



Patient perspectives on psychological care after bariatric surgery: A qualitative study

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Summary

Psychological interventions may be effective in improving adherence after bariatric surgery; however, there is limited research on patients' willingness to engage with psychological aftercare. This study aimed to qualitatively explore patient perspectives on psychological services in the bariatric setting. Participants reported believing that psychological care is essential for treatment success and indicated that they wanted support with adjusting to changes in lifestyle, self-identity, and relationships after surgery. Participants suggested that psychological aftercare should be recommended by their medical team and incorporated into standard management after bariatric surgery. These findings can be used to inform the design of services for bariatric surgery patients.

KEYWORDS

bariatric surgery, adherence, compliance, psychological care

1 | INTRODUCTION

Bariatric surgery outcomes, particularly weight loss, have been consistently linked to patients' adherence to post-operative treatment instructions regarding diet,¹ exercise, and follow up appointments.² There is growing evidence to suggest that psychological interventions may be effective in improving post-operative adherence, including adapted motivational interviewing,³ cognitive behaviour therapy,⁴ acceptance and commitment therapy,^{5,6} and mindfulness-based therapies.⁷ Given the potential benefits of psychological interventions, it is important to understand patients' willingness to engage with psychological services.

A survey of people who had received bariatric surgery revealed that 82.5% of patients showed interest in engaging with a general (i.e., not psychology-specific) post-operative program to manage weight regain.⁸ In a qualitative study of male bariatric surgery patients, however, participants reported being reluctant to seek professional support due to prior negative experiences with mental health professionals in the bariatric setting, financial barriers, and a perceived scarcity of mental health clinicians with bariatric surgery expertise.⁹

The limited available research suggests that, while patients may show interest in post-operative support and that such supports can

improve adherence and treatment outcomes, there are also potential barriers to engaging with psychological services after surgery. The aim of this study was to build on these prior studies in order to better understand patients' attitudes towards psychological aftercare. Specifically, this study explored bariatric surgery patients' experiences and challenges in weight loss maintenance, their views about the value of psychological care, and how to increase acceptability of psychological services after surgery.

2 | METHOD

2.1 | Research design

The present study used a qualitative approach involving both semi-structured focus groups and individual interviews. Data were analysed using thematic analysis, which involves identifying and making sense of patterns that emerge from qualitative data by organizing them into meaningful themes.¹⁰ Because thematic analysis adopts an inductive approach, it is particularly useful when studying under researched areas where there is insufficient knowledge to apply meaningful theories or hypotheses a priori, which is the case in this

present study of bariatric surgery patients' perspectives on psychological services.

2.2 | Participants

Individuals were eligible to participate in the study if they: (a) had received bariatric surgery at least 8 weeks prior to participation, (b) were aged 18 years or over, and (c) were fluent in spoken English. There were a total of 24 participants in this study. Fifteen participants took part in the focus groups (three groups comprised two participants, one group comprised four participants, and one group comprised five participants). Telephone interviews were conducted with nine participants. Overall, 16 of the participants were women (67%) and the mean age was 46.58 years (SD = 11.65). The surgical procedures reported included gastric sleeve (n = 10), gastric band (n = 9), and gastric bypass (n = 5). Five participants indicated that they had undergone more than one bariatric surgery. Participant characteristics, stratified into focus groups and individual interviews, are presented in Table 1, and characteristics of individual participants are presented in Table 2. Additional clinical characteristics (e.g., weight loss, body mass index) were not collected because the primary focus of this study was to explore participants' perspectives about psychological services in the bariatric setting irrespective of treatment outcomes.

2.3 | Procedure

All focus groups and individual interviews were conducted by J.K.Y.C., who was a PhD candidate and registered Provisional Psychologist at the time of the study. Email invitations were sent to patients at a large bariatric clinic in Sydney, Australia, as well as to individuals who had previously expressed interest in participating in bariatric surgery-related research. Participants were informed that the study aimed to explore "lifestyle changes and supports after bariatric surgery" and

were given information about confidentiality and the voluntary nature of the study. Participants were offered the option of participating in a focus group or an individual telephone interview. The duration of the focus groups were approximately 90 minutes and telephone interviews were approximately 30 minutes. Participants were reimbursed AU\$25 for their time. The focus groups were conducted on a university campus and a research assistant was present to provide assistance and to take field notes. Ethics approval was granted by the university human ethics panel.

Before beginning the focus groups/interviews, participants were asked to complete a brief survey, which elicited information about age, sex, surgical procedure, year of surgery, self-reported adherence to post-operative instructions (on a scale from 0 "not at all adherent" to 10 "entirely adherent"), and general satisfaction with their surgical outcomes (on a scale from 0 "not at all satisfied" to 10 "entirely satisfied"). In both focus groups and interviews, the following questions were used to investigate discussions of the topics of interest: (a) Do you think that it is important to see a psychologist after getting bariatric surgery? Why or why not?; (b) How do you think a psychologist could help people who have received bariatric surgery?; and (c) If psychological care were to be provided to patients after bariatric surgery, how could we increase the likelihood that people would take it up or accept it? What would encourage you to seek, or deter you from seeking, psychological care after surgery? Follow up questions were used when necessary to gain further insight into participants' responses to the above questions (see Table 3: Topic Guide). Focus groups and interviews were conducted until the researchers agreed that data saturation was achieved.

2.4 | Analysis

All focus group and telephone interview audio recordings were transcribed verbatim and de-identified by a research assistant. Transcripts were reviewed by J.K.Y.C. to ensure accuracy. Each participant was assigned a code (e.g., "FGM1" refers to the first male focus group participant, and "TF1" refers to the first female telephone interview participant).

Using guidelines by Braun and Clarke as a framework for thematic analysis,¹⁰ transcripts were read several times by the lead author for in-depth familiarization with the data. Following this, initial codes were created and relevant data were then organized into meaningful groups within these codes. Thematically similar codes were then organized into potential themes or sub-themes. Next, the codes and themes were reviewed and refined by the authors to ensure that the themes demonstrated a valid, accurate, and coherent pattern. When all themes were finalized, the names of the themes were refined to check that they provided a valid account of the data that they represent. All analyses in this study were conducted in NVivo version 11.¹¹ Three primary themes were explored across the focus groups and interviews: (a) *Patients' difficulties adjusting to change after bariatric surgery*; (b) *The importance of psychological care in the bariatric surgery setting*; and (c) *Factors influencing engagement with psychological services*.

TABLE 1 Participant characteristics

	Focus group (n = 15) M (SD) or n	Individual interview (n = 9) M (SD) or n
Age	46.20 (11.59)	47.22 (12.43)
Gender		
Female	8	8
Male	7	1
Surgical procedure		
Gastric sleeve	8	2
Gastric band	5	4
Gastric bypass	2	3
Years since surgery	3.93 (4.20)	4.78 (4.32)
Overall adherence	6.43 (2.74)	7.61 (2.26)
Satisfaction with surgery	8.90 (1.42)	8.67 (2.66)

TABLE 2 Individual participant characteristics

Group/interview	Age	Sex	Years since surgery	Surgery	Adherence	Satisfaction
Interview	62	F	6	Gastric bypass Gastric band	8.5	10
Interview	55	F	9	Gastric band	10	10
Interview	47	F	1	Gastric bypass Gastric sleeve	8	8
Interview	44	F	0	Gastric band (x2)	9	10
Interview	35	M	2	Gastric sleeve	8	10
Interview	65	F	12	Gastric band	8	10
Interview	29	F	2	Gastric bypass Gastric band	7	10
Interview	36	F	2	Gastric sleeve	8	8
Interview	52	F	9	Gastric band	2	2
Group	46	M	1	Gastric bypass	10	10
Group	55	F	10	Gastric band	8	7
Group	49	F	2	Gastric sleeve	10	10
Group	42	F	1	Gastric sleeve	3	5.5
Group	69	F	3	Gastric bypass	0	10
Group	46	M	4	Gastric band	8	10
Group	40	M	1	Gastric sleeve	5	9
Group	45	M	3	Gastric band	4	9
Group	62	F	16	Gastric band	8.5	10
Group	48	M	0	Gastric sleeve	8	10
Group	42	F	4	Gastric sleeve	5	9
Group	24	F	6	Gastric sleeve	5	10
Group	41	F	2	Gastric band	8	8
Group	28	M	1	Gastric sleeve	7	9
Group	56	M	5	Gastric sleeve Gastric band	7	7

TABLE 3 Focus group topic guide*Introduction*

- Welcome, introduction of the researcher (i.e., current role and involvement in research project), introductions from focus group participants.
- Overview of the study and reiterating key points from participant information sheet and consent form, including confidentiality and privacy.
- Sign consent form.
- Complete brief survey.

Topics/questions

- Elicit participant views on their perceived importance of seeing a psychologist after bariatric surgery. Discuss reasons for these views.
- Identify and elicit details on specific ways in which psychologists may be able to assist patients after bariatric surgery. For example: to treat disordered eating; to increase motivation to adhere to post-operative lifestyle changes; to provide emotional support, and so on. If needed, provide basic information regarding services/interventions psychologists can offer in weight loss settings. Elicit participants' views of such services and encourage to consider other services that may be beneficial in the bariatric surgery setting.
- Identify and elicit details on facilitators and barriers to seeking psychological care after bariatric surgery. For example: stigma, perceived irrelevance, perceived importance, cost, and so on.

Conclusion

- Sum up discussions.
- Opportunity for participants to add anything missed.
- Provide information regarding the purpose of the study in the context of PhD research project and answer any questions that participants may have about the study.
- End of focus group—thank and reimburse participants.

3 | RESULTS

3.1 | Theme 1: Patients' difficulty adjusting to changes after bariatric surgery

There was widespread agreement that patients undergo significant changes in their lives after surgery, including changes to self-identity, lifestyle, and interpersonal relationships. In this theme, patients discussed their difficulty adjusting to such changes. Themes and sub-themes are presented in Table 4.

3.1.1 | Sub-theme 1.1: Transformation of the self

Participants reported that being a person with obesity had become so ingrained in their self-identity that they felt "lost in this body" [FGF4] after drastic weight loss. The idea of being a new or different person was reflected by most participants, for example, "it's like literally being taken out of your body and put in somebody else's...it's like living two lives" [FGF4]. Similarly, TF3 said: "I don't see myself as a thin person. I still grab the biggest clothes on the rack," suggesting that these participants continue to see themselves as a person with obesity despite substantial weight loss.

Participants indicated that they had to navigate through a "psychological metamorphosis" [FGM3] in addition to the physical changes they experienced as a result of weight loss. FGM3 discussed a need to "relearn who you are as a person and learning to be undamaged" and to transform one's existing self-identity. TF1 also emphasized the impact that weight loss can have when obesity had previously been a defining characteristic of one's self-identity: "Your weight shouldn't

define you and all that but, at the same time, it can, like, in the same token, if that's all you've ever known. You just don't know where you fit in the world."

For those participants who had successfully lost weight, there was a need to discover their "new place" in the social environment. Participants expressed confusion about how to respond to the sudden shift in interactions. This sentiment was expressed by FGF8 by stating:

"All of a sudden... you just get attention whereas, before, you go through life invisible. And now you're not invisible anymore. And the only thing that's changed is that you're now just a smaller you, and I think that, um, there is definitely space for a psychologist to assist with dealing with that."

FGF4 echoed this experience of being treated differently because of the changes in her appearance: "[...] being literally half, or less than half, of the size you once were, you are treated completely different..." Together, these sentiments imply that there was a level of discomfort and perhaps distress associated with personally experiencing how differently one is treated based on one's weight, which warrants psychological attention.

3.1.2 | Sub-theme 1.2: Changes to relationship dynamics

In addition to changes in self-identity, some participants reported experiencing changes in their relationships with partners and/or

TABLE 4 Table of themes and sub-themes

Themes	Sub-themes	Sub-theme examples
Patients' difficulty adjusting to changes after bariatric surgery	Transformation of self	"It's literally like being taken out of your body and put in somebody else's..."
	Changes to relationship dynamics	"I got to a stage where I was actually lighter than my husband and then jealousy started because I looked good"
	Managing unrealistic expectations	"Because what I had thought was: band goes in, there's a physical restriction, I'm not going to eat, the weight's just going to fall off"
Importance of psychological care in the bariatric surgery setting	Pre-operative psychological care as critical for success	"There probably needs to be a bit more support mentally, like, to prepare you for the changes that are going to happen...the mental struggle is a lot harder than, you know, losing the weight"
	Post-operative psychological care as critical for success	"If you don't change your mind, nothing else works, and you relapse. Unless you can change the way you relate to food and deal with food..."
Factors influencing engagement with psychological services	Clinician characteristics	"They need to be specialized towards weight loss patients...if they specialize in the issues we generally go through, they understand a lot better..."
	Factors related to the bariatric clinic	"If it was part of, like, my post-op plan then I would have, 100%, would have gone [to the psychology appointment]..."
	Practical barriers to service engagement	"What I did find good was the fact that the cost [of psychological services] was mostly inclusive because things I tend to avoid are the things I have to pay for"

family members. It was important to participants that their loved ones could support them throughout their weight loss journey. However, this support was not always available because partners/family members did not necessarily understand patients' experiences after surgery. FGM6 suggested that pre-operative consultations needed to include partners so that they can be educated about the changes that patients experience: "The fact that I had some psychological consult prior to the surgery was excellent, but I think that kind of support needs to encompass more than just me, it needs to encompass my wife. I think she needed to be there so she could understand what it was that I was about to go through, and then after surgery, what it was that I was going through."

Participants discussed how certain relationship conflicts may have been attenuated or avoided had there been psychological help available to facilitate understanding between couples, as FGM6 explained: "And had she [FGM6's wife] been part of that psychological support, I have no doubt that I'd still be married to her. I have no doubt that my wife would have kept on board and I have no doubt that other people around me would've, um, would've understood what I went through." Likewise, TF3 suggested that psychological therapy may have been beneficial in helping her partner adjust to her weight loss: "I got to a stage where I was actually lighter than my husband and then jealousy started because I looked good...these are things that psychologists help with." FGM6 reinforces the necessity of involving partners in the bariatric surgery journey to understand patients' experiences and motivations:

"[It] is absolutely essential to have the partners involved. Have them in there, understand what you're going through, have some understanding of underlying reasons to why you started putting on weight in the beginning: feeling depressed or feeling out of control or societal reasons."

3.1.3 | Sub-theme 1.3: Managing unrealistic expectations

Some participants were surprised to find that, contrary to their expectations, weight loss did not necessarily result in improved self-esteem or make them happier. TF1 discussed her misconceptions about the emotional outcomes of bariatric surgery: "You have this notion that, um, being skinny is going to make you happy. I think, at the end of the day, I think that's why everyone goes into it [bariatric surgery], and I think you need to realise that's not going to happen, that your happiness doesn't come from the scales." FGM6 reported having unrealistic expectations about the effects of his bariatric procedure: "Because what I had thought was: band goes in, there's a physical restriction, I'm not going to eat, the weight's just going to fall off, and I do it."

The excerpts above highlight the fact that patients may have unrealistic expectations regarding the psychological and physical benefits of bariatric surgery, and failure to manage disappointments associated with unmet expectations may affect negatively on

post-operative adherence. Indeed, one participant indicated that her persistent unhappiness could, at times, compromise her motivation to adhere to post-operative instructions: "Sometimes I'm really good and, you know, like the best weight loss surgery patient ever, and, at other times, I'm just like...what even is the point...I liked myself, I looked better when I was fat!" [TF1]. Thus, educating patients on realistic expectations prior to surgery may be beneficial to improving post-operative adherence. Overall, within this theme, participant accounts highlight the issues that need to be addressed from a psychological perspective within a bariatric surgery setting.

3.2 | Theme 2: Importance of psychological care in the bariatric surgery setting

Most participants indicated that psychological intervention is vital for developing psychological changes (e.g., changing thinking patterns) and lifestyle changes that are necessary for the maintenance of weight loss. "Some people cannot stop eating and there's something in their mind, really psychological more than physical" [TF7]. Participants indicated that psychologists should be considered an integral part of the bariatric surgery team: "They're a team, and if one piece is missing, you'll feel the discomfort you're feeling...It's critical for success that you have to change your thinking...I've seen them [psychologists] for years and that's how I'm successful ten years later" [FGF2].

3.2.1 | Sub-theme 2.1: Pre-operative psychological care as critical for success

Participants placed a high value on pre-operative consultations to prepare them for post-operative lifestyle changes and believed that they would be unable to sustain such changes without adequate education and support prior to surgery: "I needed to have all that [information] drilled into me up front because, otherwise, I would find it too easy to go back to eating and living the way I was before" [TM1]. One participant [FGM6] indicated that his readiness for behaviour change was highest in the weeks leading up to his surgery and, thus, a pre-operative psychological consult could have capitalized on that motivation as well as initiated a therapeutic relationship that would increase the likelihood of engaging in psychological care after surgery: "I think education perhaps should have happened before the surgery rather than after because the motivation was highest when I decided to have it...And I would have definitely been more likely to go back to the psychologist and continue with that treatment."

Participants also emphasized the importance of "mental preparation" and setting expectations regarding the physiological, psychological, and behavioural changes that occur after surgery. TF8 reported that this type of preparation would be helpful but, in her experience, it was not sufficiently offered in the pre-operative phase: "There probably needs to be, like, a bit more support mentally, like, to prepare you for the changes that are going to happen... the mental struggle is a lot harder than, you know, losing the weight."

Some participants had the view that clinics should not approve surgery for all who request it. Rather, psychologists should be the “final gatekeepers” [FGM7] to ensure that individuals seeking out bariatric surgery are suitable for the procedure at a psychological level: “It shouldn't come down to BMI and that you're there and that you have the cash” [FGM7]. For example, psychologists should check that candidates recognize that surgery is not a “quick fix” and that they are prepared to make lifestyle changes after surgery. This suggestion was illustrated by FGF4: “Can you handle this? Are you going to be able to cope with having a literal brand new stomach and all this kind of thing? Like, kind of gauge where you're at, um, you know mentally, physically, are you capable of going through this?”

3.2.2 | Sub-theme 2.2: Post-operative psychological care as critical for success

Participants reported that psychologists could help patients to increase their likelihood of treatment success by addressing (after surgery) issues that may affect weight loss, such as reasons for obesity, relationships with food, and practical strategies for change. The majority of participants stated that it was important to understand each individual's reasons for becoming obese in order to maintain weight loss. This view was reflected in FGF4's words:

“I think, as well, that you have to really focus on your past to work on your present. Like, how you got that way in the first place, like, why you might eat that way or just really work on the, sort of, root of the problem because you can't fix anything in the future...unless you work on your headspace and everything, going through, you know, how you got that way.”

Participants raised the necessity of a lifelong change in one's mindset about food, rather than a short-term change in diet, as exemplified by FGF2: “If you don't change your mind, nothing else works, and you relapse. Unless you can change the way you relate to food and deal with food...it doesn't matter about all the rest because the rest is hanging on for a diet, and it's not about that. It's a way of life.” For FGM1, emotional eating was a pertinent issue: “when you're low, emotionally when you're down...I used to stuff my face many, many times a day. I used to eat far, far too much food.”

Accordingly, participants suggested that psychologists could teach strategies to change long-standing habits, particularly related to food intake, in order to improve post-operative adherence. In the excerpt below, TF6 highlighted the role of a psychologist in helping to break cognitive and behavioural patterns that led to or maintained obesity in the past:

“If you've been obese for 20 years or 10 years or 1 year, or you know, whatever years, you develop patterns and habits...the patterns don't disappear. You still

have to practice, you have to work...That would be what I think that a psychologist could follow up with.”

Furthermore, participants claimed that it was necessary to learn how to recover from mistakes or lapses in adherence so that patients could get back on track with their goals instead of succumbing to feelings of guilt and giving up, as TF4 explained:

“I would think a psychologist could help [with] building a relationship between the person with the food and not feeling guilt because they...you know what the biggest thing is? When, if you have a break out night or day or whatever it is, it's hard for them to get back on the wagon so they stay off the wagon. So, it's like 'move on, that was yesterday, and this is today'.”

In addition, increasing knowledge about bodily cues of hunger and satiety as well as approaches to eating (e.g., mindful eating) was identified as useful. FGM6 recounted a session with his psychologist in which she taught him a new way of eating: “[the psychologist said] 'put it in your mouth and chew it and taste it, the flavour. Savour the flavour.' If you don't then you're missing out on all the food, you just shovel it. [The psychologist] actually taught me how to eat.” Participants' accounts suggest that psychological care within the bariatric surgery setting is important to assess suitability and readiness for surgery, as well as to address cognitive and behavioural patterns that may influence post-operative adherence.

3.3 | Theme 3: Factors influencing engagement with psychological services

Participants discussed several factors that they felt would impact on patients' likelihood of accepting and engaging with psychological services.

3.3.1 | Sub-theme 3.1: Clinician characteristics

Many participants indicated a preference for psychologists with specialized training in weight loss or bariatric surgery as they were thought to have a greater understanding of the issues faced by bariatric surgery patients: “They need to be specialised towards weight loss patients as well. They're the most successful, for me anyway, as well. So, if they specialize in the issues we generally go through, they understand a lot better than just the general [psychologist]” [FGF4]. Several participants held the view that only psychologists with personal experiences of bariatric surgery could truly empathize with the patients: “So I think with psychologists who had that procedure done— probably not many of them— but I think that would be better” [FGM6].

Attitudes towards psychological care also influenced participants' uptake or acceptance of this service. FGM2 reported prior negative

experiences with mental health services, which discouraged him from seeking support post-surgery: "I've dealt with quite a few psychiatrists and psychologists over the years...and, um, personally, I'm not a fan... I've been let down by psychs in the past." Several participants also reported stigma as a deterrent to seeking psychological input, as exemplified by TM1: "There is still a stigma about seeing a psychologist. I think people think that there must be something wrong with me".

Other participants simply stated that they, personally, did not feel the need to see a psychologist because they had sufficient access to social support (e.g., "I agree that the psychologists can help, definitely, but I didn't feel I needed that...I felt like I had my parents to talk to, I had my sister to talk to, I had friends to talk to" [TF2]) or that they were coping well without professional help (e.g., "I'm pretty happy with my results and I think I'm travelling alright" [FGM2]).

3.3.2 | Sub-theme 3.2: Factors related to the bariatric clinic

Participants offered recommendations related to the bariatric surgery clinic, which they believed may increase the uptake and acceptability of psychological services. First, the majority of participants indicated that they would be more likely to attend psychological consultations if it was recommended by their medical team, as indicated by FGM2: "I really think if it's, sort of, recommended by the surgeon, that's probably the best angle to go from because, I mean, you're going to listen to your surgeon, you're going to listen to your doctor, and I suppose if the doctor says 'I recommend you do this', you'll do it." TF3 also suggested that referrals from other patients would encourage service engagement: "If somebody would say to me in waiting room, about seeing a psychologist for different things that were going on, and then saying, 'well I did, and this happened to me, and they helped me' then it's kind of like a personal referral, it gets you in the door. Just talking to somebody else that's been there and done that".

Likewise, service uptake might increase if patients were better informed about what psychologists can offer and how patients can benefit from consultations. TM1 suggested:

"[...] better educating people about what psychologists can do and make it, helping them realise that it's not, you know, seeing a psychologist doesn't mean you have a mental illness. It's really about adjusting to lifestyle changes after bariatric surgery and all the kind of different psychological components of that."

FGM7 reflected the view that patients are not always aware of what psychological consultations involve. He also suggested that psychological services could be presented as structured sessions that focused on topics of interest, such as behaviours and food, because this would be more attractive to patients than a general psychological consult: "I think it's not spelled out exactly [what psychological consultations are]...rather than having a 'psych consult', that's so broad, [instead the psychologist could say] 'so today we're going to talk about your behaviours, you know, today we're going to talk about food'. That, for me, is something I really need help with so 'yeah, cool, I will be there'."

Furthermore, participants suggested incorporating post-operative appointments with psychologists as part of standard care in order to increase acceptance: "If it was part of, like, my post-operative plan then I would have, 100%, would have went...[but] it was only pre-operative" [TF1]. Participants thought that this strategy would be particularly effective if the price was included in the bariatric surgery package so that no additional costs are incurred, but should be optional because not every person requires such a service. FGM1 said: "I feel I'm okay at the moment and that's why I opted not to go ahead with [the psychologist appointment]".

3.3.3 | Sub-theme 3.3: Practical barriers to service engagement

Participants also raised some practical barriers to attending post-operative psychologist appointments. Cost was most commonly reported as a deterrent to the uptake of psychological care, and (as discussed above) participants suggested that it would be helpful if the cost of seeing a psychologist was either included in the bariatric surgery program or covered by Medicare. As FGF6 stated: "What I did find good was the fact that the cost [of psychological services] was mostly inclusive because things I tend to avoid are things I have to pay for."

Time constraints or conflicting responsibilities (e.g., childcare) were also reported as issues that interfered with appointment attendance. When discussing reasons why she found it difficult to attend post-operative psychologist appointments, FGF1 stated: "I guess fitting things in, time and stuff as well. The right days...I don't want it to impact on my, um, doing things when my child is home". TF2 suggested that the psychologist needed to accommodate for children in sessions: "I know single mums who have put their kids first because sometimes, oh, they can't find anyone to mind their child...you might have to bring your child... it's got to be acceptable as well."

Additionally, participants reported that travel distance/time could be a barrier for some patients. As TF2 said: "It should be close to where they live because some people might say 'oh, I can't get there because I can't drive' so it's got to be accessible".

Overall, participant accounts raise potential barriers to engaging in psychological care in the bariatric setting but also offer valuable suggestions to mitigate these barriers.

4 | DISCUSSION

The aim of this qualitative study was to explore bariatric surgery patients' post-operative experiences, views towards post-operative psychological care, and the factors that may impact acceptance of psychological services within the bariatric setting. Overall, participants generally considered psychological care to be necessary for behaviour change and, consequently, treatment success. Psychologists were regarded as an important, but sometimes overlooked, member of their bariatric healthcare team. Furthermore, pre-operative consultations were viewed as essential to evaluate surgical candidates' suitability

for bariatric surgery, and to set realistic expectations for the changes and challenges that may arise after surgery.

Consistent with previous studies, participants reported experiencing significant changes to their lifestyle, self-identity, and social relationships after bariatric surgery, leading to a sense of disorientation in their attempts to grasp their new identity as an individual without obesity.^{12,13} They might also be disappointed upon realization that some of their psychological and interpersonal problems persist despite weight loss. Likewise, participants' experiences of relationship conflict after substantial weight loss corroborated with existing literature. For example, partners may struggle with insecurities about their own weight, worries about infidelity,⁹ and adjustment to post-operative personality changes (e.g., increased sociability and assertiveness)^{14,15}. However, not all research finds negative effects on patients' psychological wellbeing and relationships. Other patients (both within the present study and in the literature) have reported significant improvements in self-confidence, social interactions, and quality of life,^{16,17} and studies have found that bariatric surgery can have a positive effect on romantic relationships.^{18,19} It is apparent that there is much variability in patients' experiences after bariatric surgery, and psychological care could be used to manage and optimize each patients' idiosyncratic post-operative journey.

Additionally, participants also wished to receive psychological interventions to address barriers to weight loss success. Numerous studies have demonstrated benefits of psychological interventions for bariatric surgery patients, particularly with regard to management of maladaptive eating, such as emotional eating and binge eating. For instance, mindfulness-based CBT delivered in a group setting resulted in significant improvements in binge eating symptoms, motivation to change maladaptive eating, and emotion regulation in post-operative patients.⁷ Similarly, acceptance and commitment therapy has demonstrated effectiveness in reducing emotional eating and increasing psychological flexibility in patients after bariatric surgery.^{5,6} Taken together, the evidence suggests that psychologists can offer tools and strategies to help patients implement behavioural changes, adhere to treatment recommendations, and, consequently, optimize surgical outcomes.

Finally, several factors were identified as having an impact on patients' willingness to engage with psychological services after bariatric surgery. Participants expressed a preference for psychologists with expertise in bariatric surgery or weight loss as well as personal experiences of bariatric surgery because it was thought that these characteristics would increase understanding and empathy. Bariatric surgery clinics could also increase uptake by including education and referrals to psychologists by medical professionals, and incorporating psychologist appointments into standard aftercare (particularly if the costs were included in the surgery package so that there were no additional expenses).

5 | LIMITATIONS

This study was limited by its inclusion of three undersized focus groups (i.e., two participants each) due to the high rates of non-

attendance to those sessions, despite over-recruitment and two reminders in the week leading up to the session. Nevertheless, the lead author (and group facilitator) observed that the participants were able to openly and dynamically discuss topics with minimal intervention. Additionally, because participants had self-selected to take part in a focus group about experiences after bariatric surgery, these individuals may have greater interest and/or insight into psychosocial aspects of weight loss, which may not be representative of the general bariatric surgery population. Finally, this study was conducted in Australia; therefore, the findings may specifically reflect patient experiences within the Australian context. Over 90% of bariatric surgeries in Australia are conducted in the private healthcare system²⁰, which are funded privately, through private health insurers, or through early access to superannuation funds. Consequently, psychological care within the bariatric setting varies depending on what the private clinic chooses to offer. It is possible that patient perspectives may differ in other countries depending on the availability or accessibility of psychological management in the bariatric context.

6 | CONCLUSIONS

The present study was the first qualitative study to investigate patients' psychological needs and their perspectives on psychological services after bariatric surgery. The findings suggested that individuals are largely receptive to engaging with a psychologist in the bariatric surgery setting. Taken together with evidence that supports the effectiveness of psychological interventions in improving outcomes after bariatric surgery,²¹ there may be value in incorporating psychological care as part of routine pre- and post-operative management. Overall, this study presented novel insights into bariatric surgery patients' perspectives on psychological care, which can be used to guide the development of services for patients in order to meet their needs before and after bariatric surgery.

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CONFLICT OF INTEREST

No conflict of interest was declared.

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