to assess body weight and marital satisfaction among 1,980 married adults covering the 48 southern states. The researchers used data from the National Survey of Personal Health Practices and Consequences conducted by the National Center for Health Statistics between 1979 and 1980 (p. 751). Thirty-minute phone interviews were conducted and the survey was focused on examining marital happiness and satisfaction. The marital exchange model, social norms model, and family function model were used as theories to guide the study. A complex cluster sample design was incorporated and correlations were calculated among weight and satisfaction variables. In this study, it was found that “obese men were more likely to have marital problems, and that men who lost more weight

were less likely to report marital problems" (p. 756). It was also found that obese women reported more happiness in their relationships and that there was a correlation between weight gain among men and women and happier marriages.

Ledyard and Morrison (2008) conducted a qualitative phenomenological study that explored the meaning of weight among 11 obese couples. Nine of the couples were Caucasian and the remaining two couples were African American, with a majority of the couples living in the Midwest. The primary investigators conducted individual and conjoint interviews and asked questions regarding obesity and marriage. The researchers found that obesity becomes a third part of some couple relationships and serves as a form of triangulation for couples. They also found that some couples unite against obesity and work as a team to tackle their obesity problems. However, the researchers also found that obesity worked against and divided the couple. Fear and anger manifested in some of the participants' relationships. In addition, there were some issues with spouses having individual weight loss goals, and not being supportive of each other's weight loss attempts. In this study, researchers also found that control played a role in relationships as some spouses tried to manage their mate's food intake and rate of exercise. Ledyard and Morrison also found that some couples expressed concerns regarding their weight and sexual intimacy, specifically relating to sexual and emotional distance, decreased frequency, and reports of dissatisfaction during intercourse.

**Obesity and Sexual Intimacy**

There have been a few articles published regarding the topic of obesity and couples and some discussion around the topic of obesity status and perceptions of beauty and physical attractiveness. Some researchers have suggested that there is a correlation between body mass index and attitudes regarding sexual desirability and attractiveness. Singh and Young (1995)

conducted two studies which explored men's perceptions of women's attractiveness and sexual desirability. In the first study, Singh and Young disseminated surveys to men which consisted of pictures of women in various shapes, sizes, and body mass indexes. The participants were asked to rate each picture based on their perceptions of age, attractiveness, health, and desirability for casual and long term relationships. In the second study pictures of women with similar body weight sizes and waist-to-hip ratios, but different hips, widths, and breast sizes were used to judge the same criteria from the first study. The researchers found that "larger body size, a high waist-to-hip ratio, and larger hips make the women figure appear older, unattractive, and less desirable for engaging in romantic relationships" (p. 483). In a similar study Chen and Brown (2005) found that obese women faced discrimination due to their weight and are viewed as less sexually desirable when compared to other women who are not obese.

Boyes and Latner (2009) conducted a study involving 57 married couples that assessed the relationship between weight-related stigma and mate value. The couples resided in New Zealand and were characterized of a variety of body mass indexes. Recruited couples completed the Perceived relationship quality component scale, the Relationship Dissolution Prediction Scale, and five measures from the partner ideals scale. The investigators ran a correlation test between body mass index and mate evaluation variables. The authors found that "for the ratings of 'Nice Body' men perceived heavier women much less positively ($r=-.53$, $p<.01$). In addition, researchers also found that "heavier women thought that their partners saw them as less warm and trustworthy ($r=-.30$, $p<.05$).

**Obesity and Sexual Functioning**

One of the issues that appear most frequently in the literature is regarding sexual functioning. Researchers have suggested that obesity impacts men's reproductive system and

increases risks of sexual dysfunction and infertility. According to Hammoud et al. (2008), obesity decreases the ability for men to produce sperm and results in low sperm concentration. Hammoud et al. conducted a study and examined the impact that obesity has on sperm parameters and erectile dysfunction for men. They used data that was collected at an infertility clinic and sampled from 457 men in the United States. The researchers analyzed participants' histories, demographics, and BMIs, and administered a self-reported sexual dysfunction questionnaire. Semen was collected and analyzed for level of sperm concentration, sperm per ejaculate, and sperm morphology. The mean age in this study was 32 years. The researchers found that as BMI increased from normal weight to obese, the prevalence of oligospermia increases ($p=.011$), and the prevalence of progressively lower motile sperm increased ($p=.018$) Within this study, the erectile dysfunction rate also was shown to increase along with BMI, but was not shown to be statistically significant. Another study conducted by Pauli et al. (2008) found that "obese men were less likely to have a history of paternity compared with non-obese men, and they had circulating reproductive hormone profiles consistent with diminished reproductive capacity" (p. 349).

## Life After Bariatric Surgery

The post-surgical experience of bariatric surgery is complex and varies for individuals. To date, most of the research has been focused on medical outcomes, such as improved co-morbidities (Adams et al., 2007), improved quality of life (Dixon, Dixon, & O'Brien, 2001), and medical complications (Anderson, 2008). Researchers have also explored the impact of bariatric surgery on mental health as well as on couple relationships (Grimaldi & Van Etten, 2010). The following section of the literature review includes a discussion of psychosocial outcomes associated with life after bariatric surgery (related to the self-concept research question), a

discussion of couples' adjustment and other medical procedures (related to the relationship satisfaction and sexual intimacy research questions), and a discussion of social support (related directly to the social support research question).

**Psychosocial Outcomes**

Researchers who have examined the post-operative stage of bariatric surgery report that most individuals experience improvements in psychological health and quality of life. Herpertz et al. (2003) conducted a meta-analysis regarding psychosocial outcomes of bariatric surgery and found that rates of depression, negative body image, and anxiety decrease post-surgery. Anderson et al. (2010) specifically explored psychosocial outcomes after the duodenal switch weight loss procedure among fifty participants and found substantial improvements in symptoms of depression and anxiety. Similarly, Frezza, Shebani, and Wachtel (2007) found that people experience fewer mental health problems after having laparascopic gastric bypass surgery. In this study "postoperative visits were scheduled at 1, 2, 6, 9, 12, 15, and 18 months" (p. 441). Dixon, Dixon, and O'brien (2002) conducted a follow up study regarding bariatric surgery and found that body image improved in a sample of 122 participants. However, some individuals reported that psychosocial improvements only last for the first couple of years after surgery (Greenberg, Smith, & Rockhart, 2004). If psychological improvements only last for a couple of years after surgery, further exploration may be necessary to explore barriers to successful outcomes.

While a majority of the researchers have reported improvements post-surgery, some report negative outcomes or no change in psychological outcomes. Some individuals may experience distress related to the behavioral adjustments required after surgery. In like manner, some individuals fail at losing weight or experience weight regain due to their inability to adhere to required behavior changes and post-surgical medical appointments (Tejirian, Jensen, Lewis,

Dutson, & Mehran, 2008). In addition, some individuals develop eating disorders and other psychological issues. Bonne, Bashi, and Berry (1994) conducted a study regarding the experience of anorexia nervosa of two men who had undergone vertical gastric banding. Other researchers have reported that people suffer from binge eating disorder post-surgery (Kalarchian et al., 2002). Some individuals experience negative body image post-surgery due to the excessive amount of hanging skin that often occurs after weight loss. Therefore, some men and women decide to follow up bariatric surgery with plastic surgery. In addition, study regarding a younger population conducted by Vazzana (2008) found an increase in high risk behavior to include "drug use, gang involvement, and unsafe sexual practices" post-bariatric surgery (p. 71). Within the media, there have been discussions regarding the so called "addictions transfer" syndrome. Sarwer et al. (2008), suggest the following:

> Addiction transfer is a popular term, created by the media that refers to the ideology that patients who go through the procedure of getting bariatric surgery may develop addictions such as substance abuse, gambling, sex, and etc. to replace their preoperative "addiction" to food, (p. 55).

Some experts have suggested that people transfer their food addiction to other areas and develop negative compensatory behaviors (i.e., alcoholism, substance abuse, gambling, excessive shopping, or sexual addiction). However, these claims are only anecdotally based and have yet to be substantiated through empirically based scholarly research (Marcus, Kalarchian, & Courcoulas, 2009).

In addition to mental health changes, some may encounter difficulties in their social lives. Although one may lose excess body weight, he or she may still view themselves in a negative way or may be met with negative reactions by peers, family, and other individuals. Earvolino-

Ramirez (2008) conducted a qualitative study and explored the adjustment process of a 55-year-old Caucasian woman. Earvolino-Ramirez found that the participant experienced stigma from family members around the method chosen for weight loss. Bray and Benfield (1977) suggested that people may develop a change in mood, which may become problematic for family members (p. 125). People experiencing weight loss may also have difficulties adjusting to positive reactions they get from peers. Sogg and Gorman (2008) conducted a study and found that some individuals feel uncomfortable when receiving compliments about their new change in body size.

**Couples' Adjustment**

The research that has been conducted regarding bariatric surgery and couple relationships is inconclusive and preliminary at best, as researchers have found various results over the years. Some researchers have found that people benefit from improved couple and marital relationships post-bariatric surgery (Rand, Kuldau, & Robbins, 1982). Two researchers found no significant change in marital satisfaction (Porter & Wampler, 2000; Rand, Macgregor, & Hawkins, 1986). However, Neill, Marshall, and Yale (1978) conducted a qualitative retrospective study with 14 couples where one partner had bariatric surgery. This study consisted of 14 bariatric clients (12 women and two men). In this research respondents reported stress and turmoil in the relationship, extramarital affairs, separation, and divorce. Similarly, a study by Macias, Leal, Lopez-Ibor, Rubio, and Caballero (2004) showed that bariatric respondents experienced a greater level of marital instability post-surgery. Applegate and Friedman (2008) suggested that bariatric surgery can impact couple relationships in a negative way, but found that most people report improvements. Applegate and Friedman stated "weight loss surgery issues for couples can stem from the patient's and their partner's expectations, the patient's increase in energy, their enhanced confidence, and changes in appearance" (p. 135). In addition, Madan, Turman, and

Tichansky (2005) conducted a study on spouses of men and women who had undergone bariatric surgery. They reported that “patients’ spouses who are obese are more likely to have weight gain while the patients lose weight” (p. 191).

Other researchers who have examined bariatric surgery and couple relationships have focused exclusively on sexual intimacy and sexual satisfaction within the couple dyad. Researchers have suggested that humans experience improvements in their sexual quality of life. Kolotkin et al. (2008) conducted a study with 161 women and 26 men who experienced significant weight loss. Kolotkin et al. administered the impact of weight on quality of life questionnaire to assess for changes in sexual quality. The investigators found that women experienced significant improvements in all dimensions, whereas men showed significant change in the “not feeling sexually attractive” domain. Similarly, Camps, Zervos, Goode, and Rosemurgy (1996) conducted a qualitative study which examined changes in sexuality and body image among 28 respondents and 16 of their partners. These authors found that “sexual intercourse, orgasm, and body image improved for individuals within the couple dyad” (p. 356).

**Other Medical Procedures**

In addition to bariatric surgery, other medical procedures have been shown to impact the couple dyad. Within the literature regarding cancer, there have been a number of studies regarding treatment and couple relationships. Phillips et al. (2000) conducted a study to examine the quality of life for men and their spouses after recent surgery for prostate cancer. The investigators recruited 34 couples from Canada and conducted semi-structured qualitative interviews. The participants were interviewed both individually as well as together. The interviews were transcribed and coded using Nudist qualitative software. The authors found that some couples struggled with adjusting to new roles during the recovery period and experienced

irritability, distress, and difficulties with communication. Erectile dysfunction was also found to be an area which caused some concern within the couple dyad.

Some researchers and medical professionals also recommend some form of couples' intervention to assist individuals and their partners through the postoperative period. For example, McLean et al. (2008) conducted a study that examined the impact of an eight-week emotionally focused therapeutic intervention with 16 couples who were recovering from cancer treatment. McLean and colleagues administered the revised Dyadic Adjustment Scale, the Beck Depression Scale, the Beck Hopelessness Scale, and the Satisfaction and Benefit Scale before the intervention, after four sessions, after eight sessions, and after three months. In this study marital functioning was found to improve significantly over time ($F (3,105) = 8.19$, $p<0.0001$. Respondents were also found to have lower symptoms of depression and reported finding the intervention successful. Furthermore, medical family therapy as an emerging therapeutic approach within the field of Marriage and Family Therapy has also been incorporated in working with individuals and their families (Dankoski & Pais, 2007; Linville, Hertlein, & Lyness, 2007). The research conducted regarding other medical procedures further suggests that there are relational dynamics and processes the may be at play when a person and his or her spouse transition through a medical intervention.

**Social Support**

The importance and significance of social support after a surgical intervention has been widely discussed. Researchers who have covered topics such as social support for individuals who have encountered issues such as cancer (Helgeson & Cohen, 1996), smoking cessation (Mermelstein, Cohen, Lichtenstein, Baer, & Kamarck, 1986), substance abuse (Ellis, Bernichona, Yua, Robertsb, & Herrell, 2004), and AIDS (Serovich, Kimberly, Mosack, & Lewis,

2001). Furthermore, social support has also been viewed as important for therapy clients who may be encountering difficulties with adjusting or transitioning to life after a traumatic event, such as in the case of divorce, the death of a child, domestic abuse, or infertility (i.e., Amir, Horesh, & Lin-Stein, 1999).

Social support is a topic that has been discussed regarding weight loss. Social support has been viewed as correlated with higher rates of sustained weight loss post-bariatric surgery. Kayman, Bruvold, and Stern (1990) conducted a study regarding maintenance and relapse after weight loss. The researchers interviewed 108 women who have maintained weight loss, have relapsed after initial loss, or have never been obese (control group). Participants were interviewed using a questionnaire which covered areas related to history of weight loss, positive and negative experiences, and coping. The researchers conducted an analysis of variance and found that the women who were successful with weight loss "sought support or help in dealing with their problems from friends, family, and professionals more than did relapsers" (p. 804).

Prior to bariatric surgery, one of the things that some therapists screen for is if potential candidates have a support system (Canetti, Berry, & Elizur, 2009). However, not having adequate social support will not automatically disqualify someone from having bariatric surgery. The dominant perspective is that social support will assist the individual client with maintaining an appropriate post-operative diet, level of physical activity, and relationship with food. Orth, Madan, Tadduecci, Coday, and Tichansky (2008) conducted a study regarding social support post-bariatric surgery. The researchers disseminated questionnaires to 46 bariatric respondents who either were involved in support groups or did not utilize support groups after weight loss surgery. Researchers found that participants who attended support groups lost more weight than their non-attending counterparts.

There are a variety of avenues for individuals to obtain social support. One avenue is social support within intimate relationships and the family system. Social support within families may not only consist of emotional support, but may also involve financial support such as assisting with paying for gym memberships, purchasing specialty foods, paying for post-operative medical appointments, among others expenses. Marcoux, Trenkner, and Rosenstock, (1990) conducted a study of social support among obese individuals who were involved in a weight loss program. In the study, 26 participants completed self-report questionnaires about their weight loss experience and various types of support (general support and weight specific support). The participants were asked to complete a self-administered questionnaire that discussed social support; it had 45 items and researchers used a social networks analysis approach. Participants also completed objective measurements prior to and after the behavioral intervention. Researchers ran a correlation analysis and found positive relationships between social support and weight loss (for all domains including positive affective, appraisal, instrumental, and negative aspects of relationships). Also, with measures related to weight specific support, researchers found a positive correlation between appraisal support and weights loss. In addition, a negative relationship between instrumental support and interference with weight loss was found. The researchers also reported that when asked which one person was the most helpful in terms of losing weight, “46% of the sample reported family, 27% said spouses, 15% said friends, 8% said co-workers, and 4% said themselves” (p. 236). In addition, when asked about the least supportive individuals, 42% reported that it was the family (p. 236).

Another avenue for social support for bariatric clients exists within peer relationships such as in the form of social groups. A number of hospitals offer support groups for bariatric clients that are typically facilitated by a medical professionals, therapists, or other behavioral

specialists. Most support groups offered occur bi-monthly, such as at Trinity Hospital in Augusta, Georgia (one of the recruitment sites). The focus of the weight loss group sessions are on adhering to the post-operative diet and behavior modification (Livhitis et al., 2011). The support groups typically are for the person who had bariatric surgery only, and not for spouses or family members. However, more recently there has been the emergence of support groups for family members (Livhitis et al., 2010; Verheijden, Bakx, van Weel, Koelen, & Starveren, 2005).

These groups typically do not include the actual person who had the surgery in the meetings and operate similarly to Al-Anon for family members of alcoholics. In addition, some support groups within the hospital settings may provide a clothing exchange program such as Florida Hospital, (Geggis, 2011) and Harvard University, ("Post-opt Support Group Topic: Clothing Swap," 2011). As men and women lose weight, they may exchange their clothes with other clients who are still in the process of losing weight. This serves as an extra form of social support for people undergoing surgery. It is not uncommon for a client to lose a substantial amount of weight quickly in excess of a hundred pounds, and it can be costly to buy a completely new wardrobe at one time. Therefore, the clothing exchange assists not only in terms of emotional support but also in terms of economic support.

Participation in social support groups is recommended but is not required of medical patients (Higgs et al., 1997). Some support groups take place outside of the hospital setting and may include support groups that are facilitated by a therapist or by clients who have had surgery in the past (Peltier, 2006). Group dynamics play an important role during group process and can assist individuals in dealing with emotional problems post-operatively. Within these groups members may discuss challenges they have been encountering, physical pain associated with surgical wounds, issues within their relationships, issues related to body image and weight loss,

or changes in their work life. Group members also discuss their triumphs, post-operative success, and additional personal weight loss goals. Individuals may also discuss exercise regimens and diet protocols (Livhitis et al., 2010; Wachholtz, Binks, Eisenson, Kolotkin, & Suzuki, 2010). There are also some weight loss support groups that are specifically targeted at individuals who identify as having a food addiction, such as Food Addicts Anonymous (Gearhardt, Corbin, & Brownell, 2009). Within groups related to food addiction, group members may discuss "addiction transfer" after weight loss surgery and may also discuss concepts such as triggers, relapse, and recovery. However, everything that is learned in support groups may not necessarily be helpful to or positive for medical clients. Similar to any group process, there may be some individuals involved who are manipulative, who may promote self-sabotage, who may promote "cheating," and who may promote ways that clients can "get around their addiction," (Blumenthal & Gold, 2010; Finfgeld, 2000).

Social support also can occur within work settings. There are a number of corporate wellness programs developed within businesses which promote and encourage weight loss among employees (Gebhardt & Crump, 1990; Martin, Talamini, Johnson, Hymel, & Khavjou, 2010). Individuals who work together may decide to go on a diet together and or may decide to work out together during lunch or after work. There has also been the emergence of weight loss competitions in employment settings which has been found to serve as a form of social support (i.e., Brownell, Cohen, Stunkard, Feliex, & Cooley, 1984). In similar fashion, there have been programs created within religious groups which have served as support for individuals attempting to lose weight and become healthy (i.e., Kumanyika & Charleston, 1992).

More recently, with technological advances, there has been the emergence of Internet support groups and Internet-based therapeutic groups. Within Internet support groups,

individuals communicate and provide social support over the web. There are varying degrees to which individuals self-disclose within internet groups (Harvey-Berino et al., 2002; Joinson, 2001; Micco et al., 2007). Some individuals may disclose their real name, may post self-portraits, may post videos, and may use other mechanisms to document their weight loss (Garton, Haythornthwaite, & Wellman, 1997). Others may prefer to remain anonymous or semi-anonymous and only provide some personal information. Individuals may select pseudonyms and may also use "avatars" to represent themselves in the virtual world.

Social support is provided through words of encouragement and offering peer-to-peer advice. Communication can take place in real time or asynchronously. Some online support programs may consist of participating in a "forum" where individuals post a question and others post replies to questions (i.e., www.obesityhelp.com, and www.lapbandtalk.com). Some individuals participate in live chats using the computer, some involving a web camera and some not involving a web camera (i.e., www.youtube.com). Saperstein, Atkinson, and Gold (2007) conducted a literature review regarding the use of the Internet for weight loss. They suggested that an increasing number of individuals are turning to the Internet for support and assistance with weight loss. They also reported on the efficacy of Internet-based weight loss programs and concluded that "the internet appears to have great potential as a medium through which to deliver online weight loss programs" (p. 464). Harvey-Berino, Pintauro, and Gold (2002) conducted a research study which consisted of comparing the effectiveness of three weight loss maintenance formats (face-to-face, internet, and control). Forty-six obese clients completed a weight loss behavior program and then were randomly assigned into a maintenance group. The researchers found that individuals in the face-to-face weight loss format were more likely to attend meetings and were more satisfied with their group. However, researchers found that there was no

statistically significant difference between the face-to-face maintenance group and the Internet group in terms of total weight loss among participants.

There have also been researchers who have compared internet-based weight loss educational sites with internet-based weight loss therapeutic sites. Tate, Wing, and Winett (2001) conducted a study and compared an internet behavioral therapy program with a weight loss education website. Over 90 individuals participated in the study and were randomly placed into the education or therapy group. Each participant completed a series of questionnaires regarding experiences associated with weight loss. An analysis of variances was conducted and individuals who participated in the behavioral therapy group were found to have lost significantly more weight than the education group. In addition, "45% of participants in the behavior therapy group lost greater than or equal to 5% of initial body weight compared with 22% of those in the education group ([chi]2 = 4.03; p =.05)" (p. 1776). In addition, Tate, Jackvony, and Wing (2003) conducted a study and compared an internet-based weight loss tutorial with internet behavioral therapy. They found similar results as the previous study and reported that participants lost more weight in the internet behavior therapy group than participants in the weight loss tutorial group.

While social support has been discussed both in scholarly literature and in the media, there has not been a consensus regarding which type of support is the most effective for bariatric patients (Livhits et al., 2010). Social support has been viewed as significant in terms of long term weight loss, but has not necessarily been substantiated (Broadhead et al., 1983; Uchino, Cacioppo, & Kiecolt-Glaser, 1996). In addition, there is a lack of research which specifically addresses why clients use certain types of social support systems. There is also a lack of discussion about the ways in which intimate partners provide (or fail to provide) social support to bariatric clients. With clients often having the most access to spouses and family members, it

would be important to learn about the role spouses and family members play in providing support.

## Critical Analysis

Bariatric surgery is a complex phenomenon that impacts individuals within a variety of domains. While there has been significant research regarding the medical aspects of bariatric surgery, there has been less research regarding the psychological and social aspects of this phenomenon. Research regarding men's perspectives is a new dimension within bariatric surgery research. In additional, there have only been a few researchers who have examined client experiences in context of couple relationships. Therefore, there are several limitations within the current research *and* there are major areas where additional research is warranted. The limitations within the current research include the areas of methodology, sampling, theory, and clinical intervention.

### Methodology

One of the major limitations within the body of literature regarding bariatric surgery is research methodology. Researchers who have explored the topic of bariatric surgery generally have used quantitative research methodologies and have not embraced alternative ways of knowing. Quantitative research methodology has a number of benefits and is appropriate for studying bariatric surgery clients. One of the benefits of utilizing some form of quantitative methodology approach is that researchers may be able to generalize results of statistical analysis to larger populations. With obesity being a public health phenomenon, researchers are able to utilize quantitative analysis to gain knowledge regarding social determinants of health, epidemiology, contributing factors of obesity, and health disparities. In fact, depending on the type of quantitative methodological approach, design, and sample, some researchers may be able

to predict trends among large populations. Social scientists are able to utilize various types of quantitative research methodologies to assist in solving major social problems and epidemics such as that posed by obesity in America and abroad.

While quantitative research has its place within scholarly discourse regarding obesity and bariatric surgery, it can also place limitations on the type of research questions that can be addressed. Quantitative research is important in terms of generalizability, but it fails at being able to capture participant's lived experience. There is a lack of research that has been conducted utilizing a qualitative research perspective. Qualitative research could offer a balance to the current research methodology in that it could provide more in-depth information about the experiences of research participants. In addition, researchers have suggested that illness and surgical procedures impact couples. However, researchers have not explored in depth, *how* surgical procedures affect individuals who are in committed relationships. Qualitative research could be utilized to assist researchers with learning about couple and family processes. Qualitative research also allows for researchers to position themselves reflexively. Reflexivity is an important component of research as it provides a mechanism for self-exposure of the researcher's personal belief systems and positionality (Subreenduth & Jeong-eun, 2010).

**Limited Sampling**

One of the major limitations within the current bariatric surgery research is sampling. The current researchers have failed to incorporate diversity within their sampling and selection procedures. Issues such as gender, race, class, and sexual orientation have not been broached. Most of the literature regarding bariatric surgery has been focused on women, leaving men out of the discourse. Including the experiences and perspectives of men may provide an additional perspective that can enhance the current literature. In addition, there has been a lack of

discussion regarding race and ethnicity. While there has been significant mention of race as related to obesity research, there has not been a substantial discussion regarding race specifically related to bariatric surgery clients. Obesity disproportionately impacts African American and Latino populations (Darmon & Drewnowski, 2008). Therefore it is imperative that race becomes a part of scholarly research regarding bariatric surgery and medical clients.

Current scholars have failed at including a diverse sample as it relates to class or socioeconomic status. Most participants within the literature have been college educated and considered to be “middle class” citizens. More effort should be made to include a full spectrum of socioeconomic status within the research. In addition there must be more discussion regarding race and socioeconomic status as it relates to access to healthcare. Bariatric surgery can be very expensive and can cost between $15,000 and $30,000. Many individuals who may need bariatric surgery may not have access to treatment due to lack of personal finances to self-pay or lack of medical insurance that will cover the procedure. For those who have insurance, bariatric surgery is covered by some medical insurance companies, but not by all. There are a number of medical insurance companies that do not cover bariatric surgery, (Encinosa, Bernard, Steiner, & Chen, 2005).

Another limitation of research relates to the topic of sexual orientation. There have been no studies that have examined bariatric surgery exclusively among gay or lesbian individuals and couples. Gay and lesbian relationships have continued to be marginalized within the literature of obesity and bariatric surgery. Researchers cannot continue to omit gay and lesbian couples from research regarding bariatric surgery as they may have unique experiences that are similar to, but different from heterosexual individuals and couples. Incorporating gay and lesbian individuals in

research will expand the literature and will assist mental health professionals in learning about the process of bariatric surgery for other populations.

**Lack of Theoretical Analysis**

One of the limitations within the current research is related to theory development. There is a lack of substantial theory present in the current research. Very few researchers have acknowledged theory within their studies on bariatric surgery. Researchers have not necessarily incorporated substantial theory into their research, have not explicated their own personal theoretical perspectives, and have not contributed to developing new theories for future research. Theory is an integral part of the research process and more scholars need to identify the theoretical framework that guides their work. Social scientists also need to work towards developing new theories to enhance the field. DePoy and Gitlin (1998) stated "the primary purpose of research is to test theory" (p. 29). In the same fashion, in qualitative research, the purpose is often to develop theory. Therefore, theory should be at the center of scholarly discussions when it comes to the topic of obesity and bariatric surgery.

**No Focus on Clinical Intervention**

Another limitation within the current research is related to a lack of focus on clinical interventions. Current scholars have not addressed clinical interventions or treatment practices for couples where one partner undergoes bariatric surgery. There has been some mention of individual psychotherapy treatment and therapeutic support groups for bariatric clients (Bogers et al., 2010; Mohr, Boudweyn, Goodkin, Bostrom, & Epstein, 2001). However, there has been less focus on treatment directed towards individuals who are in committed intimate relationships. Conducting research that includes couple dynamics could provide information that may be used by mental health professionals and hospital employees to develop treatment. Research on the

topic of bariatric surgery and men’s perspectives is necessary and more research should be conducted that addresses the current gaps in the literature.

# CHAPTER THREE: RESEARCH METHODOLOGY

According to Denzin and Lincoln (2000), "qualitative researchers stress the socially constructed nature of reality, the intimate relationship between the researcher and what is studied, and the situational constraints that shape inquiry" (p. 10). This third chapter consists of an explanation regarding the proposed research methods, which includes a rationale for the use of phenomenology as a research method. It includes an explanation of the sampling, recruitment, design, and analytic strategies used, and concludes with a discussion regarding credibility, transferability, and reflexivity.

For this study, the incorporation of qualitative research (phenomenology) was the best method for answering the research questions related to men's self-concept and perceptions of relationship satisfaction, intimacy, and social support post-bariatric surgery. Consistent with phenomenology, the researcher was interested in exploring the lived experience of individuals who had bariatric surgery in order to learn more about the process of change and stability regarding the individual self and aspects of their intimate relationships. The researcher was interested in learning about challenges and barriers that may have occurred during the after surgery period, but also sought to learn about what was successful and helpful during this timeframe. A goal of this study was to provide an understanding of the phenomenon, which may prove to be useful for mental health professionals in general and marriage and family therapists specifically who may work with the bariatric population.

## Phenomenology as a Method

Phenomenology as a research method is used to explore the experiences and perspectives of bariatric clients. The literature on the topic of men who undergo bariatric surgery is limited and there is a substantial need to explore the phenomenon in greater detail. According to

Rossman and Rallis (2003), "those engaged in phenomenological research focus in depth on the meaning of a particular aspect of experience, assuming that through dialogue and reflection, the quintessential meaning will be revealed" (p. 97). Phenomenology as a research method has been widely utilized in the nursing field and has been incorporated in several studies regarding medical patients (Charalambous, Papodopoulos, & Beadsmoore, 2008; Donalek, 2004). Phenomenology has also been applied to the field of marriage and family therapy. There have been a number of marriage and family therapy researchers who have incorporated phenomenology into their studies. There have also been several book chapters on the topic of phenomenology and marriage and family therapy research (i.e., Sprenkle & Piercy, 2005). The use of phenomenology may inform intervention strategies related to the relational aspects associated with obesity and weight loss. Phenomenology is both a theoretical framework and a type of qualitative research methodology that is focused on looking at an individual or group's lived experience. However, for this dissertation, phenomenology was utilized as the research method. Phenomenology is based on the epistemological stance that knowledge is socially constructed and based on interpretation. Locke, Silverman, and Spirduso (2004) state the following:

> Phenomenology is a philosophic perspective that underlies all qualitative research traditions but, when used to examine the meaning of something (an event, role, process, status, or context) from the vantage point of someone (or some group) who actually experiences that phenomenon, both the study and the methodology are likely to be called phenomenological. (p. 153)

A phenomenologist researcher explores the qualities of an experience through interviews, stories, or observations with people who are having the experience (Connelly, 2010).

Phenomenology also complements symbolic interactionism and family systems theory by providing a mechanism by which the researcher can explore men's lived experiences. Phenomenology allows the researcher to analyze and examine how men experience the process of bariatric surgery. According to McLeod (2003), "the aim of a phenomenological investigation is to illuminate the totality of how some event or human action can be experienced or described" (p. 86). In addition, Dahl and Boss (2005) have identified the following assumptions associated with family therapy phenomenological research:

> (1) Knowledge is socially constructed and therefore inherently tentative and incomplete; (2) Because knowledge is socially constructed, objects, events, or situations can mean a variety of things to a variety of people in a family; (3) We can know through both art and science; (4) Common, everyday knowledge about family worlds is epistemologically important; (5) Language and meaning of everyday life are significant; (6) As researchers, we are not separate from the phenomena we study; and (7) Because of the desire for understanding this range of family experiences, the phenomenological approach assumes that everyday knowledge is shared and held by research participants alike (p. 65-67).

While there are a variety of ways that one could approach phenomenology (i.e., existential and transcendental phenomenology), the researcher specifically ascribes to hermeneutic phenomenology. Heidegger's (1927) hermeneutic phenomenology moves past simply obtaining a description of an experience. It focuses on meaning making and interpretation. The premise of Heidegger's hermeneutic phenomenology is that individuals are intrinsically connected to and make interpretations through their environment (Heidegger, 1927; 1962). Many researchers have utilized Heidegger's term "life world" to express the ideal that individuals' realities are invariably influenced by the world in which they live (Flood, 2010). The

"hermeneutic circle" is another term that has been used to denote one's interactions with the environment (Heidegger, 1935; Heidegger & Dahlstrom, 2005; Parsons, 2010). Utilizing a hermeneutic approach assisted the researcher with understanding the lived experience of men in the world after bariatric surgery. In like manner, symbolic interacitonism and family systems theories also have an emphasis on individuals' connections and experiences with their surroundings. Heidegger's hermeneutic phenomenology was specifically applied to the research by adding an emphasis on the interpretative aspects of experiences as they related to the construction of meaning.

**Research Questions**

The overarching research question for the project was: "How does the process of bariatric surgery influence men's perceptions of self-concept, intimate relationships, and social support?" The research questions for this study were: (1) How does the bariatric surgery process influence men's perceptions of self-concept; (2) How do men perceive dating and relationship satisfaction after weight loss surgery; (3) How do men perceive intimacy after bariatric surgery; (4) How do men perceive social support after their bariatric surgery; and (5) How do men perceive the role of a marriage and family therapist during the process of life after bariatric surgery? The interviewer (Darren Moore) asked questions under each general domain area (self-concept, relationship satisfaction, intimacy, social support) and also conducted probing of the participants' responses (*See Appendix G*, *Interview Protocol*). The sensitizing concepts which will be examined include: (a) self-concept, (b) intimacy, (c) satisfaction, and (d) social support.

**Sampling**

The researcher used a purposive sample of men who have undergone a type of bariatric surgical procedure which included but was not be limited to the lap band, roux-en-y gastric

bypass, duodenal switch, and gastroplasty. McCambridge, Mitcheson, Winstock, and Hunt (2005) suggested that “in purposive sampling, the sample is constructed according to predefined needs for data collection” (p. 1142). The men in the study were in at least one intimate or committed relationship at some point during the post-operative stage of surgery. The participants were required to have been in at least one intimate relationship post-surgery in order to demonstrate that they had a significant intimate partner as they experienced transitioning through the post-operative stage (i.e., postoperative diet, medical appointments, behavior modification, and weight-loss). Requiring the participant to have been in at least one intimate or committed relationship also assisted the researcher in learning about the experience of weight loss within the context of an intimate relationship. While there are a variety of definitions for the term *intimate relationship*, an intimate relationship was defined as a close relationship where one is afforded the opportunity to create strong emotional attachments and a sense of belonging, and is cared for within the context of a romantic or sexual relationship (Miller & Perlman, 2008). A *committed relationship* was defined as “a monogamous and supportive relationship” (Jimenez & Tatem, 2007, p. 11).

While an increasing number of young individuals are obtaining bariatric surgery, several researchers have suggested that the average individual is between 35 and 47 years of age (Cohen, Pinheiro, Correa, & Schiavon, 2006; Han, Kim, & Oh, 2005; Keshishian, Zahriya, Hartoonian, & Ayagian, 2004; Rosenthal, Szomstein, Kennedy, Soto, & Zundel, 2006). However, most of the former studies have included participants between the ages of 18 and 70. There have also been more recent studies that have included an adolescent population (Capella & Capella, 2003; Garcia, Langford, & Inge, 2003). Within qualitative research it is important to establish a homogenous sample (Patton, 2005). Therefore the participants in the study were at least 26 years

of age or older and had to have been at least 26 when they had the surgery. Therefore, an individual the age of 30 who had bariatric surgery when they were 24-years-old would be excluded from the study. The researcher selected the minimum age of 26 to specifically exclude adolescent populations and participants who would be considered emerging adults. Several researchers have suggested that emerging adulthood ends around the mid-twenties (Arnett, 2000; Schwartz, Cote, & Arnett, 2005). For the dissertation, the researcher used a sample of men between the ages of 26 and 65, as this is the age span where most individuals are undergoing surgery. The age range was also selected based on an analysis of Erickson's stages of developmental (Erickson, 1950). The related stages of the developmental life cycle include the young adult stage, middle-aged adult stage, and late adult stage. The age range of the participants were also selected using criteria from the Expanded Family Life Cycle (Carter & McGoldrick, 2009). The related family life cycle stages include the joining of families through marriage, families with young children, families with adolescents, families launching children and moving on, and families in later life.

The author specifically did not put a cut off age for participating, as a way to gain more access to research participants and to provide room for individuals who may have had surgery slightly after the reported average age range. Participants had to also be at least six months post-operative to participate in the study but could have been several years post bariatric surgery. The participants could consist of any race or ethnicity and there was not a specific religious or spiritual affiliation required. The participants also were required to reside in the United States. The participants consisted of individuals who are recruited from online sources as well as individuals who had been recruited off line primarily, within the state of Georgia and other states

where the primary researcher had access (i.e., bordering states accessible by car and states where the researcher has lived).

The researcher had two strategies for obtaining a sample, which were done online and offline to expand the possibilities of obtaining research participants. Online refers to the use of the internet to recruit participants. Online sources included but were not limited to the use of social network sites, online discussion groups, chat rooms, and online weight loss support programs. Offline refers to the use of traditional methods of recruitment such as distributing flyers in the community, specifically targeting places that could provide access to the desired sample. Traditional sources included connecting with local hospitals, therapy offices, weight loss support groups, weight loss centers, and other agencies.

Both online and offline recruitment strategies worked to incorporate the use of snowball sampling. Snowball sampling has been widely used when trying to recruit a difficult sample (Brown, 2005). Biernacki and Waldorf (1981) report that snowball sampling "yields a study sampling through referrals made among people who share or know of others who possess some characteristics that are of research interest" (p. 141). Each participant may have known of another person who might be interested in the study. Using snowball sampling was highly effective, especially when it came to recruiting men who have experience of weight loss through bariatric surgery. Men who have undergone surgery may have met other men through the process or may have connected with other men online. This enriched the study and assisted with finding additional participants. After applying to the Virginia Tech Institutional Review Board and obtaining approval, the researcher proceeded with the recruitment.

## Procedures

### Online Recruitment

Using online resources assisted the researcher with accessing a population that may otherwise have been difficult to connect with. Men who have undergone bariatric surgery have been marginalized within research and clinical practice and therefore may be difficult to find via traditional methods of recruitment. Due to the lack of resources within communities, there are not necessarily safe places where men can meet to discuss issues related to relationships, weight loss, and bariatric surgery. With the emergence of technological advances, some men and women have used the internet to discuss their experiences and perspectives of weight loss and social support.

Through the use of social network sites, blogging, and vlogging (video blogging), some men have been able to share their experiences with other men and the entire world. According to Gross and Acquisiti (2005), "in recent years online social networking has moved from a niche phenomenon to mass adoption" (p. 1). According to Acquisiti and Gross (2006) "at the most basic level, an online social network is an internet community where individuals interact, often through profiles that (re)present their public persona (and their networks of connections) to others" (p. 2). According to Ellison, Steinfield, and Lamp (2007), "these sites can be oriented towards work-related contexts (e.g., LinkedIn.com), romantic relationship initiation (the original goal of Friendster.com), connecting those with shared interests such as music or politics (e.g., MySpace.com), or the college student population (the original incarnation of Facebook.com)" (p. 1143). Men recruited from online sources may be more forthcoming and less inhibited when it comes to discussing their experiences in an open format. Some men may not feel comfortable

having a face-to-face, in-person interview with a researcher to discuss sensitive topics such as their sense of self, identity, weight loss, and intimate relationships.

The internet provides a number of benefits to the research participant. One major benefit in utilizing the internet is that the research participant will have the ability to remain anonymous. The participant may feel more comfortable communicating with someone who is far away from them. The participant may also feel more empowered through the use of the internet, because they will have the ability to control the flow of information. In addition, there have been a number of researchers who have recruited participants from social network sites and other online sources (Griffiths, 2010; Ramo, Hall, & Prochaska, 2010). The use of the internet to recruit has also been discussed in scholarly literature regarding ethics and informed consent (Keller & Lee, 2003; Madge, 2007). Varnhagen et al. (2005) specifically found that informed consent online is just as effective as an informed consent provided in person (p. 37).

The research investigator used two popular social networking websites to serve as the primary mechanism for recruitment. The researcher created a user account on YouTube (www.YouTube.com). YouTube is a social networking and video sharing website which was founded in 2005. YouTube was founded by Chad Hurley, Steve Chen, and Jawed Karim and is used as resource for individuals to post media material, videos, messages, and more. According to Lange (2008) “YouTube is a public video-sharing website where people can experience varying degrees of engagement with videos, ranging from casual viewing to sharing videos in order to maintain social relationships” (p. 361). YouTube is one of the most widely used social networking and video sharing websites in the world. Thousands of videos and information is uploaded onto the website each day. YouTube has also been widely discussed in scholarly literature (Benevenuto et al., 2008; Capra et al., 2008; Santos, Rocha, Rezende, & Loureiro,

2007). Individuals who have undergone bariatric surgery have used YouTube as s way to document some of their experiences. It is not uncommon for men and women to share videos of their weight loss journey, post before and after pictures, and connect with others for support.

The researcher created a channel on YouTube which possessed informational material about the dissertation study. The material consisted of a brief description of the study, including the purpose of the study, recruitment information, compensation, the researcher's contact information, and a copy of the informed consent form. The researcher also had the ability to send messages to targeted audiences. Interested participants had the ability to contact the researcher through the YouTube Channel. Interested participants were also provided with an email address and a contact telephone number to find out additional information or sign up to be a possible candidate.

As part of the YouTube Channel, the researcher also created a video which was accessible by the public. The video consisted of the same information about the dissertation study. The researcher had the ability to send the link of the recruitment video to individuals who may have been interested in learning more about the study. Individuals had the ability to subscribe to the YouTube channel if they desired, but it was not encouraged, required, or expected. Once the YouTube channel was activated, it started to show up when individuals searched for topics related to weight loss and bariatric surgery. The researcher was able to see how many individuals had viewed the YouTube channel. If the researcher did not get enough "traffic" on the YouTube channel, the researcher had the option to pay a nominal fee to have the channel promoted on YouTube through YouTube's advertisement channel launch program.

The second website that was used as a primary mechanism for recruitment was Facebook. Facebook is a social networking site that was created in 2004 by Mark Zuckerberg and three of

his college friends (Eduardo Saverin, Dustin Moskovitz, and Chris Hughes). Facebook has gained immense popularity and is used by individuals, businesses, institutions of higher education, and others. Facebook has also been discussed in scholarly literature (Dwyer, Hiltz, & Passerini, 2007; Hewitt & Forte, 2006; Zhao, Grasmuck, & Martin, 2008) and has been used as a research tool (Joisen, 2008). Facebook allows individuals and companies to create profiles with pictures, message boards, videos, and sound bites. It allows individuals to connect with others around the globe. Some individuals who have had bariatric surgery have embraced Facebook and used it as a way to document their experiences of weight loss, to meet others who have undergone bariatric surgery, and to gain social support by clients and non-clients. Some medical doctors also have Facebook pages and use it to connect with previous, current, or potential new patients (e.g., Johns Hopkins Center for Bariatric Surgery, http://www.Facebook.com/JohnsHopkinsBariatrics. Many institutions of higher education (including Virginia Tech) use Facebook as a way to connect with current and prospective students. In addition, a number of faculty members at Virginia Tech have personal or professional Facebook pages.

Facebook users have the ability to subscribe to and “Like” a person’s professional page. When a person subscribes or “Likes” a professional page, they have the ability to see any new updated information or “posts” to that page. The researcher created a professional page on Facebook and provided a description of the dissertation which included a brief description of the study (information about the purpose of the study, recruitment information, compensation, and the researcher’s contact information). The researcher also had the ability to send messages to targeted audiences. Interested individuals had the ability to contact the researcher by sending a personal message through Facebook. The Facebook page also displayed an alternative email and

contact telephone number for individuals who were interested in the study. The Facebook page also displayed the link to the YouTube page and video. Prospective candidates had the ability to subscribe to the researcher's Facebook page or send an individual personal message. Once the Facebook page was created, people, including faculty members who use Facebook, could subscribe. The researcher also made the professional page accessible to non-Facebook members. Once the Facebook page was activated, it started to show up when individuals searched for topics related to weight loss and bariatric surgery. The researcher also had the ability to advertise the professional page for a small fee through Facebook's advertisement program.

Prior to the dissertation project, as a member of the weight loss community, the researcher has frequented a number of websites that specifically were focused around the topic of weight loss or bariatric surgery. The researcher had also established some contacts with individuals of the online weight loss community. The researcher identified a number of internet websites that were focused around the topic of weight loss and bariatric surgery, (See Appendix A, Recruitment list.) The internet websites serve as a gathering space for individuals to discuss weight loss. Two of the websites that the researcher had most frequented include ObesityHelp (www.Obesityhelp.com) and LapBandtalk (www.lapbandtalk.com). ObesityHelp and Lapbandtalk are two popular websites that have forums where individuals who are interested in weight loss can interact, discuss experiences, and connect with others. Both of the websites have specific forums for men to discuss their own experiences, report successes, and failures. The researcher specifically posted information regarding the research project and provided contact information as well as a link to the Facebook or YouTube recruitment pages. Individual members had the opportunity to connect with the researcher by becoming a "friend" or subscribing to the researcher's page as well.

**Offline Recruitment**

The researcher recruited offline from the state of Georgia. I specifically targeted Atlanta, Georgia, the metropolitan area, but also included other cities outside of Atlanta to include Columbus, Albany, and Valdosta, among others. Atlanta, Georgia is the capitol and largest city in Georgia. The city has a substantial population, including a significant number of African American residents and other minorities, contributing to the possibility of incorporating a diverse sample of clients. With obesity being prevalent among minority populations, the researcher made an effort to include racial diversity within the sample. According to recent statistics, the estimated population for Atlanta, Georgia was 420,003 and 53% or 224,316 were African American (Census Bureau, 2010). The population for the Atlanta metro area which includes the city of Atlanta and surrounding counties (i.e., Fulton, DeKalb, Gwinnett, Cobb, and Clayton counties) was estimated at over 5 million.

The state of Georgia has consistently been among the top states for high rates of obesity. In 2009, the state of Georgia had an obesity rate of 27 % as reported by the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System (BRFSS) (CDC, 2009). The researcher lived in the state of Georgia for three years prior to starting his doctorate and moved back to Georgia for his internship. Therefore, the researcher already had some interaction with the weight loss community and was be able to travel to meet participants.

The researcher contacted local agencies and business owners who provide services to individuals who were a part of the weight loss community (See Appendix B, Recruitment Letter). The researcher contacted staff at local hospitals to ask permission to post a flyer about the research study (including but not limited to Gwinnet Medical Center, Atlanta Medical Center, DeKalb Medical Center, Emory Medical Center, and Grady Memorial Hospital) (See

Appendix C, Recruitment Flyer). At the medical hospitals, the researcher specifically targeted nutrition programs, bariatric centers, and obesity clinics. The researcher provided a written one-page synopsis of the research project to solicit support. The researcher created and delivered flyers announcing the study to be posted in public areas (in and surrounding) the medical hospitals, health centers, and medical programs. The flyers contained brief information about the study, including the purpose of the study, recruitment information, compensation, and the researcher's contact information. Interested participants had the ability to contact the researcher via email and cell phone to sign up to be a possible candidate. Flyers were also posted in bordering states or states where the researcher had existing ties.

**Eligibility**

The researcher created a list of possible research participants. I then contacted each interested candidate for a telephone pre-screening and eligibility assessment. The researcher started out by facilitating a short overview of the research study, specifically highlighting the selection criteria. Participants had to meet the following eligibility/inclusion criteria: (a) they had to identify as a heterosexual man; (b) they had weight loss surgery within the last 5 years; (c) they were 26 years old at the time of surgical intervention; (d) they was at least six months post-surgery at time of study; (e) they had been in at least one intimate or committed relationship after surgery; and (f) they had to be US residents (See Appendix E, Eligibility Form).

If the prospective applicant met the criteria, then the phone pre-screening continued. During the telephone screening, potential candidates were provided with additional information about the study and were able to have any questions answered. If research candidates were selected to participate in the study, they were scheduled for an in-person interview in their homes (or other private location requested by the participant) or scheduled for an online interview (if

they resided out of Georgia or other accessible state and/or were not able to complete an in-person interview for other reasons). Participants were informed that they would be receiving a $50 money order after completing the interview. The amount of $50 was approved by the Virginia Institutional Review Board. Participants were also informed that they could participate in an optional telephone follow up, email, online chat, or video chat, for member checking purposes. The participants were informed that they would receive a copy of their interview transcript, have the opportunity to provide clarification, and propose any needed changes if so desired, and that they would not receive compensation for any follow up correspondences. The first 15-20 individuals who fully met the criteria were included in the study.

**Research Design**

For the research design, the researcher first started with a pilot study and interviewed three individuals who had undergone bariatric surgery. A pilot study is a good way to practice interviewing skills (Thabane et al., 2010), receive feedback from participants on interview length, and determine if adjustments were needed in the interview protocol. Participants for the pilot study were solicited using the same online and offline recruitment strategies and eligibility criteria for the main study. They were compensated with $50. The first two interviews were not audiotaped and focused on testing the research questions for credibility and the extent of interview duration. The third interview focused on content and was transcribed and reviewed with the dissertation chair prior to moving on with the study.

For the dissertation study, participants were scheduled for a 60-90 minute, semi-structured interview. The researcher aimed to conduct between 15-20 interviews with the overall focus on obtaining saturation. According to Dahl and Boss (2005), “the phenomenological approach lends itself to small-N studies, in that it requires in-depth description of the experiences

of each participant," (p. 71). However, Gehart, Ratcliff, and Lyle (2001) suggested that "researchers cannot predetermine the number of cases that are needed to reach saturation based on statistics, and instead must assess the requisite number throughout the analysis process" (p. 264). In addition, Marshall (1996) suggested that "the size of the sample is determined by the optimum number necessary to enable valid inferences to be made about the population" (p. 522). Therefore, the researcher would continue to interview participants if saturation is not obtained by 20 interviews.

According to Dahl and Boss (2005), "phenomenologists believe that the phenomenon of interest, regardless of what it is, should be studied where it naturally exists and from the actor's own perspective" (p. 64). Therefore, it was decided that the interviews would take place in the participant's home, a mutually agreed upon location requested by the participant, or online via Skype. Skype is a computer program that allows individuals the capability to have voice and video interaction over the internet. Skype is a free service and can be downloaded at www.Skype.com (See Appendix F, Instructions for Skype). If in-person interviews were not able to be conducted due to location constraints, Skype was the next viable option.

**Conducting Online Research**

Utilizing the internet for research purposes has increasingly been a topic of discussion in contemporary scholarly literature (Suarez-Balcazar, Balcazar & Taylor-Ritzler, 2009). Scholars have engaged in discussions about the positive and negative aspects of utilizing the internet for the purpose of research. Most of the discussion has been around the topic of confidentiality, informed consent, and the ability to verify the participants (Kaslow, Patterson & Gottlieb, 2011). In addition, most of the issues related to the use of the internet in research have been regarding quantitative research methods (i.e., online surveys) as opposed to qualitative research (James, &

Busher, 2007). The largest benefit of using the internet for research purposes was related to access of potential research participants. Using online resources can be helpful in terms of reaching individuals who are may not be accessible via traditional routes. Utilizing the internet provides a potential researcher with access to millions of possible respondents from all around the world. Another benefit of utilizing online research methodology is that the participant can remain anonymous even to the researcher. Therefore if the research topic is of a sensitive nature, in theory an individual would be able to answer questions without fear of someone finding out their identity. Other benefits of online research are related to logistics. Using online research methods ultimately has saved researchers travel time and money required for travel.

There are several challenges to using the internet for research purposes. While anonymity may be important to participants, it can become problematic for researchers. If a researcher posts a survey geared at a certain population, they have no way of verifying that the respondent actually meets the eligibility criteria for the study. Researchers have no way of guaranteeing the age of a respondent, sex, race and ethnicity, or any other variable of the participant, which could cause an individual to question the validity of the research. For example, some quantitative online surveys include self-report measures. Utilizing self-report measures via the internet may produce results that are unable to be verified. A participant may misrepresent themselves purposely or by accident because they did not understand the study and had no way of asking the researcher for assistance. Zhang (1999) conducted a literature review regarding internet research and noted a number of issues with online survey research to include biased samples, issues with access to computers, and problems with multiple responses from the same participant.

Another limitation of online research and also a possible IRB issue has to do with confidentiality. Information that is disseminated over the internet could be the jeopardized.

Keller and Lee (2003) suggested that there is no way to protect one's self from internet hackers. Moreover, Keller and Lee reported that anyone with a court order could potentially find out the identity of research participants. One of the issues with online research has to do with the topic of informed consent. With in-person interviews, participants have the opportunity to ask questions and get clarification regarding subject material. However, with most online strategies, there is no way for participants to ask questions (Varnhagen et al., 2005). Therefore, some individuals question the ability of individuals to truly provide informed consent with online research. Madge (2007) suggested that "gaining informed consent online can be more problematic than for onsite research because it is potentially easier for participants to deceive the researcher, particularly regarding their age" (p. 658).

While there are risks associated with utilizing the internet for research purposes, the internet is continuing to serve as a mechanism for researchers to connect with individuals around the globe. There have been a number of researchers who have incorporated online tools to assist with conducting research. Several researchers have utilized the internet to recruit participants for their studies (e.g., Kimmel & Mahalik, 2005; Rezabek, 2000). There have been some researchers who have suggested that internet research is equivalent to non-internet strategies in terms of reliability and validity. Buchanan and Smith (1999) conducted psychological research and compared the validity of using an online psychometric questionnaire with a paper-based one. The researchers utilized confirmatory factor analysis and reported that the internet-mediated questionnaire had similar psychometric properties and compared favorably as a psychological measure. Similarly, Underhill and Olmsted (2003) conducted a study comparing the results of an online focus group with an in-person focus group and found that online focus groups provided

similar results to in-person groups in terms of quantity and quality of information disclosed. Other researchers have found similar results (Stanton, 1998).

For this dissertation study, the investigator did not anticipate encountering some of the methodological challenges associated with traditional online research. The researcher utilized online mechanisms for recruitment purposes in addition to the use of Skype. Therefore, issues related to participants completing multiple surveys or participants completing surveys who do not meet eligibility criteria was not an issue. The researcher recruited both online using the internet and offline which also addressed issues related to lack of access to computers and conducting the interviews using Skype. One of the benefits of Skype is that researchers have the ability to visibly see research participants (Nicholas & Rowlands, 2011). The researcher also was able be to see non-verbal communication which is something that is not available with phone interviews or online surveys. In addition, Skyping also allows users to type text if needed and desired.

There are a number of researchers who have conducted qualitative interviews using programs and tools similar to the Skype program. Kazmer and Xie (2008) discussed the use of computer-mediated interviews in qualitative research and specifically reviewed the use of email and instant messaging technologies. Within this study these scholars compared their experiences of using the following forms of interviewing (face-to-face, telephone, email, and instant messaging). They suggested that, "all four methods of data collection produced viable data for the projects they completed, but that some additional issues arose" (p. 257). They also found five major themes in the research: "(1) interview scheduling and participant retention; (2) recording and transcribing; (3) data cleaning and organizing; (4) presentation and representation of data; and (5) the detection/presentation of affective data" (p. 257). Overall they found that while these

different methods can be helpful in data collection, there are issues that come up in all of them. They also state that researchers need to "be mindful that all media are susceptible to equipment or to technology failure" (p. 273). They found that the researcher has to decide whether they want to let their participants decide the medium used in the research.

Sedgwick and Spiers (2009) conducted a study using video-conferencing technology. Within this study, researchers found that the best medium for conducting qualitative interviews via video-conferencing was to use high-bandwidth connection, "such as SuperNet or Web conferencing" with a call speed of 1,024 kbps or more (p. 1). Similarly, authors suggested that since qualitative research relies heavily on transcriptions, it would be a good idea to play around with different types of recording equipment. Authors also suggested that it is important to take into the account the individual needs of the participants when setting up videoconferencing. O'Connor and Madge (2003) wrote an article that discussed the use of "hotline Connect" as an online conferencing program within qualitative research. Within this study, the researchers found that the use of conferencing software can be very helpful for "synchronous online interviewing" (p. 133). Authors also suggested that the conferencing must be combined with "sensitive, ethical handling of both the research process and the data to overcome problems inherent in any interviewing situation" (p. 133). In addition, Sweet (2001) discussed the development of online qualitative focus groups and reports that there are added benefits such as the ability to moderate online, the instant accessibility of transcripts, the ability for participants to be engaged from any location, and the ability for participants to engage according to their own time (in the case of asynchronous groups).

**Analytic Strategy**

After the interviews were conducted, the data was transcribed. The researcher transcribed some of the interviews and also contracted out for assistance with transcription. Once the first interview was transcribed, the researcher conducted a line-by-line text analysis and developed preliminary codes which were informed by sensitizing concepts. The researcher also provided the dissertation chair with a copy of the transcript and an outline of the preliminary themes that were discovered. The dissertation chair reviewed and collaborated with the researcher regarding the interpretation of the written text and the development of the initial coding scheme. After the dissertation chair and researcher discussed the results of the first interview, the researcher began coding the remaining interviews, which involved reading the interviews several times, making initial codes, and re-working codes simultaneously. The researcher specifically became immersed in the data by reading the interviews multiple times and making notes in the margins. Dahl and Boss (2005) suggested that analyzing phenomenological data includes immersion, incubation, and reflection, as well as creative synthesis.

The researcher reflected upon the content and focused on the data which provided a rich description of men's experiences and perspectives. The analysis process involved breaking each interview apart and searching for words, thoughts, and experiences. The author assigned codes to bodies of text within the interviews and developed themes out of the codes which were utilized to show patterns in the research. According to Miles and Huberman (1994), "codes are tags or labels for assigning units of meaning to the descriptive or inferential information compiled during a study" (p. 56). The researcher then attempted to interpret and construct meaning from the data. Starks and Trinidad (2007) refer to this process as de-contextualization and suggest that

"during de-contextualization the analyst separates data from the original context of individual cases and assigns codes to units of meaning in the text" (p. 1375).

The analysis process also involved comparing and contrasting the data from the multiple interviews. The researcher specifically compared the codes and categories that emerged in all of the interviews and searched for commonalities to assist with developing the overarching themes. The investigator focused on the language that participants used to describe their experiences and perspectives of life after bariatric surgery. The author made sure to note any non-verbal communication during the interview process as well as to assist with interpretation of the verbal communication. According to Starks and Trinidad (2007), "in re-contextualization he or she [the researcher] examines the codes for patterns and then reintegrates, organizes, and reduces the data around central themes and relationships drawn across all the cases and narratives" (p. 1375).

Negative cases were also analyzed and included into the research findings. It is important to include negative cases into the research findings. Klein and Myers (1999) stated that interpretative research has the ability to assist researchers in better understanding the way in which humans think and act in social settings. Omitting negative cases may in fact take away from gaining a full understanding of how individuals experience a certain phenomenon. For example, in quantitative research there is a tendency to omit outliers, as they may skew statistical analysis and limit the ability to generalize. Within qualitative research similar manipulation can occur through omitting negative cases (Spiggle, 1994). Kaplan and Maxwell (2005) suggests that while there is pressure to ignore data that cannot be easily explained or does not fit, it is important to analyze negative cases for validity. Kaplan and Maxwell further state, "In particularly difficult cases, the only solution may be to report the discrepant evidence and allow readers to draw their own conclusions" (p. 46). According to Baxter and Eyles (1997) omitting

negative cases takes away from credibility and rigor of qualitative research. In addition, negative cases may serve as a resource for future research studies and investigation.

The researcher utilized Microsoft Word to assist with highlighting text, organizing information, and developing overarching categories. The researcher solicited the assistance of a contracted transcriptionist and one qualitative research consultant. The qualitative research team consisted of the research investigator (Darren Moore), the dissertation chair (Dr. April Few-Demo,) and one research consultant (Danielle Sukenik). Danielle Sukenik is an advanced level masters student in Marriage and Family Therapy at Valdosta State University. She has experience with qualitative research and has coding experience. Both the researcher and consultant read over the interviews and coded the data independently (i.e., Parkman, 2009). The researcher met with the consultant to discuss initial findings and results were compared and contrasted prior to developing categories. The codes were placed inside one or more of the multiple categories depending on the nature of the category. The codes, categories, and themes are presented in the results section and the results are expanded in the discussion section.

**Credibility and transferability.** Credibility and transferability are two concepts that are used to demonstrate rigor in qualitative research (Guba & Lincoln, 1994). Credibility refers to the ability of the researcher to capture the true and authentic experiences of the research participants (Baxter & Eyles, 1997). Credibility also refers to the confidence in how well data and the research methodology addresses the intended focus of the study. Credibility is woven into the process of qualitative research at the early stage of development. Graneheim and Lundman (2003) suggests that “the first question concerning credibility arises when making a decision about the focus of the study, selection of context, participants and approach to gathering data” (p. 109). As part of the research process, the primary investigator utilized the current

literature and theory to guide the study. The researcher developed the specific questions for the interview that have emerged out of the literature to demonstrate a rationale for the study.

The researcher addressed credibility through the incorporation of triangulation (Denzin, 1970). Triangulation refers to the utilization of several methods at once used to decrease or obliterate the bias inherent in individual methods (Seale, 1999). The researcher utilized several strategies to triangulate the data. He interacted closely with the dissertation chair through the entire process and solicited the assistance of a qualitative research consultant to assist with coding for validation purposes (Parkman, 2009). The research consultant was disinterested as related to the study and assisted with verifying the initial coding scheme that was developed by the primary investigator. The research consultant also assisted the primary investigator with changing the coding scheme and peer debriefing (Lincoln & Guba, 1985). The primary investigator also incorporated member checks in the research process to allow participants the opportunity to provide feedback and further clarification regarding the interview (Guba & Lincoln, 1989). Participants had access to a copy of the interview transcript and initial research findings if so desired, and could propose changes to the research document. The researcher also triangulated the data by including negative cases in the analysis and findings of the study. Including negative cases in the analysis provides some assistance with examining alternative perspectives of the phenomenon and improves the overall quality of explanations within qualitative research (Mays & Pope, 2000).

The author also made sure to incorporate transferability within the research study. Transferability refers to the ability of the researcher to "generate theories which will provide descriptive data of a phenomenon which can be used to guide wider- and larger-scale studies from an informed starting point" (Jasper, 1994, p. 313). To promote transferability the researcher

made sure to become fully integrated into the data. The primary investigator made sure to obtain a rich description of the research phenomenon to demonstrate transferability. The researcher also used the codes and themes developed to make inferences regarding possible transference. The researcher also looked at ways to connect the study to theory to increase transferability. Thus, the discussion section includes research and clinical implications for researchers, clinicians, and other professionals who work with issues related to obesity, weight loss, couples, and clients who are men.

**Researcher stance.** As a qualitative researcher, it is important for me to acknowledge my epistemology and my positionality as it relates to my dissertation topic. Exploring researcher stance provides a way for the researcher to demonstrate their commitment to rigorous research. The investigator acknowledged that he was the research instrument. Therefore, the researcher completed reflexivity assignments throughout the research process to promote and maintain credibility and dependability. Reflexivity is one of the criteria used for critiquing and judging the usefulness of a research study (Richardson & St. Pierre, 2005). This included completing a reflexivity assignment prior to starting data collection. Creswell and Miller (2000) suggested that, "this [reflexivity] is the process whereby researchers report on personal beliefs, values, and biases that may shape their inquiry" (p. 127). The reflexivity included documenting the researcher's thoughts, beliefs, assumptions, epistemology, and positionality in relation to the research question and phenomenon. In addition to the reflexivity assignment that was completed prior to collecting data, the researcher was involved in writing memos throughout the research process to increase credibility. The researcher made use of bracketing (Fischer, 2009) during the in-home interviews. I also made sure to use the participants' language when writing up their

responses to questions. The researcher also proved credibility and confirmability by maintaining strict records and the use of an audit trail (Golafshani, 2003; Lincoln & Guba, 1985).

**Experiences with obesity and weight loss.** As a 28-year-old African American doctoral candidate at Virginia Tech, I have had a number of experiences related to obesity. First and foremost, I am six feet-one and when I first started working on my dissertation, I met the body mass index criteria for obesity. I have struggled with weight for a long time, but my significant weight gain started after high school. During my first year of college, I gained a significant amount of weight. I gained more than the "freshmen 15" that many students talk about. There were a lot of things going on in my personal life and I think I used food as a way to cope. I probably gained close to 100 pounds and went from a 38-inch to a 44-inch waist. By the end of my senior year of college, I was six feet tall and 345 pounds and in the morbid obese category. During my senior year of college, I was diagnosed with obstructive sleep apnea. I considered having bariatric surgery and actually went through most of the steps required to obtain bariatric surgery. I met with a dietician, had a psychological evaluation, and met with a surgeon. However, my medical insurance at the time would not cover the full amount of the procedure. My medical insurance only was going to cover $10,000 leaving me with having to subsidize close to $15,000 (which I did not have).

During graduate school, I made several attempts to lose weight that were unsuccessful. I also considered taking out a school loan to pay for bariatric surgery. At this time, many surgeons were offering discounted rates for individuals who had to self-pay due to lack of medical insurance. I went to a consultation at the Wish Center located in San Antonio, Texas who was offering the surgery for $12,500. After visiting the weight loss program, I decided not to follow through with the program, because I did not feel comfortable having surgery in a state in which I

did not reside. During this time, I became a member of some online weight loss support groups. I also met some individuals who actually flew to Mexico to have weight loss surgery due to it being at a substantially discounted price. At this time, I found out that "medical tourism" was very popular and that many people have gone to Mexico to have weight loss surgery for less than 10,000 dollars (Cohen, 2010; Hopkins, Labonté, Runnels, & Packer, 2010; Johnston, Crooks, Snyder, & Kingsbury, 2010; Snyder, Dharamsi, & Crooks, 2011). However, I was not willing to risk my life or safety in order to have weight loss surgery by non-American board approved physicians. During my masters' program is also the time when I met my fiancé. During our relationship we have had several long discussions about weight, body image, health, and weight loss. During my time at Virginia Tech, I gained about 25 pounds and reached my highest weight of 375 pounds. Although my weight was never an issue for my fiancé, it was still something that I struggled with personally that I believed impacted my relationship.

After leaving Virginia Tech to start my internship, I decided that it was time for me to lose weight and get healthy. Between September 2010 and July 2011, I lost a total of 180 pounds strictly through diet, exercise, and adherence to my newly found personal philosophy on life which I have self-titled "Less is Moore" (Polling, 2011a; Polling, 2011b). As of July 2011, I currently weigh 190 pounds and I have dropped nine pants and seven shirt sizes. Through this process, I have made several changes which include changing what I consume, how much I consume, and my level of exercise, among others. While I have made significant changes and have lost some weight, my fiancé, who currently meets the BMI criteria for obesity, has struggled somewhat as it relates to weight loss. I have noticed that my weight loss has influenced my relationship in both positive and not-so-positive ways.

As an African American in my specific family system, obesity was not something that was discussed frequently. There are a number of overweight individuals in my family. Within my family and community I was not socialized to be health conscious or to be concerned about what I eat. Body size in my culture was a something that was not discussed within my family system. African Americans in my kinship network were not very concerned about BMI, calories, or fat consumption. Within my family, body size did not necessarily equate to being viewed as unhealthy. Similarly, body size also did not determine an individuals' physical attractiveness or beauty. In many cases, larger African American men and women were considered as equally desirable as smaller framed men and women. Within my community food was and still is used to celebrate life. In my immediate and extended family, food was something that bonded individuals together. Food was at the center of all major events (e.g., birthdays, holiday gatherings, weddings, funerals). In my family and community, weight gain was not something to be feared or concerned about. As an African American, I am also aware that obesity disproportionately affects the African American community.

Being a man and having some experiences with weight issues and obesity could have positively impacted my relationships with research participants. Having some experiences with obesity and weight issues could have made me more sensitive to research participants. Participants may have felt more comfortable with interacting with a researcher who may have some similar life experiences. However, having some experiences related to obesity and weight loss could have impacted my ability to be objective; it could have made it difficult for me to separate my own experiences from the experiences of the research participants, and could have contributed to me making assumptions about the participants.

While I have had some experience related to obesity and weight loss, I have never undergone bariatric. Not having experience with bariatric surgery allowed me to remain curious, open minded, and willing to learn during the research process. Being a man may have allowed me to connect with research participants in a unique way that perhaps would be different if I had been a woman. Being a man could have possibly impacted how participants responded to the interview questions. For example, there have been researchers who have suggested that the gender of the researcher can impact or influence the responses given by participants (Herod, 1993).

My race and ethnicity could have impacted my research. Research participants who have minority status may have felt more comfortable with a researcher who has knowledge of their specific culture's perspectives about obesity and weight loss. I may have been able to identify with African American participants in a unique and more meaningful way by virtue of having "insider status" (Nelson, 1996). There have been a number of researchers who have examined the topic of insider status within qualitative research. Most notably, Few, Stephens, and Rouse-Arnett (2003) wrote an article about African American women's experiences of being a researcher with participants (informants) who also are African American women. These researchers found that it was important for researchers to engage in reflexive work and to share commonalities with their participants to facilitate the joining process and establish trust. Therefore, I believe that as a researcher I may have revealed some aspects of my experience related to the phenomenon. Few et al. (2003) suggested that "Black women researchers who reveal little information about themselves run the risks of being mistrusted by Black women informants" (p. 5). Not revealing aspects of my experience as an African American obese man could contribute to lack of trust with the participants. However, at the same time my race and

ethnicity could pose as a barrier, specifically because it could lead to dominate assumptions about cultural group norms. My race and ethnicity shapes my perspective of obesity, and it could impact my ability to understand other's experiences who may not share the same cultural group.

# CHAPTER FOUR: RESULTS

## Pilot Study

The researcher conducted a pilot study which consisted of interviewing three individuals who met the description of the dissertation study. The researcher interviewed the first two individuals to test out research questions, assess the length of the interview, and troubleshoot any issues with the Skype video conferencing program. A description of the three participants in the pilot study follows as well as a discussion of the results and themes as they relate to self-concept, relationships, intimacy, and social support. In addition, the researcher discussed feedback provided by individuals who participated in the pilot study.

### Demographics of Pilot Study

The pilot study consisted of three individuals who were interviewed online using Skype. Two of the men who participated were recruited from Facebook, while the remaining individual was recruited from lapbandtalk.com. There was limited variation of the participants in terms of race, with all participants self-identifying as Caucasian. The participants covered a range of geographic locations, with one participant residing in the Midwest, one participant in the mid-Atlantic region, and one in a Southern state. The average age of the participants in the pilot study was 45 years. Two participants reported that they identified as Christian, while the third reported being “non-religious.” Education levels varied among individuals, from having completed high school, an associate degree program, or a masters degree program. The average annual income of the participants was $45,000. Only one participant reported having children (i.e., two children). Two reported having the lap-band surgical procedures and one had the gastric bypass. One participant was single, while the two others reported being either married for 13 years or was recently divorced. The average height for participants was six feet. The average pre-operative

weight was 358 pounds. The average post-operative weight at the time of the study was 272 pounds, with the average total weight loss being 85 pounds. Participants had an average of being nine months post-surgery at the time of the interview.

**Results and Themes of Pilot Study.**

***Motivations for surgery.*** Participants discussed motivating factors that contributed to them having surgery. They reported that health was the primary motivating factor. Although participants discussed making the decision to have surgery as an individual process, two acknowledged the role their families played in their decision making processes. Employment was another motivating factor for weight-loss surgery. One participant reported feeling that he would have more employment opportunities and faster career advancement if he lost weight. For another participant, the possibility of attracting a desirable intimate partner and experiencing a love relationship served as a motivator.

***Self-concept***. One particularly poignant theme was the belief that real masculinity was inextricably tied to one's ability to control oneself, specifically, one's weight. To lose weight by artificial means, such as weight loss surgery, was to embody weakness. One participant reported that having weight loss surgery meant that "you [were] powerless and less of a man." Participants discussed having a negative outlook on their lives and reported that the extra weight was a source of depression, loneliness, and a "jail". However, participants reported that after surgery, they felt more confident in themselves. The men talked about having a higher self-esteem, receiving more attention from others, and feeling happy about the amount of attention they received. Although all reported positive feelings about their post-surgical bodies, at least two men expressed concerns regarding excess hanging skin.

***Relationship Satisfaction.*** The men discussed the perceived impact of weight loss surgery on their intimate relationships. One participant reported that he was no longer willing to

"settle" for people after having surgery. This participant reported that he would end a relationship if it was not working, whereas, prior to surgery he would have stayed in a relationship. One participant reported that he has ended a couple of relationships post-surgery due to being incompatible. In addition, one participant reported that although he thought having surgery would enhance his relationship, that surgery did not improve his relationship at all. In fact, marital problems escalated after surgery.

***Intimacy***. Participants reported having increased interests in exploring sexual intimacy after surgery. Participants reported "having a higher level of testosterone" post-surgery. One participant reported having increased erections during the day and having more of a desire to be sexually active. The men reported feeling more attractive and positive about their looks after surgery, which they perceived impacted their interactions with the opposite sex. The divorced participant reported that he felt tempted to cheat on what was then his ex-wife after surgery, but refrained to do so. The same individual reported that his divorce was caused by his wife cheating on him. He then reported having one-night stands with random people from time to time.

***Social Support***. Participants discussed ways in which they received social support during their post-surgical experience. Support was provided from spouses, friends, and children through words of encouragement, assistance with adhering to their post-surgery diet, and verbal praise. Spouses also particularly assisted with providing medical and personal care. Participants also reported using online mechanisms to gain social support and discussed their experiences of using online weight loss forums to include Facebook, YouTube, among others. Participants reported instances where they did not received support from others. They discussed their lack of support which they reported mainly consisted of negative feedback from peers, spouses, and extended family members regarding having surgery.

***Therapy*.** Participants discussed their level of involvement with a therapist or other mental health professional during the weight loss surgery process. One participant reported meeting with a therapist to be cleared for surgery. Another participant reported that he saw a therapist prior to surgery to explore reasons behind his obesity and weight gain. The third participant wanted to see a therapist but could not afford such services. One man revealed that he was offended by his therapist not having large chairs for obese individuals. While two participants reported not working with a mental professional outside of getting an assessment, they discussed ways in which they felt they could have worked with a therapist. One participant specifically reported that working with a therapist prior to surgery could be beneficial and could assist with preparing men for behavioral and lifestyle changes. For example, Bob reported that he felt a therapist could work with men to prepare them for the anger that will exist after surgery. He mentioned that he felt angry after surgery as he was not able to continue to eat "regular" food. Bob also mentioned that he felt therapists could help clients get over the stigma of what it means to have weight loss surgery for men. For example, Bob stated:

> One of the biggest hurdles for me when it came to bariatric surgery was almost giving in to the idea that you are not man enough to do it on your own. If you can't admit that, then you'll never do it because you feel like it is an easy "non- man" way out. So I think getting men to be able to say it, and admit they can't use will power to do it, is important.

## Feedback From Participants and Researcher Reflections

Participants reported that the interview really made them think about the process of having surgery. Only one individual suggested shortening the interview. They agreed that flexibility was necessary to capture the experiences of post-surgical relationship diversity and men who were considering getting into a future relationship. They wanted to read the finished

dissertation as they were curious about how other participants would answer the research questions. The interviews averaged around 75 minutes each. After conducting the first interview, I decided to add two sub-questions regarding marriage and family therapy to specifically include an applied practice element to the research: (1) “What do you think is important for marriage and family therapists to know about life after bariatric surgery for men?” and (2) “If I was going to teach a class to marriage and family therapists about how to best serve male bariatric clients, what would you suggest be discussed in the class?”

The researcher met with the dissertation chair to discuss possible ways to improve the research process and interview protocol. One of the things discussed during the meeting was ways to draw out additional information through the use of probes with participants. Dr. Few-Demo asked a number of questions regarding participants’ responses and we discussed areas where the researcher could have used more probing to gain additional understanding and clarity. In terms of social support, we discussed the need to gain more in-depth information regarding who was supportive and the types of support that participants received. We also discussed the use of a demographic form and a bio-sketch form to assist with the interview process.

## The Dissertation Study

### Sample

Twenty men were recruited and participated in 60-90 minute semi-structured interviews. While the researcher recruited using both online and offline methods, 14 of the participants came from online sources with the remaining six coming from offline sources. Of the fourteen participants originally recruited online, five men were recruited from Facebook, three men were recruited from YouTube, three men were recruited from Obesityhelp.com, and three men were recruited from lapbandtalk.com. Of the six participants recruited offline, five individuals were

recruited from hospitals in Georgia and one participant was recruited from a hospital in Texas. Seventeen interviews were conducted via Skype with the remaining three interviews were conducted in person.

Within the study there was minimal variation in terms of race and ethnicity. Sixteen participants self-identified as Caucasian, two identified as Hispanic, and two identified as being biracial (Mexican and Caucasian; Caucasian and Native American). There was variation in terms of geography, religion, education level, income, number of children, length of being in a relationship, age, profession, type of weight loss procedure, total weight loss, and length of time out from surgery at the time of the interview. In the interview participants resided in a number of states in the Midwest, Northeast, Southern, and Western regions of the United States. Participants reported a number of religious affiliations; seven were Christian (non-denomination), one Lutheran, two Catholic, two Baptist, two Methodist, one Protestant, two Jewish (non-observant), and three with no religious affiliation. In terms of education level, nine individuals reported that their highest level of education was high school, six individuals reported having some college education but not a degree, and five individuals reported having a bachelors' degree. For income, there was a wide range. Some participants reported having zero income (unemployed) with the highest income being $115,000. The average income of the participants of those who were drawing an active salary was $43,225.

Participants varied in terms of number of children with the average number of children being two. While all individuals discussed being in a significant relationship at some point in time during the surgery process, 16 men reported being married while 4 participants identified as not being married. There was also variation in terms of length of being in a relationship for the married participants. The range for length of marriage was three years to 36 years (M=14). The

range of age of participants was 29-64 (M=44)**.** Participants had a variety of occupations and obtained a number of weight loss surgery procedures, with 17 obtaining the gastric bypass and three obtaining the lap band. The average height of participants was 5'8" and the average pre-operative weight was 363.03 pounds (M=238). The range for total weight loss was 67-190 pounds (M=122.5). The length of time post-surgery at the time of the study ranged from six months to 31 months (M=13.3 months). Each participant selected their own pseudonym that they wanted to use to protect their identity. **(See Table 2 for a list of Sample Demographics).**

**Table 2**

**Sample Demographics**

| Pseudonym | Age | Race/Ethnicity | Religion | Relationship Status and Duration | Income | Number of Children | Regions | Months post-Operative at Interview | Procedure | Total Weight Loss |
|---|---|---|---|---|---|---|---|---|---|---|
| Magician | 55 | Caucasian | Christian | Separated 1 yr | $0 | 3 | SW | 24 months | GB | 112 lbs |
| Lucas | 48 | Caucasian | Catholics | Married 25 yrs | $65,000 | 2 | W | 31 months | GB | 92 lbs |
| Al Cargo | 59 | Caucasian | None | Married 36 yrs | $35,000 | 2 | NE | 17 months | GB | 180 lbs |
| Tom | 34 | Caucasian | Christian | Married 7 yrs | $20,000 | 2 | MW | 8 months | GB | 179 lbs |
| ChampLV4 | 36 | Caucasian | None | Married 3 yrs | $60,000 | 0 | MW | 6 months | GB | 177 lbs |
| Gratz | 31 | Caucasian | Christian | Married 4 yrs | $25,000 | 0 | SW | 27 months | GB | 190 lbs |
| Bubba | 49 | Caucasian | Baptist | Married 7 yrs | $24,000 | 0 | MW | 13 months | GB | 140 lbs |
| Jbird | 51 | Caucasian | Baptist | Married 32 yrs | $0 | 4 | S | 7 months | GB | 90 lbs |
| Steve | 64 | Caucasian | Christian | Dating 2 yrs | $0 | 3 | S | 7 months | GB | 80 lbs |
| Idahoguy | 50 | Caucasian | Lutheran | Married 28.5 yrs | $27,000 | 2 | W | 7 months | GB | 105 lbs |
| Bruce | 39 | Caucasian | None | Dating 6 mos | $90,000 | 0 | W | 9 months | LB | 100 lbs |
| James | 33 | Hispanic | Christian | Married 4 yrs | $37,000 | 7 | MW | 23 months | GB | 115.2 lbs |
| Mr. Green | 51 | Caucasian | Jewish Reform | Divorced 3 mos | $0 | 0 | S | 8 months | GB | 125 lbs |
| Nobley | 42 | Caucasian | Methodist | Married 13 yrs | $110,000 | 2 | S | 12 months | GB | 98 lbs |
| Paco | 32 | Biracial | Christian | Married 11 yrs | $60,000 | 2 | MW | 14 months | GB | 195 lbs |
| Ephraim | 33 | Caucasian | Jewish | Married 9 yrs | $90,000 | 5 | W | 6 months | GB | 100 lbs |
| Rolling56 | 55 | Caucasian | Catholic | Married 10 yrs | $115,000 | 3 | S | 9 months | GB | 116 lbs |
| Andrew | 29 | Cau/NA | Methodist | Married 7 yrs | $54,000 | 2 | NE | 13 months | LB | 112 lbs |
| Jay | 56 | Caucasian | Protestant | Married 24 yrs | $52,500 | 4 | S | 14 months | GB | 67 lbs |
| Dom | 33 | Hispanic | Christian | Married 6 yrs | $0 | 2 | NE | 11 months | LB | 77 lbs |
| Average (M) | M=44 | | | | M=$43, 225 | M=2.25 | | M=13.3 | | M=122.51 |

KEY:
GB= Gastric Bypass MW= Midwest S= South
LB= Lapband SW= Southwest NE=Northeast
W= West

**Context for Understanding Mens' rationales for Surgery**

While the purpose of the dissertation was to focus on the post-operative experience of men who had weight loss surgery and the changes that occurred through the process of surgery, one aspect that is worth mentioning is motivations for surgery. The primary factor that emerged during the interviews that motivated men to have surgery was health. When discussing motivating factors, a number of the participants discussed chronic health issues that they had related to obesity such as diabetes, heart conditions, problematic breathing, and sleep apnea, among others. Participants reported that they wanted to improve their overall physical health and improve their quality of life. Specifically, men wanted to be more active and improve their ability to interact with their children and families. They all recognized that obesity negatively impacted their close relationships as well as employment opportunities. For instance, a few participants perceived obesity as denying them access for higher paying jobs. Finally, participants reported seeking surgical intervention after experiencing multiple failed attempts at weight loss.

During the interview process, participants discussed ways in which they prepared for surgical intervention. Participants discussed their process of researching various weight loss programs, doctors, and specific surgical interventions. Participants reported utilizing the internet to find out information about weight loss surgery prior to setting up their initial consultations. In addition to researching medical procedures and doctors, respondents discussed ways in which they talked about the surgery with their spouses. Participants reported that they met with their spouses and discussed their desires for surgery. One participant reported that he brought up the topic of surgery during a routine "date night" that he and his wife have. Others reported that they researched surgery individually and then discussed their findings with their partners.

Respondents also discussed requirements that had to be met by their medical insurance providers in order to qualify for surgery. Some participants discussed having to go on a pre-operative diet, complete a psychological assessment, and attend a nutrition class and at least one support group prior to surgery.

## Emerging Themes of the Study

The main objective of the dissertation study was to investigate men's experiences after weight loss surgery. Therefore, the overarching grand research question was "How does the process of bariatric surgery influence men's perceptions of self-concept, intimate relationships, and social support?" Five research questions were developed to further investigate this phenomenon, which are discussed below. In the study, five major themes emerged: (1) a shift in identity construction, (2) enhanced relationship experiences, (3) increased intimacy, (4) fluidity among informal social supports, and (5) the utility of mental health services**.** A description of each research question with emerging themes and sub-themes follows.

### Theme 1: Shift in Identity Construction: From Existing to Living.

> Prior to surgery, I didn't live a life. I existed. I went to work. I ate. I drank. I didn't drink alcohol much, but I just existed. I'd get up, go to work. I'd eat. I'd come home, and just didn't have energy to do anything. I woke up late on weekends; even rolling out of bed was difficult and tiring for me. After surgery, life is wonderful… it is something I never dreamed it would be. I couldn't have dreamed of living the life I have now. (Nobley, age 42)

The shift in identity construction theme directly addressed the first research question of the study. The first research question was *"How does the bariatric surgery process influence men's perceptions of self-concept?"* The shift in identity construction theme represented a cognitive process men experienced through the spectrum of the pre- and post-operation periods. After surgery, men reported that they thought about themselves in more positive way. They reported having a higher self-esteem. They also reported changes as they related to how they felt

about themselves and how they perceived they were viewed by others. The way that men constructed their identity changed as a result of significant weight loss and the impact it had on their bodies, social relationships, and health. This theme was comprised of three subthemes: (a) changes in perceived self-concept, (b) the evolving body, and (c) the emerging self.

***Changes in perceived self-concept.*** There was evidence that suggested that there was a change in self-concept. Prior to surgical intervention, all participants viewed themselves as "simply existing." They described themselves as depressed, lazy, fat, slow, tired, worthless, miserable, boring, negative, overweight, unhappy, lethargic, insecure, self-conscious, and sedentary, among other descriptors. When participants were interviewed they were asked to describe themselves prior to surgery to illustrate how they initially constructed their identity. During one of the questions, the interviewer asked participants to reflect on life before surgery utilizing adjectives. All twenty men provided negative adjectives when asked to describe themselves. For example, when asked what adjectives participants would use to describe themselves, James stated the following:

> Well definitely lonely, sad, depressed, angry, frustrated. I just kind of felt I was being held back by my own self, maybe oppressed….I didn't feel that anyone could relate to my situation the way I felt because I wasn't happy with the size I was.

When Mr. Green was asked to describe himself prior to surgical intervention, he referred to himself as a "non-person." Mr. Green stated the following when reflecting on his previous experiences:

> I wore the same clothes for several years and clothes were always hard…they were expensive to buy. I mean when you have a 60 inch waist and a 4X shirt, clothes are not easy to come by and of course you're a non-person at that size.

During the interview process, participants also discussed how they perceived they were viewed by others prior to surgery. Participants reported that they were viewed negatively by peers, family, and employers prior to surgery. The terms "lazy" and "undisciplined" emerged

during the interviews a number of times as adjectives that were projected onto the participants. For example, James stated:

> In the beginning, people actually referred to me as being lazy…. if you got up and exercised and if you changed the way that you eat, maybe you would lose weight…not realizing that I had been on this strict diet and exercise program for over a year.

Interestingly enough, one participant reported being viewed as “undisciplined” by members at his church due to his obesity. “Tom,” a church official, told a story about how he was demoted from a leadership position at his church. He reported that he was approached by his pastor and asked to step down from his position until he was able to set a more positive example of discipline. One thing that the interviewer found to be fascinating was when the participant reported that he actually agreed with his pastor. When reflecting on the incident, Tom stated:

> When the senior pastor came to me and talked to me about this, he’s one of my closest friends and I actually agreed with him. I don’t know that I could look at a man that is so overweight like I was and say that is a man that completely makes the right disciplined decisions in his life especially when it comes to his weight.

Other participants reported that they felt that they were viewed negatively within the workforce. Bruce specifically discussed how he thought obesity hindered upward mobility as it relates to the ability rise into higher levels of management.

After weight loss surgery, all of the participants altered the way that they viewed themselves and experienced a more positive outlook on life. After surgery, they described themselves as “excited, happy, nervous, surprised, energetic, lively, exuberant, not self-conscious, and positive.” When asked to elaborate on adjectives regarding after surgery, Bubba stated the following:

> I just feel a lot more positive. I’m ready to go on to new things…as I started losing weight I noticed people who normally didn’t have anything to do with me, all of a sudden were starting to become friendly because I was not grossly obese as I had been before.

Participants also reported feeling less self-conscious about themselves after surgery. They discussed feeling less self-conscious when it came to going out to eat in public places, sitting down in chairs, flying on airplanes, and interacting with others. One participant, Nobley, also reflected on his role as a father after surgery and stated the following:

> I think of myself as a good father and husband because now I'm able to do everything now that I never had energy to do before. I go bike riding with my boys. I go swimming with my boys. I go hiking with the cub scouts and I'm actually the dad that doesn't get tired doing these things. No…..I'm a role model to them, whereas before I was kind of ashamed of the type of person that I was, and now I'm pretty proud of who I am.

***The evolving body: still a work in progress.*** All participants reported disliking their bodies prior to surgery. After surgery, respondents discussed how their sense of body image changed as they started to lose weight. They described their post-surgical bodies as "changing in the moment," "evolving," and as a "work in progress." When was asked about how he viewed his body after surgery, Tom stated:

> A work in progress…I'm not there yet, I still have [more to lose]…I set a pretty realistic goal of 225 pounds. I still have about 66 pounds before I get to that. It's do-able, but I know when I look at myself I'm not there yet. I'm getting there.

Lucas reported a surge in self-confidence:

> I just feel more confident and I can trust when I go talk to people and I don't always think they are saying "here comes the fat guy again." I have more self-confidence and I just feel better about myself.

During the interview process, participants also reported that others viewed their bodies positively. Many participants discussed how they have been viewed specifically by their spouses, children, and peer groups. When Mr. Green was asked about the types of responses he had received, he reported, "'Way to go, keep going, we think you look great,' they just literally go wow." When asked how he felt about responses of others, Mr. Green stated, "Excellent, that's part of what makes me feel it was all worth it." Al Cargo reported that his wife liked his body.

He stated that he and his wife were a “better couple” because of the weight loss:, “It’s understandable, she is small… she is only about 105 pounds, so we are a better couple now because we are both thinner… not a big fat guy and a thin woman.”

While participants reported feeling positive about their bodies and about the responses they received from others, they also mentioned experiencing body dissatisfaction (n=13). Most of the participants felt some level of discomfort about their bodies due to excess and “loose” skin that resulted from the surgery. For instance, Al Cargo reported that he experienced some dissatisfaction with extra skin:

> Since the weight loss, I have a lot of extra skin… I’m not comfortable with my shirt off now…I am a little self-conscious. I have extra skin on my chest. I have extra skin on my stomach; there is extra skin on my whole arm… loose skin.

Many participants viewed their experiences of change in body image as a process. Respondents also reported that they were still adjusting to their new bodies. For example, Bruce Willis stated:

> I feel okay. I’m still getting used to it, you know, it’s like, I think that I look pretty slim. I wear like a 36 pants now and extra- large shirt which is like a miracle in itself, you know.

In addition, participants reported that while they had lost some weight, they still had the desire to lose more. Many participants mentioned that they had not yet achieved their weight loss goals. For example, Bruce Willis reported:

> The way I look at my body now is not an end point. Like, but I see it’s changing and so I’m now at the point where I have to just like tough it out and get through to break through this and get under 200 pounds.

While most participants reported having an overall positive outlook regarding their post-surgery bodies despite excess hanging skin, two discussed other difficulties regarding their body image. Both Andrew and Gratz reported that although they had lost weight, they still viewed themselves as being overweight. Gratz stated:

> Um…It's kind of weird to say this, I know I've lost a lot of weight. I went from a 4X shirt down to a M but I still view myself as being the same size…I expected to have the surgery, lose the weight, feel great, want to go do things, and show off my new body, but I still tend to be shy. I don't want to take my shirt off in public. Mentally, I'm still the same.

***The emerging self: From insecurity to self-confidence.*** As participants started to lose weight, they reported feeling more secure of themselves and more confident (n=19). Participants reported feeling as if they had the ability to do more things after surgery than they were able to do before surgery. For example, Paco stated:

> I'm a lot more sure of myself. I think at 405 pounds I had almost given up on myself, given up on challenging myself and chasing my dreams. But now, it's like I feel like there's nothing I can't do if I work hard enough. I mean I have goals…and I think if I just stay focused on them and work hard, I will get there. Whereas before, I just kind of gave up on pursuing them.

Participants also discussed how surgery resulted in an increased level of social interaction (n=18). Some participants who previously self-identified as an "introvert" became more socially active. When asked about life after surgery, Lucas stated:

> Before I was just kind of like an introvert, like in a shell, because I was really afraid to talk and would always be off to the side at a party, until I drank enough and built up the courage…But now, when I walk in I don't mind being in the center of attention and cracking jokes. I do a lot more of that now that I'm less heavy.

Participants also discussed feeling more confident in their ability to accomplish goals as it related to their careers. When asked to discuss the changes he had made after surgery, Lucas stated:

> I joined Toast-masters, I have started to get into public speaking, I have a side business and I'm feeling more confident talking to people about it. Now that I have lost weight, I feel more confident now. I am going to try to make my side business a full time job.

While most participants reported an increase in social interaction after surgery, there was only one participant who reported becoming less socially active. ChampLV4 reported that prior to surgery, he was very social. He also reported that he "put up with others" because he wanted

to be accepted. However, after surgery ChampLV4 reported that he became more selective regarding the people with whom he interacted. He reported that feeling accepted was less important after surgery. ChampLV4 shared:

> I don't hang out with people I don't enjoy, but before I may have put up with it to hang out with someone...Yeah, I just don't put up with silly people anymore…it's just something that's changed since surgery. I would rather just hang out with one or two close friends than be out with a whole bunch of people.

During the interviews, participants also talked about how their mental health had been impacted through the weight loss process as it relates to feeling of depression. Many participants reported feeling happy after surgery and reported that they no longer struggled with depression. For example, James reported:

> I think just with the depression being gone, I think that was one of the biggest things that was holding me back just from doing anything. I feel now that I'm not as insecure about what people may think about me because of my size.

**Theme 2: Enhanced Relationship Experiences.**

> I am very happy and a lot more content because I'm not as argumentative as I was before. Before my wife and I were always arguing and I think it was deep down my weight. I would be mad because I work out and some of my friends don't go to the gym at all and they look like toothpicks, it's really frustrating to me, and when I think about that, we would argue for no reason. And now that I have had the surgery, I don't think I'm as argumentative as I was before. (Lucas, age 48)

The enhanced relationship experiences theme directly addressed the second research question of the study. The second research question was *"How do men perceive dating and relationship satisfaction after weight loss surgery?"* The enhanced relationships theme represented the major improvements that were reported by research participants regarding intimate couple relationships after surgery. During the interview process, participants were asked about their experiences within their couple relationships as they transitioned through the weight loss surgery process. Specifically men reported that their relationships significantly improved, relationship satisfaction increased, and commitment to their spouses or intimate partners

increased. The theme was comprised of three subthemes: (a) happy and more content, (b) perceived insecurities, and (c) commitment to relationships.

***"Happy and More Content."*** During the interview, participants were asked questions specifically about how they perceived relationship satisfaction after surgery. Fifteen participants reported that they experienced an increased level of happiness in their relationship post-surgery. Participants discussed ways in which their relationships improved post-surgery and credited the improvements to the weight loss. They noted that through the weight loss, they felt better about themselves and this feeling impacted how they interacted with their spouses. Participants also noted that improved interactions contributed to their overall level of satisfaction in their relationships.

When Bubba was asked about his relationship after surgery, he reflected on how is mood has changed. Bubba reported that prior to surgical intervention he presented with a negative mood and experienced unhappiness in his life. He appeared to connect his level of unhappiness with his obesity, and specifically mentioned the negative impact it has had on his couple relationship. When Bubba was asked about his level of contentment with his spouse, he stated:

> Very much so, and it wasn't that I was unhappy with my relationship beforehand, but I was unhappy with myself and did not realize that the frustrations made life difficult. I made things difficult for myself and sure made it difficult for her.

Other participants discussed being satisfied in their relationships but focused on explaining how their level of satisfaction depended on their spouse's level of contentment. For example, when Andrew was asked about his level of satisfaction in his relationship, he focused on talking about how he was now able to please his wife. He specifically reported that his wife was happy that he was now able to engage in increased physical activity with their daughter. He further explained that his wife's happiness made him more satisfied. At the same time, when

Paco was asked about his level of contentment in his relationship, he focused on his ability to take on more responsibilities in the home. Paco went as far as to say that he and his wife became "more of a team" now, and stated:

> I think before surgery I felt like I'd go to work and I'd come home and I would already be tired…I think we are a lot stronger as a team now, so when I come home I still have energy to help with homework or cook dinner or, you know, all that kind of stuff that married couples should do to make a good team.

Similarly, Dom reported that he experienced an increased level of relationship satisfaction due to now having the ability to become more active with his intimate partner. Dom discussed how his increased level of physical activity contributed to his wife's happiness. When asked if he was happier in the relationship after surgery, Dom stated:

> Well the fact that I'm not sitting on the couch all day watching TV or playing video games and choose to go out with my wife and family more. It's helped out the marriage a lot. Going dancing with my wife makes her happy and my healthy lifestyle has made her lifestyle healthier.

The remaining participants in the study (n=5) reported that their level of contentment in their relationship did not change or significantly improve. For example, when Al Cargo was asked if he was more content in his relationship after surgery, he stated:

> No, no about the same. I am just as happy as I was before… I don't think it's changed my relationship any…I think my wife is happier that I'm healthier; it's not a concern for her anymore like it was.

Although Al Cargo reported that he was not more content in his relationship after surgery, he also reported that his wife was more content; which is interesting given that his wife did not have a surgical intervention.

***Perceived insecurities: Fear of abandonment*.** While a majority of participants reported having an increased level of relationship satisfaction, there were some who also reported on problems that occurred after weight loss surgery (n=7). A number of participants reported that

their intimate partners felt insecure within their relationships due to the surgery and the subsequent weight loss. Participants also discussed how negative body image, the spouse's self-concept of the spouse, feelings of intimidation, and jealousy compounded the level of insecurity within their relationships. When James was interviewed he reported that his wife feared that he was going to leave the relationship and stated:

> [In the beginning] she thought I would have the surgery, lose the weight and possibly end our relationship, because I would end up wanting or desiring to be with someone else. I think her sense of security was in the fact that we were both overweight and thinking if I lost the weight, she would possibly lose me.

Another issue that connected to perceived insecurities was men's perspectives regarding surpassing their spouses' weights. Some participants mentioned that surpassing their partner's weight would be problematic for their partners. Andrew mentioned that he thought his wife was starting to become jealous because he was getting close to her weight. When asked to reflect further about the idea of insecurity, Andrew stated the following:

> I think her fear is someday I'll catch up her and she will be the heavy one. Or that I'll get to a point where I look skinnier than she does. I think all those things together when it comes to my weight loss scared her.

When asked about negative aspects of his relationship after surgery, Paco stated, "I was always larger than my wife but after I lost 100 pounds. I went under her weight and she felt uncomfortable…because I'm smaller than she is and the man should be bigger. That's what she thinks."

Magician also reported that his wife dealt with issues related to fear and insecurity. Magician stated the following:

> I could tell that my wife felt pressured to keep up as I received such positive feedback from the changes I made. The focus of attention was on the progress I was making and not on the things she was doing…I am confident that my wife adjusted her diet and habits based on not only wanting to be supportive of me, but also a sense of not wanting to be left behind.

In addition, some men reported that their spouses became jealous and attempted to make them feel guilty when they would leave the home to exercise. For example, Nobley discussed how his wife struggled with feeling pressure to keep up with his new lifestyle of running marathons. It was also reported that since some intimate partners were already dealing with their own weight and body image issues, their levels of insecurity within the relationships were exacerbated.

***Commitment to relationships: Divorce is not an option.*** Commitment to relationships emerged as a theme related to relationship satisfaction. During the interview participants were asked a series of questions to explore commitment during life after bariatric surgery. During the interviews, participants were asked if they had received romantic attention from outside of their relationship. Several participants reported that they had. Eighteen participants reported that although they may have received romantic "attention" from individuals outside of their relationships, they often did not act upon advances made by others. There was also a couple of individuals who either reported that they did not receive any attention from others or reported not being sure if they actually received romantic "attention" from others. Participants (n=16) expressed a strong level of commitment to their couple or marital relationships which included spouses, intimate partners, and children]. They reported that their level of commitment to their spouses was and still was what prevented them from acting on the advances that they received from others.

While there were a number of individuals who reported that they had received romantic attention from women outside of their relationships post-surgery, one notable participant was Tom. Tom reflected on an incident that happened when he was out at a restaurant:

> I was having a beer and I was listening to the music… a girl came up and sat with me and flat out asked me to go home with her after our 20-minute conversation. And so…after

> that I was like yes! I said no and explained to her that I was married. It's hard now because since I lost so much weight I can't wear my wedding ring so I'm waiting until I lose more weight to have it resized.

Rolling 56 also had an interesting response when asked about receiving romantic attention after surgery. For example, Rolling 56 stated:

> Yeah, I've had women come up to me and you know, I wonder what it's like now. They touch me. They rub my back now and they rub my shoulders. It's a good feeling that they want to touch me now…but at the same time, I just let them rub my back and shoulders and leave it at that, I don't go beyond that.

During the interview, only three men reported that while they would not act on the romantic attention received by others, they enjoyed it, were curious about others, and were tempted at times. Along with that, during the interview process, participants were asked if they ever thought about leaving their relationship after surgery. Paco reported that he has never considered leaving his relationship. Paco reported that he had surgery so that he could be around for his family. He mentioned that it would not make sense for him to leave his relationship. When asked if he had ever thought about leaving his wife post-surgery, Paco stated the following:

> No because my biggest reason for having the surgery was to be around for a longer time to have a better quality of life with my wife and kids and for myself too. And that would kind of defeat the purpose of me being a happier healthier person with my family.

Although a majority of participants reported that they had not thought about leaving their relationship, four men reported that they had thought about leaving their relationships. Interestingly enough, three out of the four identified as being in a relationship, but not married. One individual in particular (Steve) reported that he sees a future with another woman. In addition, one individual (Dom) engaged in activities that one might say demonstrates a lack of commitment (flirting and exchanging telephone numbers with the opposite sex). Dom reported that he had received romantic attention from women outside of his relationship. He reported that

he gave his telephone number to someone at a bar. Dom also mentioned that he had received romantic attention through one of the online weight loss support groups that he frequents. Dom reported that some people made sexual advances towards him and engaged in conversations of a sexual nature. When asked to elaborate about the website, Dom stated:

> The Afterdark [website] just more casual conversation…a lot of sexual conversations come up every once in a while….like I guess when people talk about "you know" like what they like and what they dislike, things like that and of that nature. Things they like "to do," conversations like that.

While Dom reported receiving romantic attention via the website and even flirting with women on the website, he said that he did not see it as problematic because it was happening online as opposed to in person. He also reported that his wife was not aware of this website that he frequents often. Dom reported that he is committed to his relationship, although he also stated that weight loss could be a way to escape his relationship.

**Theme 3: Increased Intimacy.**

> Before surgery our sex life was very infrequent. Our sex life started increasing relatively soon after surgery the…we actually talk now. Before we didn't really talk. If something was bothering us we held it in until it blew up. Sometimes that would be days, weeks, months, even years. (Nobley, age 42)

The increased intimacy theme directly addresses the third research question. The third research question was, *"How do men perceive intimacy after bariatric surgery?"* Increased intimacy refers to the level of emotional and sexual connection between men and their spouses after weight loss surgery. During the interview, men discussed their perceptions of their level of emotional connection and sexual interaction as it relates to intimacy. Participants were asked to describe their level of emotional connection after surgery. Participants were specifically asked if they felt more or less emotionally connected to their spouses after surgery. In addition, participants were asked about frequency of sexual interaction and about the level of enjoyment

with sexual interaction after weight loss surgery. This theme was comprised of two subthemes: (a) stronger emotional intimacy through better communication; and (b) sexual interaction.

***Stronger emotional intimacy through better communication.*** Participants were asked to describe how emotional connection or intimacy was expressed in their relationships after surgery. Sixteen reported an increased level of emotional connection after surgery, with the remaining four participants reporting that there was no improvement. Participants who discussed emotional connection after surgery reported that emotional connection was expressed through an increase in verbal and non-verbal communication as well as physical touch. Participants reported less arguing, feeling emotionally close to their spouses, and engaging in better communication after surgery. When Nobley was asked to describe his experiences after surgery as it relates to intimacy, he stated:

> Emotionally now we're more solid, were able to be more honest with each other…so we talk about things before they become a problem. It's not always easy to hear what the person is saying, but even those things that are difficult to talk about, we at least talk about then now.

Likewise, when Mr. Green was asked about his relationship after surgery as it related to intimacy, he stated, "We're very close. I can basically almost know what she's thinking. We snuggle again as a couple, very very close. I mean it's back to the way it was when we first met each other. It's wonderful."

Respondents were also asked to describe how emotional intimacy was expressed in their relationships after surgery. Participants reported that their spouses showed affection by compliments, intimate embraces, kissing, cuddling, spending more time together, and engaging in more communication. For example, when Gratz was asked to describe emotional intimacy after surgery, he stated the following:

> She tells me she loves me all the time. She's a big toucher, hugger, kisser…We always ask how each other's day was. We take time to communicate. That's our biggest thing, we communicate a lot. We don't keep secrets. We tell everything.

Participants were also asked if they would change anything regarding their level of emotional intimacy after surgery. A significant number (n=16) reported that they would not change anything in their relationship. For example, when Idahoguy was asked if he would change his level of emotional intimacy he stated, "No, I think we're stronger now than even the first years of our marriage." However, there were a few participants (n=4) who reported a desire to have increased emotional connection after surgery. When Lucas was asked what he would change about his level of emotional intimacy he stated, "I wish she would give more emotion back. Whenever I give her a hug or a kiss, I'm the one instigating it and I would like for her to give me a hug…I wish it would be more often."

***Sexual interaction: better than before, but still desires more.*** Sexual interaction appeared to be a way that participants express emotional connection and intimacy within their couple relationships. During the interview, most participants reported that sexual intimacy increased after surgery (n=19). They also reported feeling more enjoyment from their sexual encounters. When participants were asked about how their partners felt about sexual intimacy, most participants perceived that their partners experienced improvements as well. Participants discussed having more stamina during intercourse, feeling less weight conscious, feeling more comfortable with initiating sex, and feeling less sexually inhibited. For example, when Andrew was asked about sexual intimacy after surgery, he stated:

> It used to be hit or miss. It could be once a month. It used to be I'd have to literally almost beg…Now I don't even have to be the one to initiate it, which to me makes me happy. Now it can be more than once a week, which to me is like the Guinness Book of World Records, because that never happened so.

There was one participant within the study who reported that sexual intimacy did not improve after surgery (Ephraim). Ephraim reported that he and his wife lead busy lives and do not have time for romance. He reported that he has a low sex drive due to being on pain medication. He also reported that his wife stays home with his children and is often tired. In addition, over half of the participants (n=13) reported having an increased desire for sexual intimacy after surgery. Although they reported having an increased desire for sexual intimacy, they reported being content overall with their sex life. For example, when Rolling56 was asked if there was any aspect of sexual relationship he would change, he stated, "Change, oh no, I think it's great now, it's a lot better than what it was. Before, I was big and fat and she didn't want to do anything."

However, there were some participants (n=7) who reported that they had a desire to change aspects of their sexual intimacy after surgery. The men mainly voiced the desire for sexual interaction to occur more frequently, with some stating that they desired to have sex daily. Participants also reported wanting to engage in more experimentation during sexual intimacy. Individuals also reported that although they wanted more sex, their spouses may have not experienced an increased libido. Some participants reported that their spouses dealt with their own issues related to depression and weight concerns.

When ChampLV4 was asked if he would change anything about his sexual interaction with his partner, he stated "I think guys always want to have sex more than women, they want more of the emotional relationship and guys want more physical, so more often." In addition when Jbird was asked if he experienced an increase in sexual interaction with his spouse, he stated:

> Well, not as I would like it to be, every day. She still comes home tired and worn out, and but once a week is great, because before, for three years, I was on that couch, lonely, by

> myself, like an old ship-wrecked whale or something, you know, on the couch. But now I'm all excited.

**Theme 4: Fluidity in Informal Social Supports.**

> She was very supportive. She was there for me, she made it a lot easier, but there was one point about two weeks after the surgery where I could only eat pretty much just water and soup and she came home from work eating a Wendy's cheeseburger and fries and I wanted to kill her. (Gratz, Age 31 )

The fluidity in informal social supports theme directly addresses the fourth research question. The fourth research question was, *"How do men perceive social support after their bariatric surgery?"* The term "fluidity" signifies the complexities involved in receiving social support after weight loss surgery. During the interviews participants suggested that there were both instances where they received informal social support, while at the same time experiencing times where they felt unsupported. Participants reported that support and lack of support occurred simultaneously. Participants also reported that while their spouses were supportive, there were a number of times when they were not supportive. Additionally, participants also discussed times in which they received informal support and experienced lack of support by children, extended family, co-workers, and church officials. The theme is comprised of three subthemes: (a) encouragement with accountability; (b) lack of support; and (c) formal social support.

***Encouragement with accountability.*** During the interview process, participants discussed their perceptions of social support received by their spouses, children, extended family, and co-workers. All participants reported on instances where they received support. Social support occurred through the use of encouragement, accountability, verbal praise, changing eating habits, assisting with after care, financial support, and attendance at support groups. While there were a variety of support systems used, most participants discussed the role that their spouse and family had during the weight loss surgery process. Spouses were viewed as

key players in the weight loss surgery process, from deciding to have surgery and preparing to have surgery to aftercare. Nobley reported that his wife played a pivotal role during his weight loss:

> She was the pivotal role. She scheduled all my appointments. She was at every pre-op appointment with me. She goes to all of my follow up visits. She stayed in the hospital with me….I would not be here at the point I am in my post-op life if it wasn't for her.

Participants also reported that their spouses assisted with providing "nursing" like personal care (n=5). Participants discussed ways in which their spouses assisted with monitoring their compliance with post-operative medication, which included attending medical appointments, communicating with medical professionals, and administering medication. JBird reported that his wife was encouraging, but also helped him remain accountable when he attended post-operative medical appointments:

> She ratted on me the very first doctor visit about two weeks after the thing [surgery]. She said, "I want you to know he's eating a candy bar." It was Easter time and the Easter candy was out. She said, "He's eating a chocolate bunny, 270 calories." I said, "Baby, don't tell the doctor all that stuff." He said, "You got a good wife. She's going to keep you straight."

In addition, JBird also reported that his wife was responsible for giving him his B-12 injections.

Participants also mentioned that spouses and extended family provided support by changing their eating habits. When Idahoguy was interviewed, he reported that his wife changed her eating habits. Idahoguy stated, "As soon as we knew what the surgeon had to say, we eliminated the pastas, grains, rice…she's living the same way I am even though she hasn't had the surgery." Other participants reported that they felt supported when their intimate partners replaced their regular-sized eating utensils with small eating utensils.

During the interview process only one participant explained that he received financial support from family. Idahoguy reported that he was $5,000 dollars short and was not going to be

able to pay for his surgery. He reported that his mother gave him the money. He also reported that his wife provided financial support by working extra hours at work so that he could afford a gym membership after surgery.

In addition, all participants reported that some spouses, family, friends, and co-workers assisted with providing words of encouragement, compliments, and verbal praise, which they said made them feel good. However, while most of the participants reported being encouraged by the positive support that they have received from others, a few participants (n=4) mentioned feeling uncomfortable with receiving support. Participants reported that they often felt embarrassed when people gave them compliments about their weight loss. They reported having an issue with their new found “fame,” in that they felt uncomfortable being the center of attention. When Nobley was asked to elaborate on his discomfort he stated, “I got to the point where I just didn’t want to go to work because I didn’t want people talking about me, I didn’t want to be the center of conversation.”

***Lack of support: He’s just taking the easy way out, lack of empathy.*** Although participants reported obtaining support from friends, family, and peers, many of them also reported instances where they felt unsupported (n=17). Failure of support consisted of negative feedback when discussing the desire for surgery, lack of changing eating habits by partners, negative feedback when participants attempted to exercise, negative responses by parental figures and siblings, and discouraging feedback from church members, among others. One of the most reported issues related to lack of support occurred when participants were contemplating surgery (n=12). Participants reported that many of their peers and family did not understand the struggles that obese individuals go through. They also reported that many family members and peers did not support the decision to have surgery. It was reported that some family members and

peers believed that surgery was "taking the easy way out." Therefore participants were met with resistance from family members and peers when contemplating surgical intervention.

While being interviewed, some participants reported that their intimate partners failed to change their eating habits, which they viewed as being counterproductive to their new lifestyle (n=3). In addition, there were other issues raised during the interviews regarding lack of support by spouses and family members. One issue was related to intimate partners not attending support groups. Lack of empathy was also raised. Tom felt that his wife was not emotionally there for him when he was undergoing surgery. He verbalized that he was fearful of dying on the surgery table and he reported that his wife failed to comfort him during this time.

In addition, there were a few individuals (n=4) who reported on their experiences of receiving negative feedback from peers and family regarding their weight loss. Participants reported being told that they had lost too much weight. Participants also reported that they were told to stop losing weight by their peers. One participant (James) specifically reported that he was told that he looked sick due to losing so much weight. He mentioned that he thought it was ironic that when he was overweight and had medical issues, no one ever asked if he was sick. He pointed out that now that he was healthy and had lost weight, people thought he is sick. He further elaborated and stated:

> It's disturbing in the sense that being obese is considered normal. I consider myself now to be at a healthy weight and my healthy weight to some people is considered abnormal. That is a little disturbing to me.

***Formal social support: Face-to-face and online support groups.*** Participants discussed their level of involvement with formal social support systems such as face-to-face support groups and online support. Slightly over half of the men participated in face-to-face support groups (n=11). Some participant's went to face-to-face support groups prior to surgery, some went to

them after surgery, and some went to support groups both before and after surgery. Some individuals reported attending face-to-face support groups as they were either encouraged or required to do in order to obtain weight loss surgery. Individuals who attended face-to-face support groups reported that they were able to meet other individuals who were going through the same surgical process. Most participants reported that they attended support groups individually. However, there were a few (n=6) individuals who reported that their spouses attended some of the support groups.

Participants reported feeling safe and comfortable in the face-to-face support groups. Individuals reported that they discussed the following topics: preparing for surgery, preparing for life after surgery, health and fitness after surgery, food addiction, medical issues, and adjusting to life after surgery. Individuals reported feeling as if they were able to communicate with others who understood their experiences of being overweight and struggling with obesity. The men used the terms “family” and “bond” when they described the relationships that were developed from the face-to-face support groups. One individual in particular used the term “kinship” when referring to the face-to-face support group he attended and stated:

> There’s a kinship in there and I like being involved in it. So within the support groups, I find support in the sense that they draw my experience… they allow me to see their perspective…..their very warm friends.

While a number of participants attended face-to-face support groups, there were nine men who did not participate in these groups. Individuals reported not attending face-to-face support groups due to issues with scheduling, location, format, desire for confidentiality, and perceived isolation of men. A number of men reported feeling that they would be the only man at the support group meetings. Some men who went to a support group reported feeling uncomfortable after seeing a room full of women. Others reported having a busy schedule and not being able to

take the time out of their lives to attend an in-person support group. Some also mentioned that there were no support groups that were in close proximity to their homes. Gratz explained that his surgery took place at a hospital that was over an hour away from his home, and that he was not able to drive an hour every week to attend a support group. During the interview some participants reported concerns with confidentiality. For example, Bruce reported that he did not attend face-to-face support groups because he was a "private person."

While some participants reported attending face-to-face support groups, an overwhelming majority also participated in online support (n=18). Online support consisted of support groups sponsored by hospitals and weight loss surgery websites (obesityhelp.com and lapbandtalk.com) as well as popular social networking websites (YouTube and Facebook). For the most part, participants reported positive aspects of online support. They told how they were able to go online any time during the day or night, and that they were able to interact with other men who shared similar experiences. Participants reported other positive aspects of utilizing online support which included having the ability to interact with others from around the world, to connect with others who shared the same surgeon, to control their level of interaction, and to connect from home.

Participants reported that they received more support via online social networks and websites compared to face-to-face support groups. For example, James reported that he received more online support than support from face-to-face interaction. He mentioned that he used YouTube and connected with others who had weight loss surgery. He told of how he was able to receive feedback about what he was experiencing. He would post videos on YouTube where he would talk about whatever issues he was struggling with related to his weight loss surgery

experience. He reported that although his wife tried to be supportive, she was not as helpful as the online community due to her inexperience and lack of knowledge regarding surgery.

Privacy was one of the topics that came up frequently during the interviews as a reason why men preferred to interact online instead of in face-to-face support groups. One of the benefits discussed during the interviews was that participants had the ability to control their level of interaction and engagement. For example, some individuals reported that they posted videos regarding their weight loss experience, while some were against posting videos. In addition, some posted pictures and audio files using their voice, while others preferred not to post pictures or upload audio files. In addition, some participants used their real names, while others created fictitious names or “avatars.”

Another benefit that was stated regarding the use of online support was the flexibility of scheduling and the ability to manage visibility and level of engagement. Ephraim explained that he likes that he has the power to control what he does online. He reported that he can get online at night or during the day which provides extra flexibility. He also mentioned that he can chose if he wants to open a message board, if he wants to respond to a message, or if he simply wants to read post without engaging in communication with others.

Participants were asked about how they interacted online. Some individuals reported that they created profiles on YouTube and Facebook and provided updates to their subscribers or “friends.” They mentioned that they would create blogs that were accessible to their subscribers and also mentioned that they communicate via private messages. Some individuals also created videos and others posted before and after pictures of themselves as a way to document their weight loss journey. Ephraim was one of the men who reported being very active with online social networks. When discussing his level of interaction online he stated:

> I posted pictures probably 3 to 4 times. I posted some before and after pictures and I've posted pictures of my progress. People like it when you post pictures and I like it when other people do. It's a nice way to kind of bring it alive and see what's really going on and look at people and see the difference.

Social support was viewed as highly important by individuals. Social support was not only received by the participants but also was provided by men. Many of the participants who initially received support also continued to provide support to others who were not as far along in their surgery process. Beyond that, individuals provided support to one another throughout their daily lives as opposed to once a month or week in face-to-face groups. Andrew reported that he would provide support to others and would receive support simultaneously when engaged online. He reported that he would answer questions posed by others and would ask questions as well. Similarly, Al Cargo also provided feedback to others online. When discussing online support, Al Cargo stated:

> I feel good. I mean, it makes me feel good that I can help people and I've come to really enjoy helping people. I give my phone number out, I give my email address out and I tell people they can call me anytime if they have some kind of a crisis…so I've had people call me, and a few men in the group call me because our problems are a little bit different than women.

While most of the feedback on online support was positive, there were also some drawbacks reported. Bruce mentioned that there was also lot of negativity online. He reported that the people who tend to gravitate towards websites are individuals who have had problems or issues with surgery. He mentioned that prior to surgery he would read posts made by others that talked about negative experiences and "horror stories" regarding weight loss surgery. He also mentioned that he had access to the online community at all times as he received messages on his cell phone, which appeared to bombard his life from time to time.

In addition, there were three research participants who opted not to participate in online support. The participants did not disclose why they decided this. However, looking back at the

demographics two of the participants (Jay & Steve), they were older individuals aged 55 and 64. The third individual who did not participate in online support also did not participate in face-to-face support groups.

**Theme 5: Mental Health Services: Initial Resistance but Acknowledged Value.**

> I don't like to go to doctors, period. I can be on my death bed and finally my wife will convince me to go to the doctor. I'm just not a doctor person… you can do the chat with the therapist and no one else outside the home has to know. If I could avoid the drive and the waiting in the lobby and just log on at 10 a.m. and do a quick thing, heck yeah. (Gratz, age 31)

The mental health services theme specifically addresses the fifth research question. The fifth research question is, *"How do men perceive the role of marriage and family therapists during the process of life after bariatric surgery?"* Mental health services were discussed as it relates to the treatment of obesity and the weight loss surgery process. Participants were asked to discuss their experiences and perceptions of mental health services. All participants reported that they had to see a mental health professional as a requirement to qualify for surgery (utilizing medical insurance). Most individuals (n=18) discussed negative experiences during the psychological exam or reported that they simply saw the psychological assessment as a way to qualify for surgery. In addition, participants appeared to be oppositional to retrieving mental health services during life after bariatric surgery. However participants reflected on their experiences and appeared to acknowledge some value in mental health services during the weight loss surgery process. The theme comprised of two subthemes: (a) fear and negative perceptions of mental health services, and (b) Positive perceptions.

***Fear and negative perceptions of mental health services.*** With the exception of JBird who saw a mental health professional after surgery for depression, none of the other participants reported seeking mental health services. Beyond seeing a mental health professional for the

purpose of qualifying for surgery, participants did not see any value in seeking mental health services. Participants reported that they did not seek mental health services for a number of reasons which included fear, negative perceptions of therapy, feeling as if there was no need for therapy, negative past experiences of therapy, financial stress, confidentiality concerns, and lack of qualified professionals trained to work with obese men. Paco reported that he contemplated seeing a therapist after surgery, but mentioned that he decided against it. He reported that he felt he was still struggling with "food addictions." When asked if participants considered seeing a mental health professional after surgery, Jay reported that perceptions of therapy could pose a barrier to seeking mental health services by men. Jay reported that men have an issue with asking others for help. In reference to therapy and asking for help, Jay stated, "I think particularly in our society it's hard for a guy to say I need help. I couldn't do this on my own. We're guys, we're fixers. We're supposed to take care of stuff." In addition, James suggested that men are less inclined to seek therapy services and discuss their feelings. When James was asked to explain what he meant, he stated "Men in general are not inclined to share their feelings with strangers, therapists, well, people that they maybe don't know so much."

Participants reported that mental health services beyond the psychological assessment were not covered by medical insurance. They reported that one of the reasons they did not attempt to seek mental health services was that they would have had to pay for it out of pocket. Mr. Green reported that he did not see a therapist after surgery due to his lack of employment and his inability to self-pay for services. When Mr. Green was asked about mental health services after surgery, he stated, "I don't have insurance anymore. Like I said, if I can set up some state-sponsored sessions with a therapist that would be awesome, but right now I've been concentrating on getting my business going." Likewise, Gratz reported that he would see a

therapist if monetary issues did not pose a barrier. Interestingly enough, Gratz reported that he would prefer to have a mental health professional come to his home to offer services.

Another issue that was discussed regarding barriers to mental health services was that there is a lack of professionals that are qualified or appropriately trained to work with the bariatric population. Nobley reported that he had not requested mental health services to assist with adjusting to life after surgery. He reported that there was a lack of professionals where he lived that had a specific focus of working with bariatric clients. He also mentioned having issues with finding a professional that he trusted. Nobley explained that in order for him to trust a mental health professional, he would need to feel that the professional could identify with him. When asked what he meant by the professional being able to "identify" with clients, he further mentioned that he would want to see a therapist that had undergone bariatric surgery.

***Positive perceptions: The utility of marriage and family therapeutic intervention.*** While participants reported limited or no interaction with a mental health professional or marriage and family therapist after surgery, all participants reflected back on their experiences and acknowledged instances where the saw the utility of marriage and family therapy intervention. Participants reported on areas where they believed marriage and family therapists could intervene to provide assistance to clients and their families. They discussed the need for therapists to address specific issues for men and specific issues for couples. They also reported that they thought marriage and family therapists could assist with exploring the reasons behind overeating, motivating factors of surgery, expectations of surgery, preparing for surgery, adjusting to life after surgery, nutrition, dieting, exercise, and attitudes towards food.

During the interview process, Steve suggested that it is important that therapists provide a safe space for men to talk about issues, fears, and concerns regarding weight loss surgery and life

after surgery. Concerns around notions of masculinity emerged as an issue that some men may need assistance with. For example, Paco reported feeling as if he was less masculine now that he had lost weight. Paco specifically stated,

> For me I, it's like before surgery everybody would call you big dog or big daddy or that kind of thing and now nobody calls me that. It just seems everybody thinks the bigger you are the more masculine you are….In fact sometimes, now, I feel less masculine. I guess because I'm smaller.

One of the areas that were discussed by research participants was related to marriage and family therapist addressing issues related to why men overeat. A number of participants discussed their relationships with food. Some participants acknowledged that it could be important to explore why one eats so that issues with overeating do not persist after surgical intervention. A number of men reported that issues during childhood, past trauma, and other psychological issues contributed to overeating. Another area that men acknowledged the utility of therapeutic intervention after surgery was related to body image. Participants discussed the need for assistance with adjusting to feedback that they would receive about their bodies after surgery. They also mentioned the need to work with men regarding eating disorders and body dysmorphia. When Tom was asked about ways in which therapy professionals could work with men he stated:

> Talk to guys about a positive body image of themselves. Body dysmorphia is a big issue for weight loss surgery patients. If I take my shirt off, I feel like a big lard butt. If I have my shirt on, I feel like Arnold Schwarzenegger. I'm pumped up and ready to go. I haven't been able to completely wrap my mind around it either. What I see with my clothes on is different than what I see with my clothes off.

Related to body image is the topic of weight loss plateau. Lucas and a number of other participants reported that men who have had weight loss surgery sometimes struggle with their weight. They may experience weight loss plateaus and some may even experience weight regain.

Participants mentioned that a marriage and family therapist could be helpful when addressing weight loss issues.

In addition to individual issues being addressed by marriage and family therapists, participants also reflected on ways in which therapists could work with couples and families. It was reported that weight loss significantly impacts couples. One topic that was discussed was related to family support. For example, Al Cargo stressed the importance of the family being involved in therapy. Al Cargo stated the following:

> I think they may have to work with the family more than the actual patient. I think that the family needs to understand what the patient is going to and how much support that they need after surgery and even before surgery, I think that the family has to…I think you have to try to get the family more involved in the patient's life after surgery.

In the same fashion, another topic that was discussed was the increasing amount of attention that men may receive as they lose weight. Weight loss in one partner may contribute to issues within the couple dyad. Mr. Green recommends that therapists work with couples to prepare them for the potential of receiving attention from the opposite sex after surgery. When discussing ways in which therapists could intervene, Mr. Green stated:

> The main thing that's going to happen is you're going to get your looks back, you're going to be desirable and any problems in the marriage that had resulted from that kind of thing are going to be enhanced…you're going to be on the market even if you don't want to or not. There are women out there that will go for you even if you're married – they don't care.

Other couple relational issues that were discussed included increasing the level of communication between clients and their spouses. Men reported feeling as if their intimate partners did not understand the transition that they were going through. It was recommended that therapists work with couples to help them adjust to the changes that occur within intimate relationships. Lucas specifically suggested that marriage and family therapists work with spouses

regarding making sure they provide support during the weight loss surgery process. When asked how a marriage and family therapist could work with men, Lucas stated:

> Your mate doesn't understand what you're going through…she wants to but she doesn't because she hasn't gone through it. They should get more people that have gone through it to open up to therapists and talk about issues they face every day…they also need to have some follow-up system to help with how to handle life a couple years after surgery.

Spouses were also recognized as being under a significant amount of stress as their partners started to lose weight. During the interview, men acknowledged that their partners experienced difficulty with adjusting to weight loss. Participants recommended that therapists should work with spouses to address potential insecurities and depression that could emerge as their partners lose weight. When discussing the need for therapists to address potential insecurities, Mr. Green stated:

> I've seen couples that both partners are very, very large people so when one starts losing the weight the other one may feel depressed because they're not losing the weight fast enough… they may feel threatened because maybe their relationship is co-dependent. I think therapists need to work with both the men, the women, and as a couple, all of it. Anything that can help keep them together if they truly want to be together.

Another issue that was mentioned was that participants could use support from therapists to address stressors that may occur during life after surgery. In addition to relational issues, some participants discussed issues with employment, finances, among other crises that negatively impacted their relationships. Participants reported that dealing with other stressors compounded issues for couples and families and made it more difficult to cope with life adjustments after surgery. Participants reported that marriage and family therapists could work with couples to cope with stressors that potentially could affect surgery outcome.

When discussing therapy with participants, individuals were asked when they thought therapists should work with individuals or couples. Participants suggested that therapy could be

utilized prior so surgery, but also mentioned that therapy could be utilized after surgery. When Andrew was asked about when therapy should occur, he stated:

> I think before and after. It's something you can talk about, but until you experience it you're not even going to know that it's occurring. So to prepare for that would be good, but to also be aware of it as it's going on. Obviously I didn't pick up on it until something was said to me by my spouse.

When Dom was asked about when he envisioned therapy being most helpful, he suggested that therapy should take place after surgery. When asked about therapy Dom stated the following:

> I guess I don't want to let all these compliments go to my head. I didn't want to ruin what I have over something that's meaningless. So I guess therapists should touch up on that to let the husbands know that they should consider what they have and if it's worth keeping don't let it go… They could give the husbands advice or let them know that just because you feel better about yourself that doesn't mean that this is a get out of jail free card in a sense. That you shouldn't stray from marriage, you have responsibility to your spouse and to your family, and you should work on it. This shouldn't be a reason to get up and go.

The usefulness of a therapist was also discussed in terms of educating the public about weight loss surgery. Participants thought that marriage and family therapists could assist with disseminating accurate information regarding obesity and weight loss surgery. Mr. Green was very vocal in suggesting that therapists should educate the public about obesity. When discussing how therapist could assist in this endeavor, Mr. Green stated:

> They [therapists] need to make people understand that big people are still people. We're not just gluttons. We're not just these pitiful creatures that hide away in corners. A lot of people have some terrible things happen to them that they compensated by eating. We're not any less human than anybody else and they need to really push that.

Participants also reported that there are a lot of misperceptions regarding bariatric surgery that they think marriage and family therapists could debunk. Participants reported that individuals in the media appear to think that bariatric surgery is a quick fix. They expressed that surgery is a tool and not something that is done lightly. They also mentioned that bariatric surgery requires hard work and long-term commitment. Men reported that marriage and family

therapists could assist with communicating that surgery is not taking the easy way out to spouses and future clients.

**Negative Cases**

There were no negative cases that stood out among the participants within the study. Most of the participants reported similar experiences regarding the type of support received from intimate partners. Also, most of the participants shared similar experiences as they related to receiving support from face-to-face or online resources. However, there was one participant who appeared to have a very positive experience with weight loss. Lucas did not report any instances where he felt unsupported during the bariatric surgery process which was different than most other participants. While he did acknowledge ways in which therapists could intervene, he appeared to have had a wonderful experience. Al Cargo and Magician also reported that they experienced no instances of lack of support by intimate partners. However, it should be mentioned that Al Cargo did report receiving some negative reactions by friends about losing too much weight. In addition, while Magician reported no periods where he felt unsupported by his wife, it should be noted that he recently had become separated from his wife. Magician, therefore, did not have daily interaction with his wife, which could account for why he did not report much about his wife. However, one could argue that being separated during weight loss surgery could in fact be a way of showing lack of support, although Magician reports that the separation had nothing to do with obesity or weight loss surgery.

Another interesting participant was Gratz, who was the only individual who did not participate in either online or face-to-face support before or after surgery. All of the other individuals participated in either face-to-face support groups, online support groups, or both. Gratz reported that he seldom communicates with others outside of his family and two to three

close friends. Although Gratz reported not going to face-to-face or accessing online support groups, he did say that probably should have. Gratz further elaborated on the benefits of attending a support group and stated:

> It would have been nice to see how people who have recently had the surgery, how they're doing and what things were making them sick that were making me sick. There were a few times where I'd get real sick with stuff and it was a rough time. Maybe if I had talked to others it would have been more understood, maybe avoided.

**Member Checking**

While engaged in the analysis process, the researcher developed four questions to seek clarification regarding men's experiences after weight loss surgery. Four questions were emailed to the entire list of research participants to ensure that the researcher fully understood the phenomenon of life after surgery for men. The four questions that were posed include the following:

1. While some of the participants in my study reported that they were in a committed
2. Relationship, some individuals also talked about weight loss surgery in terms of it being a "way out" of their relationship. Some reported that having weight loss surgery can empower a man to leave a relationship if they are no longer satisfied. Can you explain to me in your own words how you make sense of this?
3. Some participants discussed how society views men who have weight loss surgery. Some suggest that from society's perspective, for men, bariatric surgery is frowned upon and means that you are "weak" and "less of a man" because the man could not lose weight without "help." Have you had to deal with these types of messages from society? If so, how did you deal with these messages?
4. Some participants felt inadequately prepared for the changes they experienced after the surgery and suggested the use of therapists could help aid with the adjustment before or

after surgery. What types of changes did you experience post-surgery that you felt particularly unprepared for?

5. Some participants said they had experienced struggles with their wife's jealousy and concern about their own weight. Have you experienced this with your wife? If so, how did you and your wife work through this?

There were two individuals who responded to these questions posed by the researcher. ChampLV4 and Steve provided answers to all of the questions. The most significant question that was answered was question one. In response to the question regarding weight loss surgery being a "way out," ChampLV4 stated, "I think you find yourself more physically attractive and publicly accepted after surgery, thus making it easier to leave the less than perfect relationships because it's easier after losing the weight to meet people." Steve reported that he has left the relationship that he was in when he was interviewed. He said that he was now in a more meaningful relationship with another person which he thinks could evolve into marriage. When Steve was asked about what he thought about surgery being "the way out" he stated:

> Weight loss gives me confidence and encouragement that I am acceptable by not just one woman, but by others. The initial relationship can't blossom into anything more than just a friendship due to the vast age difference between us (22 yrs). This one, the lady is 9 yrs my junior and age doesn't become a concern. We're both mobile and able to "see the world." We are taking our first cruise the beginning of Dec 2011.

ChampLV4 also provided an interesting answer for the fourth question. When asked about the jealousy among his spouse, ChampLV4 stated, "Yes, I have experienced this. Found out she is regularly checking my text messages and internet conversations…she mistakenly took some IM's [instant messages] with another weight loss patient as flirting or more…very annoying."

While participants appeared to not value the use of marriage and family therapists as they were preparing for surgery, they later reflected on the many ways that therapists could have been helpful. They reported on ways in which therapists could assist future clients and families that

are transitioning through the weight loss surgery process. Barriers to mental health and lack of support by medical professionals (lack of medical insurance coverage) also appeared to impact whether individuals were able to access mental health services beyond a psychological assessment. Gender and dominant notions of masculinity also appeared to impact men who sought additional mental health services, although men reported feeling isolated at face-to-face support groups. In the following chapter, the researcher will engage in a discussion regarding theory, how the results fit within the current body of literature, research implications, and clinical implications.

# CHAPTER 5: DISCUSSION

The purpose of this dissertation study was to explore men's perspectives regarding life after bariatric surgery. Therefore, twenty men were interviewed and asked questions regarding self-concept, intimate relationships, and social support. The grand research question for the dissertation study was "How does the process of bariatric surgery influence men's perceptions of self-concept, intimate relationships, and social support?" Five research questions were developed using symbolic interactionism and family systems theory to guide the study. In this chapter, the researcher provides a discussion regarding the research findings. The phenomenology of life after bariatric surgery for men includes the following themes for discussion: (a) becoming a real man; (b) an increase in relationship satisfaction; (c) informal and formal social support matters; and (d) MFTs are invisible but services are valued. In addition, the researcher discusses research implications, clinical implications, educational implications, and policy implications. Future direction for research and strengths are also discussed at the end of the chapter.

## Searching for Masculinity: Becoming a Real Man

The phenomenology of life after bariatric surgery for men includes the topic of masculinity and becoming a real man. During the surgery process men had to cope with perspectives regarding what it means to be a real man. Dominant notions around the idea of masculinity had a huge influence on how men understood weight loss and how men experienced the surgical process (Sabinsky, Toft, Raben, & Holm 2007). The theme "shift in identity construction" is representative of the idea that men who have had weight loss surgery change in the way that they viewed themselves, the way they perceived how they were viewed by others, and the way in which they constructed their identity. Men's identity seemed directly connected to how they understood their own masculinity. Masculinity is a complex social phenomenon, in that it can have multiple meanings based on an individuals' race, class, gender, and cultural

group (Philaretou & Allen, 2001). Masculinity in some ways regulates the actions, behaviors, and thoughts of men. In western society, a "real man" is masculine, has a hard body, and does not ask for help (Galli & Reel, 2009). In addition, a real man presents with muscles, fashion sense, and the appearance of success (Alexander, 2003).

Many of the men in the study reported how they felt uncomfortable with the idea of having surgery. They discussed the idea that having weight loss surgery was admitting that they had a problem that they could not deny. Having surgery meant that men were weak. Men also believed that other men also looked at them in this way. Thus, the men initially delayed weight loss surgery. From the literature on male body image, men who are overweight are considered less masculine. The male body has been referred to as either the "soft body" or the "hard" body. Feminist scholar Susan Bordo (1999) suggested that "The hard body is a symbolic representation of manhood, strength, virility, and dominance, while a soft body is a representation of femininity and weakness" (p. 57). Bordo (1999) also stated, "To be exposed as 'soft' at the core is one of the worst things a man can suffer in this culture" (p. 55).

Men who presented for surgery dealt with the fact that they were viewed as less masculine and with the stigma of asking for help. Many of the men also reported that the people around them, including friends and family, perceived surgery to be taking the "easy way out." The men had to eventually get over having surgery, but the idea of masculinity definitely contributed to a certain level of anxiety in them. For example, there were some men who purposely withheld the fact that they had surgery. They denied that they had surgery and reported that they would prefer to keep their surgery private to prevent others from judging them. The need to keep surgery private arguably also contributes to the marginalization of men who have surgery. This is consistent with the literature regarding men and masculinities as it relates to

barriers to men seeking help for weight loss (De Souza & Ciclitira, 2005; Sabinsky, Toft, Raben & Holm, 2007).

After surgery men viewed themselves more positively, had an increased self-concept, and experienced a shift in identity construction. The term self-concept, according to Zhao et al. (2008) can be defined as the "totality of a person's thoughts and feelings in reference to oneself as an object" (p. 1,817). Self-concept includes four dimensions: cognitive, social, and physical appearance, and self-esteem (Jackson et al., 2009). During the weight loss process men found that they viewed themselves in a more positive way which influenced how they felt about themselves. Part of identity construction and self-concept includes how an individual perceives he is viewed by others. Men reported that they perceived they were viewed negatively by peers, family, and friends, among others. However, they reported that after surgery, they perceived that they were viewed more positively by others for the most part. Therefore, the change in perceived self-concept included both the individual's perceptions of himself as well as the individual's perception of how he is viewed by others. These changes occurred while the individual was transitioning through the weight loss surgery process. The changes that they experienced included the following: (a) changes in perceived self-concept; (b) bodies as evolving entities; and (c) change of attitude from insecurity to self-confidence.

When reviewing the existing literature on body image and weight loss, researchers found that bariatric patients typically experience a kind of identity shift after they undergo surgical intervention (Schroeder, Garrison, & Johnson, 2011). Similarly, "the shift" appears to be positive as they experience an increase in self-concept. Researchers have suggested that prior to surgery, individuals present with a negative self-concept, based on body mass index (Geller, Johnston, & Madsen, 1997); depression (Chen, Jiang, & Mao, 2009; Napolitano & Foster, 2008); negative

body image (Ramirez & Rosen, 2001); and are victims of discrimination and weight based discrimination (Swami et al., 2008). Additionally, researchers have suggested that after surgery, mental health and psychological issues decrease as the person loses weight (Frezza, Shebani, & Wachtel, 2007).

The changes that men experienced included losing a significant amount of weight, feeling more positive about their bodies, and feeling more secure. These ideas all relate to hegemonic masculinity. Masculinity does not only deal with how the body looks, but also with what the body does. After surgery, men were able to become more physically active, which contributed to feeling more positive about their lives. According to Philips and Drummond (2001), "High levels of body satisfaction are exhibited and associated with the ability to perform physical activity well" (p. 95).

Men who had surgery became real men although they still dealt with issues. In many ways, masculinity could be viewed as complex and something that men are always striving to achieve. One question that could be posed is, "does one man ever attain 'real' masculinity?" According to Ricciardelli, Clow and White (2010), "hegemonic masculinity remains an ideal that is not realizable for most men although it represents a benchmark against which men scrutinize their identities" (p. 65). For example, it is true that the men lost significant weight. Some also even became more physically active and started to exercise on a daily basis. In some ways, surgery served to legitimize men and made them feel real and alive. Men received more attention from others, felt attractive, and felt better about how others viewed them.

Simultaneously, although men reported positive feelings, they also felt uncomfortable with their bodies. This paradox is consistent with other studies regarding men's body image (Drummond, 2005). During the study, men reported viewing their bodies as a work in progress,

thus still evolving. Many of the men lost half of their body size or close to it. During the interviews, men reported that they perceived their bodies to be "still a work in progress." They reported that they wanted to lose more weight and that they saw their bodies as still needing improvement. The term "still a work in progress" also represents the perception that men's bodies have not reached their full potential. Moreover, men also reported having some issues with body dissatisfaction. Although men lost weight, many of them still had a "soft body" due to the enormous amount of hanging skin that they had. Many men reported not only wanting to lose weight, but also wanting to gain muscle. Within the literature regarding men and masculinities, the muscular body is viewed as ideal. Pope, Phillips, and Olivarida (2000) state the following:

> We believe the muscular body is the ideal because it is intimately tied to cultural views of masculinity and the male sex role, which prescribes that men be powerful, strong, efficacious - even domineering and destructive…A muscular physique may serve as an embodiment of these personal characteristics (p. 51).

Filiault (2007) postulated a similar belief and suggested the following:

> The reason for such importance of muscle to men may be its cultural association with masculinity, in that muscle is thought to be indicative of masculinity and a man's status as a man (p. 128).

Although their evolving bodies provided affirmable indicators of masculinity, the men still struggled with body image. The struggle with body image may contribute to the increase in men attempting to obtain body contouring after surgery (Song et al., 2006) or an increase in the use of supplements to enhance their bodies (Atkinson, 2007).

It should be noted that men reported feeling more confident in their ability to live a normal well-adjusted life. Prior to surgery, they reported that they felt insecure about their weight and their bodies. However, they mentioned that as they began to lose weight, they started to feel an increased level of confidence. They reported transitioning from a life of mere existence to one that was vibrant. It is important to note that men were depressed, felt alone, and did not enjoy

their relationships prior to surgery. They experienced significant changes which made them self-identify with more positive attributes.

At the same time, the men still questioned their masculinity as they faced the challenge of adapting to new eating habits after surgery. For example, the specter of significant weight loss and reaching the masculine ideal could be lost if men do not adapt to a new eating regimen. In addition, if men do not properly adhere to post-operative eating habits, they could risk going back to the way they were. In this regard, masculinity could be viewed as fragile, as going back to the way they were, and as returning to not being a "real man."

The research findings were consistent with the literature regarding masculinity. Masculinity is a central part of weight loss for men. It appeared that men's decision making process included, or at least was constructed around, dominant notions of masculinity. To have surgery meant to ask for help, which becomes problematic for men who need medical intervention for surgery. The perspective that men simply existed and "were not real" prior to surgical intervention presents a set of negative implications for men's health. On one hand, obese men have to fight for the legitimacy of their manhood. They are put in direct opposition to their bodies based on societal constructions of the ideal masculine body.

Adhering to hegemonic masculinity could in fact play a role in men deciding not to have surgical intervention. In addition, men may still have difficulties living up to the standards of the ideal masculine body even after they lose a significant amount of weight. There needs to be a discourse for men to discuss, confront, and cope with societal notions of masculinity. From a clinical point of view, it might be helpful to help men deconstruct notions of masculinity in order to help them develop a new relationship with dominant hegemonic masculinity. From a clinical perspective, it might be important to assist men with re-authoring their own lives in effort to

dismantle hegemonic masculinity and counteract the internalization of dominant notions of masculinity.

Symbolic interactionism can be defined as a perspective that views human beings as social beings. Symbolic interactionists view individuals and societies as connected (Burbank & Martins, 2010). Individuals formulate opinions about themselves and construct meaning based on their interactions with others. For example, prior to surgery, men reported being viewed as lazy and undisciplined by their family, employers, and peers. Being viewed as lazy played a huge role in terms of how men constructed their identity. Identity construction is a topic that has been discussed in the human development, psychology, and marriage and family therapy fields as it relates to individuals' self-esteem and self-concept. According to Zhao, Grasmuck, and Martin (2008), identity construction is a process that involves both the ‘‘identity announcement" made by the individual claiming the identity and the ‘‘identity placement" made by others who support the claimed identity. This means that an identity is established when there is a coincidence of placements and announcements. Identity construction is described as a social and intersubjective process. A sense of self is produced and reproduced in face-to-face, in-the-moment interactions, which are embedded in specific social contexts and more general cultural-historical epochs (Oyserman & Packer, 1996). Identity construction refers to how an individual conceptualizes the self in relation to others. It includes how an individual represents himself and how an individual perceives he or she is viewed by others.

Men received feedback that influenced how they thought about themselves. Given that social interaction is a bi-directional process, it can be hypothesized that this psychological and emotional shift, a shift in men's identity, has an influence on how the men co-construct their

intimate relationships with their romantic partners after weight loss. Therefore, arguably, identity construction could be co-occurring for both spouses within the family system.

The way that individuals and couples construct meaning around bariatric surgery may also influence how men experience life after surgery. One future study could explore differences and similarities regarding how men and intimate partners co-construct meaning around weight loss surgery. In theory, one could hypothesize that couples have more success in their intimate relationships when they have more similar perceptions regarding the meaning of bariatric surgery. One also could hypothesize that the more unified a couple is regarding the bariatric surgery, the more successful they will be in terms of relationship satisfaction and success with long term weight loss. A future study could examine how the level of cohesion around the meaning making of bariatric surgery relates to relationship and surgical outcomes.

From a family systems theory perspective, men's surgical intervention can be viewed as an attempt to create change within the family system. From a systems perspective, change in one part of the system, impacts the entire system, so it is not surprising to see that surgical intervention created changes for men as individuals and for men's intimate relationships and family systems. From a family systems theoretical perspective, individuals must be viewed relationally. Therefore, men who have had weight loss surgery cannot be viewed as isolated individuals. Men must be viewed as being a part of a larger system which in the dissertation study includes intimate partners, children, extended family, and peers, among others. Reflecting back on the term non-summativity, one must also acknowledge that the whole is greater than the sum of its parts. Therefore, the system that is being changed through the weight loss surgery includes men, their partners, other subsystems, and the interactions among and between each subsystem. Bariatric surgery completely shocks the family system. It induces rapid and

significant weight loss which ultimately impacts everyone within the system. It challenges the status quo or stability of the family system by attempting to create or amplify change (positive feedback).

As men shifted, this also contributed to a significant change for the family system. Prior to the change, intimate partners may have become used to having an overweight man with a negative self-concept and depressed mood. For example, the intimate partner's role in the family system could have been to make their counterpart feel better about themselves. As a result of the intervention, men felt more comfortable with themselves and presented with a more positive self-concept. In addition, the spouse's role as a caretaker may have become obsolete. Therefore, intimate partners may have to re-develop their own identity and role within the relationship. Regardless of whether obesity and negative self-concept are positive or negative attributes, they may work to serve a function for the family system. When change occurs, this function ceases to be a problem, thus altering everyone's role in the system. For example, an intimate partner could feel as if they lost their job (caretaking role). This could contribute to feelings of insecurity, fear, and resentment, among other feelings.

**Increase in Relationship Satisfaction**

The phenomenology of men includes the perception of enhanced relationship satisfaction and intimacy. The term enhanced is indicative of improvement or an increase in effectiveness (Driskell, Copper, & Moran, 1994). Men reported that overall they had a better relationship post-surgery than they had prior to surgery. One of the issues that emerged during interaction with participants was men's perceptions of their romantic partner's insecurity. Men noted that a result of their weight loss process not only included men feeling better about themselves, but also included men perceiving insecurities among their romantic partners. Men reported that their

partners became fearful that the men would want to leave the relationship and find another more compatible partner. This fear, as the men viewed it, contributed to some conflict and issues with social support. Other issues or concerns that were reported, which contributed to insecurities, included perceptions of the intimate partners' issues with their own weight, body image, and self-esteem.

It was found that increased relationship satisfaction was somewhat consistent with the existing literature. The theme is somewhat consistent because the existing research that has been conducted is dated and has shown mixed results. For example, Rand, Kuldau, and Robbins (1982) found that clients benefit from improved couple and marital relationships post-bariatric surgery. For example, in the study by Rand et al. participants "rated their marriages as good, reported better relationships with their spouses, and experienced an enhanced sexual functioning" (p. 1419). However, other researchers have found that couples experience stress, turmoil, extramarital affairs, marital instability, separation, and divorce, after weight loss surgery (Macías, Leal, López-Ibor, Rubio, & Caballero, 2004; Neill, Marshall, & Yale, 1978). In this study, men emphasized their commitment to their relationships with partners and reported an enhanced relationship after surgery.

The discussion of intimacy has been centered around sexual intimacy, with less of a discussion regarding emotional intimacy. The researchers who have examined sexual intimacy in individuals after bariatric surgery have concluded that sexual frequency increases and sexual intimacy improves (Camps et al., 1996; Kolotkin et al., 2008). The research that has been conducted has mainly consisted of women in the sample. It appears that sexual intimacy and frequency improve as individuals start to lose weight and improve in how they view themselves. It also seems logical that this happens for men who lose a significant amount of weight, similarly

to women. The theme of increased relationship satisfaction provides new information regarding the topic of bariatric surgery for men.

A new finding is that while men experienced increased sexual intimacy after surgery, many also still desired additional sexual interaction. The new sexual desire may contribute to concerns and or conflict within couple relationships. One notable aspects of the phenomenon regarding sexual intimacy, is that while men may have the desire for more sexual interaction and intimacy, their spouses who have not undergone weight loss surgery may not experience the same desire. One possible scenario could include a couple where one partner is sexually incompatible with the other partner. The incompatibility could be new information that comes to light after surgery. While the men in the study reported being committed to their romantic partners as discussed earlier, they may have also had difficulty with commitment. While no men in the study specifically discussed infidelity, many of the men reported receiving romantic attention from outside of their intimate relationships.

A question that may emerge is how do men cope with conflict within relationship? For example, one participant reported flirting with other women. More research is needed to explore what happens when one partner desires sexual intimacy while the other does not. Conflict and issues around sexual intimacy could possibly lead to break up, separation, divorce, infidelity, porn addiction, and an increase in masturbation (Metz & Epstein, 2002; Young, 2004). The existing scholarship suggests that infidelity is likely to occur after surgery (Macias et al., 2004; Mauro, Taylor, Wharton, & Sharma, 2008; Meana & Ricciardi, 2008, Neill, Marshall, & Yale, 1978). However, the men in the study reported that there were no occurrences of infidelity. At this point, it is important to note that the research on infidelity, for the most part, has been based on women as it relates to weight loss. Only one article indicated that men have lower levels of

infidelity when compared to women. Brand, Markey, Mills and Hodges (2007) conducted a study consisting of 543 participants and found that women reported being as unfaithful or more unfaithful than men. The researchers assessed for sex differences in the prevalence, incidence, reasons for, and consequences of infidelity. The study consisted of researchers administering questionnaires to a large undergraduate population at a university in the Pacific Northwest, including 391 women and 170 men. In the study, the average age was 19, but the range was 17-36. The researchers conducted a chi square test and found that more women (31.4%) reported infidelity than men (24.0%), with a Pearson's chi square=3.08 (p=.08).

In addition, there may be issues related to how infidelity is defined. Infidelity is mostly discussed as it relates to sexual infidelity. There has been less discussion regarding emotional infidelity. For example, one individual reported that he engaged in online interaction with a woman who provided romantic attention. This participant did not classify his interaction as infidelity as he was not physically involved with the person. There are debates regarding if online interaction with someone should be viewed as infidelity (Mileham, 2007). Another issue that could contribute to the finding could be related to the concept of social desirability (Mortel, 2008). According to Crutzen and Goritz (2011), "social desirability is the tendency of respondents to distort self-reports in a favorable direction" (p. 1). According to Herbert et al. (1997), "social desirability (the tendency to respond in such a way as to avoid criticism) and social approval (the tendency to seek praise) are two prominent response set biases evident in answers on structured questionnaires" (p. 1046). Men may feel compelled to give what they perceive to be socially desirable answers.

For the first time in a long time, men were able to have relationships with their wives that included an increased level of emotional and sexual intimacy. Prior to intervention, they were not

connected due to feelings of physical and sexual inadequacy, isolation, shame, and guilt. During the weight loss surgery process, men are simultaneously co-constructing a new relationship with their romantic partners. Perhaps, men now can have the type of relationship that they had longed for. Perhaps, they see their new identity and role as being more appreciated by their spouse. Another result of surgery was the feeling that men were not only becoming real men, they were in fact becoming better humans, better husbands, and better fathers. While fatherhood was not discussed explicitly, it was viewed as a very important part of the men's lives. Going back to motivating factors of surgery, most men reported wanting to have surgery to improve their health. However, the entire dialogue about health was centered around the idea that the men wanted to be around for their children and wives or girlfriends. If it is true that one reason men obtained surgery in the first place was to become real and have a more stable position within the family, it could make sense that once they lost weight, they decided to stay in their relationships and remain faithful to romantic partners.

Another explanation for the lack of reporting infidelity may be that these are men in transition. The men in this study simultaneously are changing the way they see themselves as men and as men in their committed intimate relationships. There could be a number of other reasons why the results of the dissertation study rendered different outcomes than the existing research. One issue is that the research that has been done has focused on patients who are women. There may be a difference in how men and women make sense of bariatric surgery and infidelity. Most of the men in the study were married for a significant number of years, which may contribute to an increased level of commitment and a lack of response to romantic attention from others. Likewise, most of the participants had children, which could have played a role in their desire to remain committed to their spouses. Similarly, most of the men reported being of a

religious denomination and reported possessing a strong faith in a higher being, which could have contributed to their level of commitment to their relationships.

The other new finding that emerged in this study was that of stronger emotional intimacy through better communication. Better communication included feeling more comfortable with engaging in communication, increased frequency of communication, and less tension regarding discussing thoughts, feelings, and areas of conflict. The researchers who have conducted previous studies regarding bariatric surgery and couples have not explored emotional intimacy or patterns of communication patterns. Additional research related to emotional closeness, communication, and sexual interaction, could be conducted to further explore emotional intimacy.

From a family systems theoretical perspective, increased relationship satisfaction makes sense as the surgical intervention created a change that impacted the entire family system (Alexander, 1973). The main aspect of family systems theory that is relevant to the study is that change is inevitable and ultimately impacts everyone (Boulding, 1956). From a family systems perspective, individuals experience the most stress during periods of transition. Weight loss surgery ignites a transition phase for individuals, couples, and families. How a system broaches bariatric surgery may in fact influence how a couple experiences life after weight loss surgery. From this theoretical perspective, an open system may produce a more positive experience for individuals, couples, and families. A system that is open is more accepting of change, whereas a closed system may produce a negative experience as closed systems may not embrace change. In addition, one hypothesis could be that a more positive experience may contribute to a better outcome in terms of long term weight loss. Also, preparing individuals and couples for such a significant change may produce a better outcome for the entire family system.

Family systems theory also could be applied to the notion of men receiving romantic attention from others outside of their intimate relationships. When thinking about change and the concept of wholeness, experiencing romantic attention could both impact men and their partners. For example, the increase in attention that men received perhaps could contribute to men's increase level of self-confidence and self-concept. As the men received more positive attention from others (through the social interaction with spouses, peers, friends, and co-workers, among others), they felt better about their bodies, about their level of attractiveness, and about their ability to perform sexually.

However, the increase in self-confidence could also influence the intimate partner's level of security within the relationship. The perceived insecurities could have been related to fear of not knowing their role and position within the relationship. Insecurities can be viewed as being directly related to the feedback (social interaction) that intimate partners received from men after surgery. Intimate partners may have felt insecure based on information received during their interactions with the men. However, it is important to note that there were 13 men who reported that they did not perceive their partners to feel insecure in the relationship. Perhaps, other variables such as pre-existing relational conflict and partner's mental health may explain men's perceptions of romantic partner insecurities. Thus, men's demonstration of commitment could have been a contributing factor to partners not feeling insecure.

In the same vein, from a symbolic interactionism perspective, relationship satisfaction could be connected to how men communicate their level of commitment. Through social interaction and communication, men contribute to how partners make sense of their relationship. Romantic partners may perceive surgery as a threat to enhanced relationships based on how they interpret their interactions with men. However, a threat to relationship satisfaction is the

perceived emergence of partner insecurity that results from the romantic partner's interactions with the men after rapid weight loss.

One important aspect of symbolic interactionism theory that is related to enhanced relationships is meaning making. It appears that individuals have a variety of ways that they interpreted and made sense of weight loss surgery. Meaning making is developed based on an individual's interaction with the outside world. For the men, it appeared that weight loss surgery meant a new beginning, a second chance, a way to improve one's life, and a way to become a real man. Based on some of the feedback that was received by seven men, it could be hypothesized that women may view weight loss surgery as initiating the end of a relationship and an escape clause. During the interview, some men reported that women alleged that their partners wanted to have surgery so that they could leave the relationship. One future study could include exploring how meaning making differences around weight loss influence couple dynamics. It would make sense for a spouse to become insecure within a relationship if they perceived the main outcome of weight loss to be about abandonment.

However, perhaps romantic partners would not feel as insecure regarding the process if they focused on the concept of surgery being about a new beginning, a new relationship, and health. When one person shifts and the spouse does not (in the case that one has surgery while the other stays the same), it can contribute to the spouse feeling as if the man has one foot in the relationship and one foot outside of the door (Neill, Marshall, & Yale, 1978). An increase in self-concept in one part of the relational system could in fact contribute to a decrease in self-concept in a spouse, especially if now the person who loses weight becomes the center of attention, while the spouse becomes viewed as lazy and non-supportive for not keeping up and losing weight. This could contribute to the man feeling guilty about having surgery and could contribute to the

spouse feeling guilty for not losing weight (assuming they both needed to lose weight) (Ravitch & Brolin, 1979).

While an increase in self-concept is important especially for men who presumably were depressed prior to surgery, this same positive attribute can also create an imbalance within the relational system. The way that weight loss surgery is socially constructed by individuals within the relationship and by others outside of the relationship also contributes to how individuals respond to surgery. How individuals create meaning around surgery does not just influence relational systems as it relates to perceived insecurities, but also influences couples in terms of social support.

**Informal and formal social support matters**

Informal and formal social support is an important part of the adjustment that individuals make after bariatric surgery. During the research the men reported on the fluidity of social support as it relates to transitioning through the weight loss surgery procedure. The term fluidity suggests that there was variation within the type of social support received by men, how and whom provided social support, and the consistency of it over time. The term fluidity suggests a degree of constant changes and may be perceived as the opposite of stability (Onorato & Turner, 2004). Men obtained support from their spouses, peers, and families, while experiencing areas (such as diet and exercise) where they felt lack of support from the same individuals. While men received support and lack of support from their romantic partners, peers, and families, they also at the time interacted with men through face-to-face and online support mechanisms.

For example, men reported that their intimate partners assisted with providing medical care, gave words of encouragement, and provided financial help, and held them accountable as it related to making sure that they adhered to post-operative diet. Formal social support was viewed

equally as important if not more important for men at times. Many men emphasized a need to interact with others who were "like them." Some men reported that while their family tried to be supportive, there were some areas where there was a lack of connection. Men reportedly felt more included in online support when compared to face-to-face support groups as face-to-face support groups consisted primarily of women counterparts. They also appeared to desire a place of their own where they could talk about men's issues, concerns, and experiences. The term fictive kin and kinship network surfaced when conducting interviews. Many men reported that their formal support systems were "like a second family." The importance of social support has been discussed in the literature (Kayman, Bruvold, & Stern, 1990). Thus, the use of both informal and formal social support networks indicated fluidity in how social support was received and utilized.

While there has been some discussion regarding various mechanisms of social support as it pertains to weight loss, there has not been a substantial discussion regarding how men gain social support. In addition, there has not been significant discussion regarding the role that spouses play in social support for men who have weight loss surgery. The existing literature is saturated with discussions around social support as it relates to long-term weight loss. Researchers have focused on examining if individuals who participate in social support groups lose more weight when compared to clients who do not participate in support groups. In a like manner, there has been a discussion about the emergence of the internet for weight loss support, (Saperstein, Atkinson, & Gold 2007). However, there has not been any discussion regarding men who utilize online weight loss support groups.

**Barriers to social support.** When reflecting back on family systems theory, one acknowledges that families are self-regulating systems (cybernetics). How one self-regulates

depends on the rules of the system. One rule within some family systems could be that men are supposed to be overweight. Obesity therefore could be viewed as serving the function of stabilizing the family system. Furthermore, as suggested by Doherty and Harkaway (1990), obesity could be viewed as a bond and represent loyalty. Therefore, weight loss surgery could be viewed as an attempt to challenge the system, and in essence could be viewed as breaking the family's rules. Many of the men in the study experienced periods where they felt that their intimate partners, extended families, and even peers were not accepting of weight loss surgery. Many of the men felt as if they were not supported and received negative comments by others. From a systems perspective, the lack of support (negative feedback) could be viewed as an attempt to divert the system back to the way it was prior to surgery (homeostasis).

Related to homeostasis is the concept of open and closed systems. Within an open system, families might be more encouraging and supportive as men transition through the weight loss surgery process. Also, a closed system might deter men away from maintaining a healthy lifestyle after surgery. A future study could include exploring the factors that contribute to a system being open or closed. One of the things that were discussed by men was their partners' inability to understand the drastic changes required after surgery. Some men reported feeling guilty about leaving the home to go to the gym. Men's feelings of guilt occurred based on the interactions they had with intimate partners. Through social interaction, men received feedback which made them more confident or less confident about their new identities. Cooley's term, the looking-glass self, seems to be pertinent here as the men based their perceptions of self through the eyes of others.

Family systems theory also is applicable to the topic of social support specifically as it relates to meaning making. How a family makes sense of weight loss and how open a family is

to weight loss will determine the extent to which it is accepted into the system. Likewise, how individuals within a man's social network construct meaning around weight loss surgery will also determine to what extent a man receives social support. In some ways, social support could be a threat to the relationship. It could be viewed as contributing to the demise of the relationship. If a spouse perceives social support to be about their husband being taken away from them, then it could make sense that they would have a negative perspective regarding their spouse participating in social support. The fact that spouses reportedly did not participate in social support groups in-person or online makes one wonder how they make sense of social support. Do spouses like the idea that their partner is forming new relationships and bonds with other people, some of which could be women who have had weight loss surgery? Do romantic partners they see social support as interfering in their interpersonal relationships with their partners? Even when simply thinking about the time social support takes away from the home, a scholar could hypothesize that social support could have a negative impact on the couple and family system. Face-to-face support requires traveling to a meeting which takes away time from home and time spent with spouses and children.

Within online support men may be physically present (in the home) but emotionally disconnected to home life. Online support requires a certain level of emotional engagement which could be viewed as counterproductive to establishing and maintaining a healthy relationship with a spouse (Young, 1999; Young, 2004). In addition, social support contributes to men feeling better about themselves as they are able to share in group identity. The increased self-concept obtained from interacting with others who share similar experiences could also contribute to a shift in self-concept of the spouse. For example, through social support similar to group therapy, men may experience transference as they interact with other men (Dore, 1994;

Glatzer, 2010; Guttmacher, 1971). This change in social support obtained by men may influence romantic partners (interdependence). As men feel more comfortable about their bodies and their experiences, presumably, their spouses could in fact start to feel alone, abandoned, left out, depressed, and isolated. It may be worth exploring the topic of social support from more of a relational perspective to promote inclusion of spouses, partners, and children with the consideration that weight loss surgery is a family process and not simply an individual process. Weight loss surgery impacts the entire system, so it may be worth thinking about how to work with the whole family so that men can receive support, but that children and spouses also receive support as they are experiencing a huge shift themselves.

**MFTs Are Invisible But Services Are Valued**

Men reported being hesitant and perhaps apprehensive about mental health services. Beyond meeting with a mental health professional for a psychological assessment required to have surgery, men did not see the usefulness of mental health services. Some men reported having negative experiences when interacting with mental health professionals. Perhaps men's resistance to accessing mental health professionals relates to the men's constructions of masculinity. Some men admitted that they did not feel comfortable asking for help and that a stigma was attached to mental health services. In order to seek help, men have to admit that there is something wrong. If we go back to identity construction, one acknowledges that a substantial part of identity for men is being tough. It could be hard to admit that there is a problem to the world. Admitting this could in fact require men to take off the guise of toughness and masculinity. It may actually require men to be vulnerable in a way that is frowned upon by the larger society. For example, psychologist Frank Pittman (1993) suggests that men often pose masculinity. He further states that "men go through life struggling with what they believe to be

the demands of their masculinity" (p. 4). There have been numerous authors who have written about men being apprehensive about seeking services. For example, Liburd and Namageyo-Funa (2007) found that dominant notions of masculinity have prevented men from seeking services and addressing health concerns regarding Type II Diabetes. A number of researchers have suggested masculinity scripts also prevent men from seeking mental health services (Branney & White, 2007; Mahalik, Good, & Englar-Carlson, 2003; Parent, 2011).

One of the other barriers to men seeking mental health services has to do with larger social and political issues. Within the medical field, there is a lack of value placed on mental health services by primary health providers and medical insurance providers (Appelbaum, 2003). There is also a history of discrimination regarding mental health reimbursement with a) mental health services not being covered by medical insurance companies, and b) consumers being responsible to pay for mental health services out of pocket. When considering class and social economic status, finances definitely pose as a barrier to seeking mental health services. Within the mental health field, the cost of the psychiatric assessment which is not always covered by medical insurance can cost $400 for an hour or two (Pierce, 2011). In addition, the average cost of a therapy appointment can be anywhere from $90 to $250 per hour depending on the credentials of the professional (e.g., clinical social worker, professional counselor, marriage and family therapist, psychiatric nurse practitioner, psychologist, psychiatrist) (Pierce). The cost of healthcare and the lack of coverage pose as a barrier for many weight loss surgery clients. In addition, there may be a shortage of mental health providers who accept certain types of medical insurance. Medical insurance companies have a history of reimbursing mental health providers at lower rates when compared to primary health providers. This has contributed to some mental health professionals refusing to accept certain forms of medical insurance. While several states

may have implemented new strategies to address the mental health reimbursement crisis (e.g., the Mental Health Parity Act,) there are still problems inherent which pose as barriers to mental health (Appelbaum, 2002).

Although there is research which suggests that collaborative healthcare including mental health could be beneficial (Glenn, 1987), there is still a lack of mental health services in medical settings. Despite research which suggests that there are psychological and social components to some medical issues, medical providers and insurance companies are slow to include mental health professionals and to reimburse for their services. In addition, to their being a lack of focus on mental health and a biopsychosocial model of healthcare, there is a lack of value as it relates to systemic treatment (marriage and family therapy) within primary health care settings.

While advocates within the field of marriage and family therapy have made strides in their efforts to create and effect change in policy (e.g., U.S. Department of Veteran Affairs, and substance abuse), there is still a lack of visibility of marriage and family therapists who work within medical settings. Medical family therapy is becoming popular within the field, but mental health providers still are met with resistance by some medical professionals and insurance providers (Gitterman, Sturm, & Scheffler, 2001). There also is inherent lack of value regarding the need for systemic treatment. This impacts the ability of marriage and family therapists to become more involved in systemic treatment of medical issues such as obesity and weight loss surgery. Historically, the field of marriage and family therapy has had difficulties in gaining acceptance as qualified mental health providers (Shields, Wynne, McDaniel, & Gawinski, 1994). Also, marriage and family therapists have had issues with gaining medical insurance reimbursements specifically as it relates to a treatment issue that is of a relational nature (Simola, Parker, & Froese, 1999).

While there are a variety of barriers to seeking mental health services as it relates to the weight loss surgery process, men did acknowledge areas where mental health services could have been utilized during the surgical process. They reported that therapists might be able to work with men both prior to surgical intervention and after surgical intervention. Men also reported that spouses could be included in therapy to address couple concerns. Men also discussed specific concerns for men and ways to make therapy more approachable as it relates to environmental factors such as the location of therapeutic services.

The theme of marriage and family therapists being invisible, but their potential services being valued was a new finding. The existing scholars in the field have not discussed men's perspectives regarding mental health as it relates to obesity and weight loss surgery (Hebl & Turchin, 2005). It appears that the very topic of marriage and family therapy intervention for obesity and weight loss surgery has not been discussed specifically for men. There has not been a discussion specifically about how to work with men and how to attend to men's issues or concerns. In additional there has not been a discussion regarding ways to make therapy more accessible for men who may be confronted with the inherent stigma of seeking services. Future research should explore therapeutic intervention for men in order to further examine the phenomenon and address the gaps in the literature specifically regarding obesity and men.

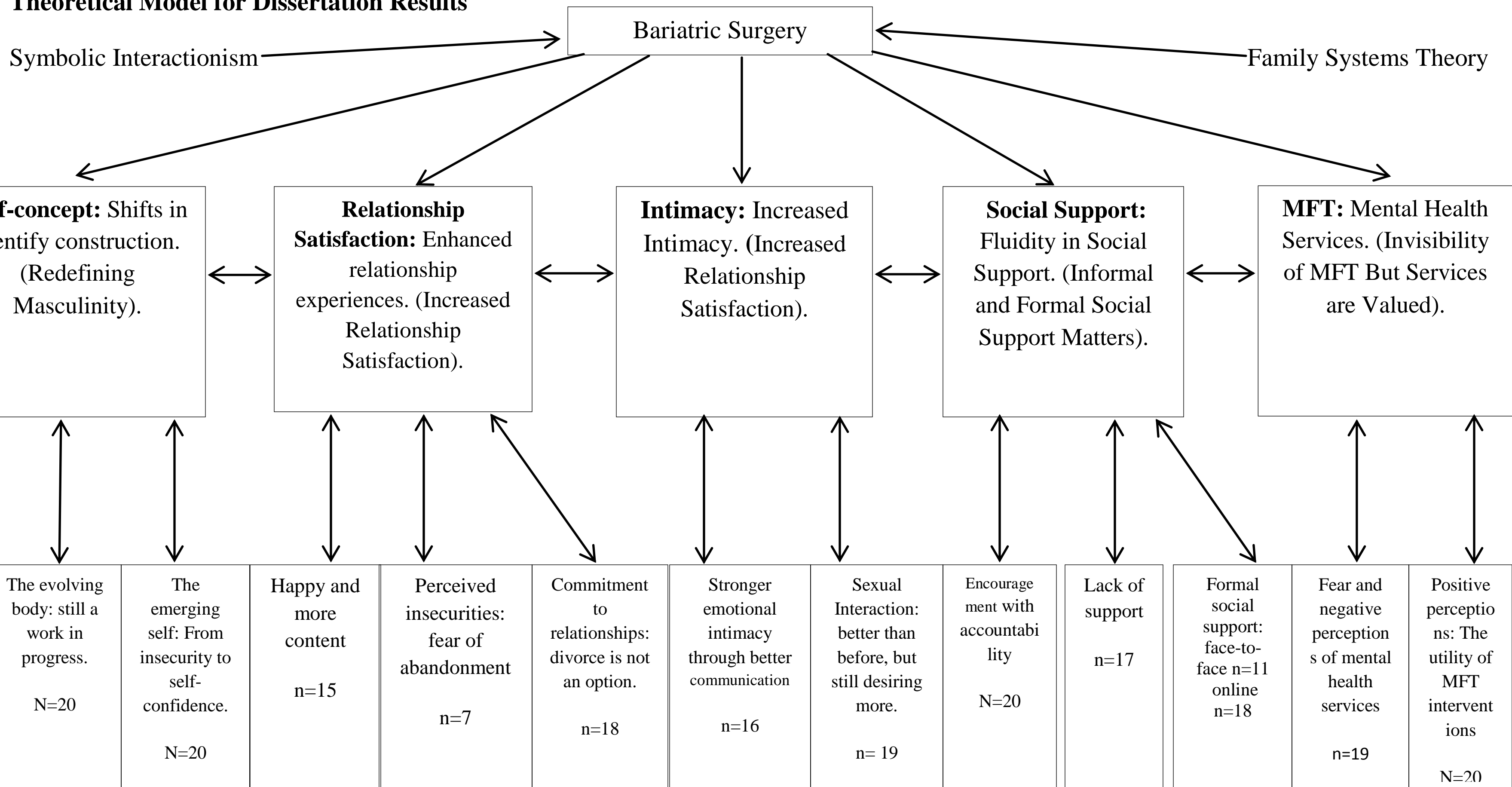
Symbolic interactionism relates to how individuals understand and interpret the social construction of mental health services. The value of mental health services is determined by how society defines it. Individuals within society negotiate and construct meaning around mental health. For instance, masculinity scripts become internalized by men based on their interactions with society. Masculinity scripts promote the idea that it is not fitting for a man to request mental health services. Unfortunately, this contributes to men "suffering in silence."

Family systems theory relates to the findings in that weight loss surgery impacts the entire family system. It makes sense that men were able to reflect on areas where they could have benefited from working with a marriage and family therapist. MFTs utilize family systems theory as a way to conceptualize relational systems (Nichols, 1984). MFTs also acknowledge that change can be met with resistance, fear, and anxiety (Harkaway, 1986). Men reported that they could have used a marriage and family therapist to assist with helping the couple prepare for surgery and adjust to life after surgery. A marriage and family therapist would utilize systems theory in thinking about the family as an open or closed system. They would also employ concepts of interdependence, recursion, and feedback loops in their clinical work with clients.

Family systems theory and symbolic interactionism focus on different aspects of life after bariatric surgery. However, both theories must be viewed together in order to obtain a full understanding of the results of the dissertation study. Bariatric surgical intervention is a complex phenomenon. Focusing on the family system without including an analysis of the social interactions that occur between and among couples, extended family, and peers omits a critical piece of the weight loss surgery process for men. Conversely, focusing on the social interactions that occur between individuals without including an analysis of the family system omits important context factors needed to understand the complexities inherent in obesity and weight loss. Family systems theory and symbolic interaction theory intertwine through the topic of bariatric surgery. The two theories operate at different levels of abstraction, but must be viewed from an integrative epistemology. **(See Figure 2 for the Theoretical Model of Dissertation Results).**

**Figure 2**

**Theoretical Model for Dissertation Results**



**Research Implications**

There are a number of research implications that have emerged from the dissertation results. Bariatric surgery was found to not only impact men as individuals, but was also found to have a significant influence on intimate relationships. A shift in identity construction emerged as a theme that impacted men and their partners. In this study, it was revealed that as men experienced a positive self-concept, some of their partners may have shifted by developing a negative self-concept. One recommendation is that future research includes romantic partner's perceptions of identity through the weight loss surgery process. Another aspect that could be further explored in a future study includes open and closed systems. Some of the family systems involved in the dissertation study could be defined as open systems, while others could be defined as closed. One hypothesis is that a closed system might deter men away from maintaining a healthy lifestyle. In a future study, researchers should explore factors around what contributes to a system being open or closed.

A future study could be conducted to investigate if preparing individuals and couples for surgical intervention would produce a better surgical and relational outcome. For example, one hypothesis could be that a couple's negative experience after surgery is in some way connected to pre-existing marital conflict. A researcher could explore if some sort of intervention to reduce pre-existing conflict might have a more positive outcome in terms of relationship satisfaction and long term weight loss. In addition, a researcher could conduct a study utilizing an experimental design and could incorporate a pre- and post-test to test the effectiveness of a specific intervention. One of the topics discussed in the theoretical section was that of couple's cohesion

around the meaning making of bariatric surgery. A future study could be conducted to examine how the level of this cohesion impacts relationship and surgical outcome.

One of the factors that was also investigated was men's level of commitment to their partners. A future study could be conducted to further explore factors that influence men's level of commitment. Social support was discussed and is viewed as an important factor for successful weight loss surgery. During the study men received social support from within their couple and family system and also received support from outside of their couple and family system. A future study could be conducted to examine which type of support (informal, face-to-face, or online) is the most helpful for men in terms of influencing long term weight loss. Future researchers should conduct a study to examine how men's interactions with formal support outside of the family system influences couple relationships.

The dissertation study was centered on men and their experiences and perspectives. Acknowledging that men are only one part of a system, a future stud could include women. For example, a future study could explore how intimate partners experience life after a partner's bariatric surgery. In addition, one could conduct a study where couples are interviewed as dyads and compared to other couples regarding their experiences after surgery. Life after bariatric surgery was the focus of the dissertation, but there appears to be significant information that might be relevant that occurs within intimate relationships prior to surgical intervention. A future study could be conducted to explore more information regarding family dynamics prior to surgical intervention.

While the focus of the dissertation study was on men who had surgical intervention, research could be expanded to include medical professionals (doctors, nurses, registered

dieticians) and mental health professionals (psychologists, counselors, and marriage and family therapists). A future study could include an exploration of medical doctors' perspectives regarding weight loss surgery for couples. Perspectives regarding the utility of marriage and family therapy intervention in obesity treatment could also be explored in a future study. Additionally, a future study could include an investigation into how marriage and family therapists make sense of working with weight loss surgery clients.

In addition to the research implications the researcher will expand the research topic in a number of ways. The researcher plans to conduct a similar study exclusively with African American men to assess for additional contextual factors. During the dissertation study, the researcher was not able to recruit any African American participants. Researchers have suggested that there are a number of factors that impact if an African American would agree to participate in scholarly research. One factor that may potentially pose as a barrier for African American men may include a negative history of being exploited in research studies (e.g., Tuskegee Syphilis experiment, 1932-1972). While there are current debates regarding the reasons behind the lack of African Americans participating in research, there are definitely cultural notions and historical events that might suggest distrust (i.e., Skloot, 2010; Washington, 2008).

According to research, obesity disproportionately impacts African Americans (Cossrow & Falkner, 2004). Therefore it is important to explore men's perspectives regarding obesity and weight loss surgery. In a future investigation, a sample consisting of African American men could be utilized to explore cultural group differences. While reflecting back, I am not sure exactly why I was not able to obtain participants who are African American. There is forum on

obesityhelp.com that is specifically tailored for African Americans that could be used as one source to recruit participants. The researcher also found a number of African American weight loss surgery clients on YouTube, but most of them were women, or did not respond to my recruitment page. YouTube could be utilized as a possible referral source in the future. With African Americans being depicted in the media as undergoing weight loss surgery (i.e., Al Roker, Milt, 2003), research should be conducted to explore how weight loss in African American men shapes men's identity and couple and family relationships.

During the dissertation, the researcher actually sent Al Roker an email to see if he would consider being in the study. Unfortunately, the researcher did not get a response from the celebrity. It would have been fascination to hear the perspectives of an African American man who is a well-known celebrity. It also would be fascinating to include African American couples in a future study to explore relational aspects of weight loss. After graduation the researcher plans to apply for funding through the Health Disparities Research Grant program or the clinical research grant program for individuals from disadvantaged backgrounds through the National Institute of Health (US Department of Health and Human Services, 2010) to conduct a study utilizing a sample of African American men.

A variable that could be explored in a future study is sexual orientation. A future study could utilize a sample of gay men to see if their experiences are similar or different from heterosexual men. The dissertation study focused on heterosexual participants. However, while recruiting for the dissertation study, there appeared to be a lot of interest from the Gay Lesbian Bisexual and Transgendered community (GLBT). When the researcher visited hospitals in Georgia, he was approached by a significant number gay and bisexual men who expressed

interests in the study. Many individuals asked if the researcher was considering including gay men in the dissertation study or in future studies. For example, while visiting a hospital in South Georgia, the researcher was asked by a medical provider if gay men could participate in the study. The medical provider reported that the experiences of gay men could provide an alternative perspective regarding obesity and weight loss. For example, one medical provider reported that she knew a heterosexual man who decided to explore a same sex relationship after having bariatric surgery.

In addition, there were a few men who identified as gay who connected with me through Facebook and Youtube who expressed an interest in my study. Along with that, obesityhelp.com and lapbandtalk.com have forums specifically that target the GLBT community, which could be used for recruitment in a future study. While on Facebook, the researcher received a chat request from a man who identified as gay. This individual went on to report that his weight loss impacted his relationship with his partner. Although he was not able to be included in the study, it was fascinating to hear alternative perspectives regarding the phenomenon. A future study could also include a sample of men who identify as gay specifically as it relates to shifts in identity construction. Researchers suggest that body image and masculinity is complex for gay obese men (Duncan, 2007). Researchers also have suggested having a larger sized body is one way for some gay men to exert their masculinity (i.e., bears and cubs; Manley, Levitt, & Mosher, 2007). Presumably, weight loss could challenge one's masculinity and contribute to changing one's identity through interaction with others. Gay and bisexual men and their spouses could also be incorporated into a future study to explore the relational dynamics that occur during weight loss surgery process.

**Clinical Implications**

The fifth research question in the dissertation study had an applied practice focus and included exploring men's perceptions of marriage and family therapists as it relates to bariatric surgery. Men identified a number of areas where marriage and family therapists could intervene and provide assistance during the life-after-surgery process. Many of the participants reported that marriage and family therapists could provide assistance to men by helping them prepare for surgical intervention. As noted in the theoretical model, bariatric surgery impacts men as individuals and in the context of their couple relationships. Men reported that there may be some issues or concerns that they may feel more comfortable addressing in the context of individual therapy. Men reported that marriage and family therapists could assist with identifying reasons why men overeat, addressing issues related to body image, attitudes towards food, and sexual intimacy. In addition, men also discussed the benefit of a marriage and family therapists working with them and their intimate partners prior to surgical intervention. They reported that marriage and family therapists could help couples prepare for having surgery by discussing motivations for surgery, goals and expectations for after surgery, intimacy, social support, self-esteem, and couple dynamics.

Another thought that was disclosed was that MFTs could assist with facilitating communication regarding fear, insecurity, relationship dynamics, and intimacy, among others. From a secondary level of intervention, marriage and family therapists could facilitate more in-depth work with clients who may be at risk for developing barriers to long-term success in terms of weight loss and couple relationships (i.e., high level of marital discord, relational dissatisfaction, lack of support system). From a tertiary level of intervention, marriage and

family therapists could work with individuals and couples who have already struggled with barriers to successful weight loss and positive couple relationships.

One of the topics discussed during the interviews was related to formal social support. Men reported that they benefited from interacting with others who have had weight loss surgery. Marriage and family therapists could assist men who have had weight loss surgery by facilitating support groups. One of the concerns that were raised regarding face-to-face support groups was the fact that men felt isolated as support groups consisted of primarily of women who have had surgery. Marriage and family therapist could provide face-to-face support groups that are specifically for men. In addition, marriage and family therapists could provide group therapy for men. Group therapy would allow men the opportunity to address mental health and psychological issues, which is currently not offered in traditional face-to-face support groups. Group therapy would also provide a safe space to discuss issues, concerns, and experiences. Marriage and family therapists could also provide support groups and group therapy for intimate partners so that they could have a space to address any issues or concerns with other partners. In addition, support groups and group therapy could be implemented for couples, children, and extended family.

One of the other concerns discussed by men related to therapeutic intervention included confidentiality. One of the benefits of online social support is that men can interact with others but also have their confidentiality protected. During the study one participant in particular reported that he would be interested in working with a therapist if he could do it utilizing video conferencing technology such as Skype or Face Time. While the field of marriage and family therapy does not necessarily have protocols regarding online therapy, it is a mechanism that

more therapists are utilizing to work with clients. Assuming that ethical issues are addressed and applicable licensing laws are followed, online therapy could be a viable option for men who have had weight loss surgery. In addition, therapists could also incorporate the integration of online social networks as part of the therapeutic services. The researcher does admit that online therapy is still controversial and there may be some ethical concerns utilizing online methods of mental health treatment. However, researchers have suggested that increasing numbers of professionals are using online therapy to reach wider audiences (Morak et al., 2008; Riva, Bacchetta, Baruffi, & Molinari, 2001). While online treatment has been under recent critique by mental health professionals including marriage and family therapists, its predecessor, telemedicine therapy, has been incorporated by medical professionals and mental health professionals to treat individuals who reside in rural areas (Russell, 2004). Satellite therapy has also been incorporated into treatment programs for individuals who are in the military so that mental health and medical professionals can gain access to officers who are deployed overseas or who, for other reasons, are inaccessible (Detweiler et al., 2011).

Another way in which marriage and family therapists could work with men could be through the incorporation of home-based therapy. During the study, one of the participants reported that he would be more willing to work with a therapist if the therapist came to their home. While home-based therapy historically has been implemented with children and families (i.e., Functional Family Therapy, intensive family intervention, multisystemic therapy), it has also been used in working with obese populations. For example, home-based therapy has been shown to be effective in the treatment of obesity among African Americans (Ellis et al., 2010).

Therefore, home-based therapy could be a viable option for working with men who have had weight loss surgery.

Marriage and family therapists could utilize the existing therapeutic models when working with men and their romantic partners (i.e., Structural family therapy, Harkaway, 1986; and the family firo model, Doherty & Harkaway, 1990). However, research suggests that there are no major differences in terms of the outcomes obtained by specific models (Lambert & Bergin, 1994). In addition, from a common factors perspective, there are four factors which are shared between different psychotherapy approaches, which include client and extra therapeutic factors; relationship factors; model and technique factors; and placebo factors (Miller, Duncan, & Hubble, 1997). According to Blow and Sprenkle (2001), model techniques only account for 15% of therapeutic change, whereas client and therapeutic relationship accounts for 30% of therapeutic change. Therefore, instead of focusing on one specific therapeutic model, one may suggests utilizing an integrative therapeutic approach and focusing on joining and developing a favorable client therapeutic relationship.

In addition, it may be more important for therapists to concentrate on how they approach working with men. Many of the men in the study reported that they dealt with issues regarding masculinity, perceived weakness for having surgery, and negative feedback received by others. Therefore, it may be advantageous for therapists to approach men in a way that is non-judgmental. It may also be important for therapist to take the non-expert and one down approach when working with men and their partners (Anderson & Goolishian, 1992). A one-down approach and non-expert approach are techniques that are employed by many postmodern therapists in efforts to make clients feel comfortable in the therapy room (Monk & Gehart,

2003). The premise of these techniques includes the idea that the client is the expert of their own life experiences. Therefore, therapists must approach the client from a position of curiosity and must make a conscious effort to ask questions in a way that is inviting. Some possible techniques that could be utilized include the use of circular questioning (Penn, 1982); scaling questions (De Jong & Miller, 1995); unique outcomes (White & Epston, 1990); exception questions (Berg, 1994); reframing (Watzlawick, Weakland, & Fisch, 1974), and re-authoring (White & Epston, 1990).

**Implications for Training and Education**

As part of the applied research question, participants were asked about how they perceive the role of marriage and family therapists during the process of life after bariatric surgery. Specifically, participants provided information that could be used to train therapists in working with men who have weight loss surgery. Currently most AAMFT-accredited educational programs do not include training in obesity within their standard curriculum. The lack of training programs prevents therapists from being able to gain special credentials that would qualify them to work with bariatric clients. Therefore, one way that the findings could be used could be through its incorporation into formal graduate school education. For example, one recommendation could be that the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) consider incorporating training in working with weight loss surgery clients into the standard graduate school curriculum. Other recommendations could be the incorporation of training via distance learning, workshops, and clinical internships.

In additional to marriage and family therapy education, the findings of the dissertation study could be used to train medical professionals on how to work with men who have had

weight loss surgery via in-service trainings. In addition, the findings could be used to teach future bariatric clients and their spouses about relational dynamics that can occur during weight loss as a result of surgical intervention. A class could be developed specifically for men, for spouses, or for couples on how to prepare for surgery, how to manage possible conflict after surgery, how to provide social support, and how to address other mental health and psychological issues that may indirectly or directly impact the surgical process.

**Policy Implications**

One policy recommendation regarding bariatric surgery might be that medical insurance providers consider covering mental health services for weight loss surgery clients. Mental health providers should be reimbursed at equal rates as primary health providers so that mental health providers can continue to provide services to individuals who have medical insurance coverage. Mental health services should be implemented and required as part of standard obesity and weight loss surgery treatment. Another recommendation is that mental health evaluations should be required prior to bariatric surgery. Evaluations should not only be focused on personality traits and motivation for change, but should incorporate social support and family dynamics. There should be more in-depth therapeutic sessions prior to surgery which include the family and other social support providers. In addition, there should be required mental health “check-ups” after bariatric surgery. In addition, current medical practitioners should consider incorporating systemic and biopsychosocial models of health into their treatment modalities (Boyd, Watters, Canfield, & Nativ, 2011; Doherty, McDaniel, & Hepworth, 1994).

Other policy recommendations include mental health professionals becoming advocates for their weight loss surgery clients. Mental health professionals must continue to advocate for

clients and for the full inclusion of mental services within primary health care settings. Mental health professionals must conduct research to show the effectiveness and necessity of mental health services during weight loss surgery treatment. From an economic standpoint, mental health professionals also need to conduct research that determines the benefits and cost-effectiveness of mental health services. In theory, mental health professionals help decrease the rate of weight loss failure, subsequent costs for obesity-related medical issues, and subsequent costs for multiple surgeries. However, more research is needed to support the efficacy of mental health services during weight loss surgery. In addition, marriage and family therapists must engage in scholarship and research to show the benefit of systemic perspectives in healthcare as it relates to obesity and weight loss surgery treatment.

**Limitations of Research**

The researcher has identified some of the limitations of the dissertation study. When looking at the demographics of the study, the sample included mainly middle class men. The researcher would have liked to obtained men who have lower and higher social economic statuses, to investigate if class or socio-economic status influences how a couple experiences the weight loss surgery process. Another weakness regarding the sample relates to race and ethnicity. The researcher was not able to obtain participants from the African American community, which could have enriched the study especially due to the increasing rates of obesity among this population. Another weakness of the research is related to the use of the internet for recruitment. When thinking about the research study from a race, class, and gender perspective, the researcher recognizes that many individuals may not have access to a computer. Utilizing a sample that is purely obtained from the internet may in fact omit a number of men who may not

have access to a working computer. Individuals who may not have access to a computer include people from a lower socio-economic status and perhaps some racial and ethnic minorities. Lack of access to a computer could have prevented the researcher from gaining rich data that could have enriched the study.

Including the perspectives of men who may have a lower socio-economic status and individuals who hold minority status may have enriched the study and provided unique perspectives. However, it is important to acknowledge that the primary investigator also recruited offline utilizing traditional methods. Therefore, older populations, individuals with lower socio-economic status, and some racial and ethnic minorities in fact had the opportunity to participate in the research study. In addition, the researcher focused offline recruitment in major cities in the state of Georgia which include large samples of diverse populations.

**Strengths of Research**

There are a number of strengths in the proposed study. One of the major strengths of this study is that the researcher has identified a gap within the literature regarding obesity, bariatric surgery, and weight loss. The dissertation study is a contribution to the field and specifically adds men's experiences and perspectives about the post-operative process of bariatric surgery. I addressed experiences of bariatric patients within the context of men's relationships, which informs the field of marriage and family. While marriage and family therapists have conducted research within the field of medical family therapy, bariatric surgery and obesity from men's perspectives have not been addressed. The study is not only valuable for marriage and family therapists, but also informs medical doctors, nurses, nutritionists, dieticians, and other professionals who may work with men who seek bariatric surgery. For example, the research

informs doctors regarding the relational dynamics that occur during the weight loss process. Therefore, when doctors are discussing post-operative care, they may find it beneficial to include romantic partners and other forms of social support.

The author provides information that could assist with improving post-operative care for surgery clients such as implication regarding the inclusion of the family system in treatment. For example, the researcher found that some couples may experience difficulties within their relationship as a result of the weight loss surgery process. The author suggests that one way to combat difficulties with transition could be an increased focused on relational dynamics through the weight loss surgery process.

Another strength that has been identified relates to the incorporation of qualitative research methods. Most of the previous researchers who have conducted studies regarding bariatric patients have focused on the use of quantitative methods. Incorporating qualitative methods adds depth to the discussion regarding bariatric surgery and weight loss for men (Bryman, 1984). Qualitative research also allows the investigator to find out important information that may not emerge in a quantitative research study (Bocchieri, Meana, & Fisher, 2002). In addition to qualitative research methodology, innovative recruitment techniques were employed which include the use of Facebook, YouTube, and online weight loss websites, and video conferencing (Skype). Incorporating innovative techniques such as online recruitment allowed the researcher access to a larger population sample. Likewise, utilizing video conferencing allowed the researcher the ability to correspond with individuals across the nation.

Another strength of the study included the fact that the researcher was able to capture a new phenomenon (men who have weight loss surgery). During the study, men reported feeling

comfortable with the interview process and specifically reported how they appreciated being able to interview via Skype. Men reported that utilizing Skype made them feel safe and ensured them that their confidentiality was protected. During the interviews, men opened up and presented as genuine when being asked questions. Men mentioned feeling safe enough to disclose private information regarding their intimate relationships. Traditionally, individuals may not feel comfortable discussing culturally sanctioned topics, due to the stigma associated with obesity and weight loss for men (Hebl & Turchin, 2005).

The final strength was that during the study, men were so excited and impressed with the research topic, that they told their peers about the study and referred others to participate in the study. Men reported that they were happy that a researcher was interested in hearing their perspectives regarding obesity and weight loss surgery. Many of the participants mentioned that they wanted to share their story to help other men who may decide to have surgery in the future. In addition, many of the men asked for the researcher contact information and verbalized that they were interested in future research studies.

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Appendix A: Recruitment List

**Online Recruitment**

| **Name of Website** | **Brief Description** | **Website** |
|---|---|---|
| YouTube | Weight Loss Surgery Forums | www.Youtube.com |
| Facebook | Weight Loss Surgery Forums | www.Facebook.com |
| ObesityHelp | Weight Loss Surgery Forums | www.obesityhelp.com |
| LapBandTalk | Weight Loss Surgery Forums | www.lapbandtalk.com |
| Lap-Band For Men | Weight Loss Surgery Forums | http://lap-band-for-men.com/ |
| Diet.com | Weight Loss Surgery Forums | http://www.diet.com/ |
| 3Fatchicks.com | Weight Loss Surgery Forums | www.3fatchicks.com |
| Obesity Control Center | Weight Loss Surgery Forums | http://www.occforum.com/ |
| FatBlog.Org | Weight Loss Surgery Forums | http://forum.fatblog.org/ |
| The Weight-Loss Surgery Forum | Weight Loss Surgery Forums | http://www.connectionwls.com/forum/content.php |
| A Lighter Me | Weight Loss Surgery Forums | http://www.alighterme.com/ |
| Obesity Discussion | Weight Loss Surgery Forums | http://www.obesitydiscussion.com/forums/registration-introductions-and-website-information/ |

| | | |
|---|---|---|
| Thinner Times | Weight Loss Surgery Forums | http://www.thinnertimesforum.com/ |
| Renewed Reflections | Weight Loss Surgery Forums | http://www.renewedreflections.com/forums/ |
| Life After Bariatric Surgery | Weight Loss Surgery Forums | http://lifeafterbariatricsurgery.com/ |
| Weight Loss Surgery Club Forum | Weight Loss Surgery Forums | http://weightlosssurgeryclub.net/ |
| Cosmetic Surgery Forums | Weight Loss Surgery Forums | http://www.cosmeticsurgeryforums.com/forum/fitness-weight-loss-forum/ |
| Streamline Surgical | Weight Loss Surgery Forums | http://www.streamline-surgical.com/forum/forum.php |

**Offline Recruitment**

| Name of Business | Brief Description | Website | Address | Telephone |
|---|---|---|---|---|
| Smith Northview<br><br>Bariatric Centter | Hospital | http://www.smithhospital.com/Bariatric_Surgery_Center | 4280 North Valdosta Road<br>P.O. Box 10010<br>Valdosta, Georgia 31604 | 229-671-2000 |
| Thin Again | Weight Loss Center | No Website | 1308 Baytree Rd, Valdosta, GA 31602 | 229-249-7737 |
| South Georgia Medical Spa | Medical Spa/Weight loss Center | No website | 814 Northwood Park Drive, Valdosta, Georgia, 31602 | 229-259-0032 |
| Metabolic | Weight Loss | http://www.emetabolic.co | 1525 Baytree Rd., | 229-241- |

| | | | | |
|---|---|---|---|---|
| Research Center | Center | m/locations/locationdetails.asp?Location=119 | Ste F, Valdosta, GA 31602 | 9638 |
| Med Loss Weight Control Center | Weight Loss Center | No website | 701 Baytree Road<br><br>Valdosta, GA 31602 | 229-244-2665 |
| Georgia Bariatrics | Bariatric/<br><br>Weight Loss Center | http://www.georgiabariatrics.com/ | 2904 Macon Road Columbus, Georgia 31906 | 706-322-4073 |
| Georgia Center for Bariatric Surgery | Hospital | http://www.gcfbs.com/support/index.html | 285 Boulevard, NE Suite 515<br>Atlanta, GA 30312 | 678-904-1606 |
| Northeast Georgia Health Systems | Hospital | http://www.nghs.com/Bariatrics.aspx?id=74 | 743 Spring Street Gainesville, GA 30501 | 770-219-0597 |
| Palmyral Surgical LLC | Bariatric surgery center | http://www.palmyrasurgical.com/ | 810 13th Ave<br>Suite 108<br>Albany, GA 31701 | 229-432-8484 |
| Videoscopic Institute of Atlanta | Bariatric Surgery | http://www.drchampion.com/ | 140 Vann Street #350<br>Marietta, Georgia 30060 | 770-425-5525 |
| Radiance Anti-Aging and Body Sculpting | Weight Loss Center | http://www.radiancewellnessga.com/ | 2416 C Westgate Drive Albany, GA 31707 | 229-878-4448 |
| Emory Bariatric | Hospital | http://www.emoryhealthca | The Emory Clinic A 1365 Clifton Road, | 404-778- |

| | | | | |
|---|---|---|---|---|
| Center | | re.<br><br>org/bariatrics/index.html. | NE<br>Atlanta, Georgia 30322 | 7777 |
| Gwinnet Medical Center | Hospital | http://gwinnettbariatrics.org/ | 3620 Howell Ferry Road<br>Duluth, GA 30096 | 678-312-6800 |
| Atlanta Medical Center | Hospital | http://www.atlantamedcenter.com/en-US/ourServices/medicalServices/Pages/Surgical%20Weight%20Loss%20Program.aspx | 303 Parkway Drive Ne<br>Atlanta, GA 30312<br>404-265-4000 | 1-888-836-3848 |
| Dekab Medical Center | Hospital | http://www.dekalbmedical.org/ProgramsandServicesSurgicalWeightLoss/SurgicalWeightLossMain.aspx | DeKalb Medical, 2701 North Decatur Rd., Decatur, GA 30033 | 404-501-5200 |

Appendix B: Recruitment Letter

Dear______________,

My name is Darren Moore and I am a Ph.D. candidate in the Department of Human Development at Virginia tech. I am in the Marriage and Family Therapy program. My research, teaching, and clinical interests are related to the study of obesity (within the family system) and the study of obesity as a public health phenomenon. I am contacting you because I would like to share some information with you regarding my dissertation and would like your assistance with publicizing my research study.

My study is regarding men's experiences with bariatric surgery. My study involves investigating how the bariatric surgery process influences men's self-concept, their relationships satisfaction, and perceptions of social support. Interviews may last between 60 to 90 minutes. The potential finding of this study is a rich description of the phenomena, which will provide insight for medical professionals, marriage and family therapists, as well as patients who may undergo bariatric surgery.

Again, I would like to request your permission to post a flyer of my research study in your facility just in case any of your customers 1) would like to learn more about my research, 2) would like to participate in my research, or 3) may know of someone who might qualify to participate. My research has been approved by the Institutional Review Board at Virginia Tech. If you would like to learn about my research study, please feel free to contact me. I have included a copy of my recruitment flyer. Thank you for taking the time to read my letter.

Sincerely,

Darren D. Moore, Ph.D. candidate

Department of Human Development

Marriage and Family Therapy Program

Virginia Tech

Blacksburg, Virginia, 24061

Cell: (612) 296-3758

Email: ddmoore@vt.edu

Appendix C: Recruitment flyer

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**LIFE AFTER BARIATRIC SURGERY: MEN'S PERSPECTIVES ON SELF-CONCEPT, RELATIONSHIP SATISFACTION, AND SOCIAL SUPPORT.**

Are you an adult heterosexual male who has undergone weight loss surgery within the last 5 years? Were you over the age of 25 at the time of the surgery? Has it been at least 6 months since you had the surgery? Have you been in at least one intimate relationship after weight loss surgery? Do you think sharing your story would help others? Would you like to be interviewed and earn 50 Dollars? Then please consider participating in my study!

Hello all, my name is Darren Moore and I am a Ph.D. Candidate in the Marriage and Family Therapy Program at Virginia Tech. I am currently recruiting participants for my dissertation study, which will examine men's experiences after having weight loss surgery. By participating in this study, you will help marriage and family therapists, doctors, nurses, and future patients learn about the experiences of men who undergo bariatric surgery. Your story may assist professionals with improving treatment for bariatric patients.

If you are interested in sharing your story, please contact me!

*Individuals will earn $50 for the completion of one interview.

**Darren Moore, Ph.D. Candidate**
**Department of Human Development:**
**Marriage and Family Therapy Program**
**Virginia Tech**
**Blacksburg, Virginia, 24061**

**Email:** ddmoore@vt.edu
**Phone:** 612-296-3758
**YoutTube Channel:** http://www.youtube.com/user/DarrensDissertation?feature=mhee
**Facebook Page:** http://www.facebook.com/people/Darren-Moore/100000501550672

Appendix D: Approval for Recruitment

Trinity Hospital

Quoting Carla Harrison <cdharr@hotmail.com>

Mr. Moore-

I would be happy to support you in your quest for knowledge. Our support groups meet the 1st and 3rd Thursday of each month at 7pm. Currently, we average around 70 participants at each meeting. To reach the widest audience, I suggest presenting at both meetings. How long is your presentation? Our group has a private message board with over 450 bariatric patients; I would be happy to post your information there as well.

Feel free to call me with any questions you might have.

Carla

706-945-5272

Date: Fri, 24 Jun 2011 00:08:17 -0400
From: Carla Harrison <cdharr@hotmail.com>
Subject: RE: Hello
To: ddmoore@vt.edu

Mr. Moore -

You have the support group meeting dates correct; July 7th & 21st at 7pm. We meet in the ground floor conference room at Trinity Hospital of Augusta, 2260 Wrightsboro Road, Augusta 30904. When you enter the hospital, there are stairs immediately on the right. Go down the stairs and we will be in the room at the bottom. We have a speaker planned for the meeting on the 7th, so your brief presentation will work for that meeting. I do not have a speaker scheduled for the meeting on the 21st. If you could do the same presentation on the 21st that you are doing for the Gainesville meeting, that would be perfect! We spend the first 15 - 20 minutes of each meeting with announcements and acknowledgements, then move on to the speaker. Your information has been posted on our group's message board. I hope that you will be contacted by a good number of our male patients. I didn't think to ask when I responded to your initial email; how did you come across my contact information? I'm always curious how information is reaching people.

Carla

Obesityhelp.com

Forwarded message from tammy@obesityhelp.com
Date: Mon, 13 Jun 2011 14:51:09 -0400
From: Tammy Colter <tammy@obesityhelp.com>
Subject: RE: Hello
To: ddmoore@vt.edu
Cc: 'ObesityHelp Staff' <membermail@obesityhelp.com>

Hi Darren,

You may publish this in the Men's forum. Please put a note that you are

Posting with permission.

All my best,

Tammy Colter

ObesityHelp.com

Bariatric Medical Institute of Texas

Quoting Melinda Verduzco <Melinda.Verduzco@bmioftexas.com>:

Hello Darren,

Dr. Duperier is out of town, but I'd be willing to help you out. Please provide us with your IRB approval, Recruitment letter, Recruitment Flyer, Eligibility Criteria, and Informed Consent so we have it on record and I can review it with our other physician Dr. Seger. It seems like a great topic to explore and we have plenty of male bariatric patients so we look forward to hearing from you.

Thank you,

Melinda V. Gonzalez

Physician Assistant

Forwarded message from Melinda.Verduzco@bmioftexas.com
Date: Fri, 24 Jun 2011 19:20:46 -0500
From: Melinda Verduzco Melinda.Verduzco@bmioftexas.com
Subject: RE: Hello
To: "'ddmoore@vt.edu'" <ddmoore@vt.edu>

Hi Darren,

We will help you recruit for your study. Let me know when you'd like

to get started.

Melinda

Lapbandtalk.com

Forwarded message from support@WLSBoard.com
Date: Tue, 07 Jun 2011 11:27:37 -0400
From: Alex Brecher <support@WLSBoard.com>
Reply-To: support@WLSBoard.com
Subject: [#DOQ-306-96097]: My Dissertation Study
To: ddmoore@vt.edu

Darren,

I've reviewed your request and you have my full permission to post this in our forums. Please post only once and email me the link so I can make it sticky for a week or two. Are you planning to publish it once it's completed ?

Best Regards,

Alex Brecher, Founder
WLSBoards.com
O: 212.203.4846
C: 917.807.3241
1429 E. 37th Street
Brooklyn, NY 11234

## Appendix E: Eligibility Form

Participants must meet the following eligibility/Inclusion criteria:

1) Do you describe yourself as a heterosexual man?
2) In the last 5 years have you had weight loss surgery?
3) Were you over the age of 25 at the time of the surgery?
4) Are you at least 6 months post-surgery?
5) Have you been in at least one intimate and/or committed relationship after weight loss surgery?
6) Do you live in the United States of America?

## Appendix F: Instructions for Skype

1. If you do not already have a Skype account you can download it for free by going to the following website: http://www.Skype.com/intl/en-us/home.
2. Click on the "Get Skype" tab and select an option under the "computer selection" tab (based on the type of computer you are using).
3. Click download and wait for the program to take you through the steps of registration.
4. A shortcut will appear on your computer desktop
5. Once you are registered click on the "Skype" icon located on your desktop.
6. Log in using your Skype name and password.
7. Once you are logged in click on the "add a contact" tab.
8. Once the window opens up, type "moore0415" on the last line where it asks for "Skype name."
9. After the interviewers name and photo appear, click "add contact."
10. The interviewers contact icon should now appear on your contact page.
11. To connect simply double click on the interviewers icon
12. Once the next window opens up double click on "video call."
13. Make sure your webcam is on and the volume on your computer is turned up.
14. You should now be able to connect with the researcher.

*If you need additional help, please contact the researcher and he will walk you through setting up an account on Skype and provide assistance with connecting on the day of the interview.

## Appendix G: Interview Protocol

The interviewer will complete the following tasks prior to starting the recorder:

A. Engage in a general conversation to build rapport with the participant.

B. Review of Informed Consent

C. Review of the Interview format

D. Instruct the participant to complete and submit demographic information.

Demographic Data

Name: ______________________________________________________________________

Pseudonym (Please select a fictitious name that will be used to identify you in the research, this assists with maintaining your confidentiality): ________________________________________

Email: ______________________________________________________________________

Telephone: __________________________________________________________________

What is your age: _____________________________________________________________

Race/ethnicity: _______________________________________________________________

Religion: ____________________________________________________________________

Current Relationship Status: _____________________________________________________

Individual yearly income: _______________________________________________________

What is your profession:_________________________________________________________

Do you have children? (If so how many?): _________________________________________

Highest degree earned: _________________________________________________________

What city or town do you reside in? ______________________________________________

How many partners did you have between a year prior to and after surgery? ______________

Please list the duration of each relationship (ex. 1-3months, 4-6 months, 7 or more months)

_________________________________________________________________________

_____________________________________________________________________________

Date of Surgery: ___________________________________________________________

Location of Surgery (city, state):_________________________________________________

Type of Surgical Process (laparoscopic banding, duodenal switch, vertical banded gastroplasty, roux-en-y gastric bypass, or other): _______________________________________________

Height: ____________________________________________________________________

Preoperative weight: _________________________________________________________

Postoperative Weight (total loss after surgery):_______________________________________

Interview Questions

**Biographical Questions:**

1. What made you decide to get bariatric surgery?

   *Probe:* Did anything motivate you in particular?

   *Probe:* How did you go about making the decision to have weight loss surgery?

   *Probe:* Was this an individual decision?

   *Probe:* Was your relationship or relationship status a factor in your decision to have weight loss surgery?

2. How did you prepare for having bariatric surgery?

   *Probe:* How did you and your partner talk about this process before weight loss surgery?

3. What made you select ________ weight loss procedure?

**Domain area 1 (Self-concept):** *How does the bariatric surgery process influence men's perceptions of self-concept?*

1. How has the way that you think about your body changed?

   *Probe:* If so, in what way?

   *Probe:* How do you feel about your body now?

2. How do you think your partner views your body now? (If you are no longer in a relationship, how did you think your past partner viewed your body)?

   *Probe: How do you think potential mates will view your body?*

3. Do you think that you've changed as a person after the surgery?

*Probe:* In what ways have you changed as a person?

*Probe:* In what ways do you think differently about yourself?

*Probe:* How would you describe yourself prior to the surgery versus after the surgery?

*Probe:* What adjectives would you use to describe yourself prior and after the surgery?

4. Tell me how others talk about you since the surgery?
   *Probe:* What responses have you received by others about your body?
   *Probe:* So how does that make you feel?

**<u>Domain area 2 (Relationship satisfaction):</u>** *How do men perceive dating and relationship satisfaction after weight loss surgery?*

1. When you think about your dating life or relationship after surgery, how is it satisfying to you?

   *Probe*: Are you happier and more content now within your relationship?

2. Have you ever had negative thoughts or feelings about your relationship during this process? (If they have had a different partner after surgery, the researcher will ask, "Have you ever had negative thoughts or feelings about your relationship after the surgery?)"

3. Now that you have lost some weight, have you ever thought about leaving your relationship or dating other people?

   *Probe:* Why or why not?

**<u>Domain area 3 (Intimacy):</u>** *How do men perceive intimacy after bariatric surgery?*

1. How connected do you feel to your partner?

   *Probe:* How is emotional intimacy expressed in your relationship?

*Probe:* Tell me some examples.

*Probe:* Do you think your partner would agree and why?

2. Has that feeling of connection changed during this process? (if same partner prior to surgery)

3. Do you feel more or less comfortable engaging in sexual activity with your partner now after the surgery or do you feel the same? (If they are not in a relationship, the researcher will ask, do you feel more or less comfortable engaging in sexual activity with others?) *Probe:* Are you more comfortable with your body now after the surgery or do you feel about the same?

4. After the surgery, do you think your sex life has gotten better?

   *Probe:* Has the frequency increased?

   *Probe:* Do you think your partner would agree and why?

5. Have you ever received any romantic or sexual attention from outside of your relationship?

   *Probe:* After the surgery, have you dated women other than your partner?

   *Probe:* Is that any different than your behavior prior to the surgery? (If the participant answers yes: Why are you seeing other people now when you were not doing it prior?)

6. Is there anything you would change about your emotional connection to your partner or future partners? *Probe* Is there anything you would change about your sex life with your partner or future partner?

**<u>Domain area 4: (Social support):</u>** *How do men perceive social support after bariatric surgery?*

1. Is there anyone who did not want you to have bariatric surgery?

*Probe:* How did you feel about that?

2. What role did your partner play during this process?

3. In which ways did you feel supported or not supported by your partner?
   *Probe:* Give me some examples: [change in eating or diet habits; tells you she loves you more; cooks or eats tempting foods in front of you]
   *Probe:* Did your partner participate in support groups or therapy with you?
   *Probe:* If so, how?

4. Other than your partner, who else supported you doing this process?
   *Probe:* Did you receive support from family/friends/therapy/face-to-face or online support groups?

**Wrap- up Questions:**

*As we prepare to conclude the study, there are a few last questions that I would like you to think about and answer.*

1. Tell me overall, what is life like after bariatric surgery for you?

   *Probe:* How did you feel the day after surgery?

   *Probe:* How are things different for you after surgery?

2. During the process of before or after, have you consulted a therapist?

   *Probe:* If so, why and when?

   *Probe:* If not, why not?

3. What changes have you made in your life since getting the surgery?

   *Probe:* Did one of the changes in your life involve seeing a therapist?

*Probe:* If yes, why, for what reason?

*Probe:* If no, why not?

*Probe:* Have you seen a therapist before?

4. What do you think is important for marriage and family therapists to know about life after bariatric surgery for men?
   *Probe:* In what ways do you think marriage and family therapist could work with this population?

5. If I was going to teach a class to marriage and family therapists about how to best serve male bariatric patients, what would you suggest be discussed in the class?

6. Is there anything else that you want to share about bariatric surgery that I did not ask you that you feel is important for me to know?

## Appendix H: Final Coding Scheme

**Theme 1: Shift in identity construction: "From existing to living"**
- Sub: Changes in perceived self-concept
- Sub: The evolving body: Still a work at progress
- Sub: The emerging self: From insecurity to self confidence
- Sub: Perceived enhanced quality of life

**Theme 2: Enhanced relationship experiences**
- Sub: Happy and more content
- Sub: Perceived insecurities: Fear of abandonment.
- Sub: Commitment to relationships: Divorce is not an option.

**Theme 3: Increased Intimacy**
- Sub: Stronger emotional intimacy through better communication.
- Sub: Sexual interaction: better than before, but still desires more.

**Theme 4: Fluidity of Informal Social Supports**
- Sub: Encouragement with accountability
- Sub: Lack of support. He's just taking the easy way out, lack of empathy.
- Sub: Formal social support: "Face-to-face and online support groups"

**Theme 5: Mental health services: Initial resistance but acknowledged value**
- Sub: Fear and negative perceptions of mental health services
- Sub: Positive perceptions: The utility of marriage and family therapeutic intervention.