



“When the honeymoon is over, the real work begins:” Gastric bypass patients' weight loss trajectories and dietary change experiences



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ABSTRACT

To understand gastric bypass patients' experiences with managing food and eating for long-term weight management, this study examined patients' self-reported dietary changes and weight loss patterns. Thirteen women and three men between 15 months and 10 years post-gastric bypass surgery were recruited in Upstate New York. They completed two qualitative, in-depth interviews about their weight loss and dietary experiences. Using verbatim transcripts, researchers created timelines for each participant that summarized weight changes and the associated dietary behaviors. Constant comparative analysis of the timelines and transcripts identified a common, initial rapid weight loss period followed by weight stabilization, after which participants' weight loss patterns diverged into three possible long-term trajectories (Maintaining, Regained/Losing, and Regained) and one short-term trajectory (Losing). Dietary management over the periods of weight loss involved six components: physical needs, hunger and fullness, relationship with food, strategy use, habit formation, and awareness of eating. In the “honeymoon period” weight loss was “easy” because “surgery does the work” in limiting appetite, portion sizes, and interest in foods. As weight stabilized, “the work begins” as participants became capable of eating a greater quantity and a wider variety of foods. Differences in weight loss trajectories were associated with participants' abilities to maintain changes in relationship with food, dietary strategies and habits, and awareness of eating behaviors. Viewing weight loss outcomes of gastric bypass surgery as trajectories that develop as the result of dietary transitions and changes in dietary management suggests that patients need to be counseled on a variety of cognitive and behavioral strategies.

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1. Introduction

Major weight loss resulting from bariatric surgery loss has been described as a “self-transformation” (Sutton et al., 2009). Drastic changes in weight alter self-perceptions and body image, leading to changes in identity, confidence, and social interactions (Bocchieri et al., 2002). The physical transformations happen quickly, as patients who undergo gastric bypass surgery can expect to lose approximately 35% of their body weight in the first year, with averages of approximately 95 pounds (Buchwald et al., 2004).

Long-term studies have reported that between 14% and 29% of patients regain more than 10% of their weight loss (Freire et al., 2012; Valezi et al., 2013), suggesting the cognitive and behavioral changes needed to sustain weight loss are not always permanent. Although the processes involved are not well understood, poor weight loss outcomes (e.g. regain or inadequate loss) have been

associated with maladaptive eating behaviors such as grazing (Colles et al., 2008), emotional eating (Mathus-Vliegen, 2006), and loss of control when eating (Kofman et al., 2010). (Sarwer et al., 2008). Factors which promote adequate and/or sustained weight loss include avoiding maladaptive eating behaviors, compliance with post-surgery dietary recommendations (Sarwer et al., 2008), support group attendance (Livhits et al., 2010) and physical activity (Welch et al., 2008).

Gastric bypass patients must also make dietary changes to accommodate their permanently altered digestive tract. Gastric bypass surgery promotes weight loss by reducing the size of the stomach to between 15 and 25 ml and reconfiguring the small intestine, whereby food does not pass through the duodenum and proximal jejunum (Buchwald, 2005). Decreased intake is due to limits on volume of food consumed and reduced hunger due to changes in secretions of appetite hormones (Ochner et al., 2011). Food selection frequently changes within the first year. Patients may avoid high fat foods (Thomas and Marcus, 2008) or reduce

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protein intake (Moize et al., 2003) due to intolerances. Presumably many changes are due to dumping syndrome, a variety of unpleasant gastrointestinal symptoms (e.g. diarrhea) and/or hypoglycemia that occurs after consuming high sugar or high fat foods, and other side-effects of surgery (Overs et al., 2012), or alterations in taste and craving (Behary and Miras, 2015). However, studies find that macronutrients and food selections return to pre-surgery patterns in a year (Miller et al., 2014; Sarwer et al., 2008). Thus, there remains a gap in our understanding of motives for dietary changes and influences on the stability of these changes.

An integrated, grounded theory model of the food choice process (Sobal and Bisogni, 2009) provides a useful framework for examining gastric bypass patients' long-term dietary management. This model takes a social constructivist perspective (Charmaz, 2000) viewing individuals as actively constructing their thoughts, feelings, and behaviors based on a variety of personal, social, cultural, economic, and environmental factors (Sobal and Bisogni, 2009). People develop personal systems of meanings and cognitive processes for making tradeoffs among conflicting food choice values (e.g. health and taste), ways of classifying foods and situations (Blake et al., 2007), and scripts and routines for familiar situations (Blake, 2008).

From the life course perspective (Wethington, 2005), gastric bypass surgery is a critical turning point with the potential to permanently alter the path of one's food choices and dietary patterns, just as it alters one's weight and body. Studies examining patients' experiences with food and eating post-surgery have uncovered changed relationships to food, challenges in dealing with emotional eating, and an increased awareness of eating behaviors (Benson-Davies et al., 2013; Wood and Ogden, 2015). Ogden et al. (2006) found that after an adjustment period, patients felt they had more control over their eating behaviors. In addition, Lynch and Bisogni (2014) documented patients' intentional use of strategies to manage weight, promote health, and avoid negative reactions to eating. Although these studies highlight important cognitive and emotional processes that shape patients' experiences and behaviors, they generally focus on diet and weight as separate, emergent themes. However, the two change concurrently. This study aims to add to the literature by describing the experiences of weight loss and the processes of changing dietary behaviors simultaneously and providing a conceptual model to explain how these occur together. Using a social constructivist perspective and qualitative interviews, the researchers examined detailed information from patients regarding their experiences with dietary changes and weight loss management after surgery.

2. Methods

Purposive sampling (Lincoln and Guba, 1985) was used to recruit adult gastric bypass surgery recipients, who were a minimum of 12 months post-surgery. The researchers assumed that by one year, participants would have experienced maximum weight loss (Sjöström et al., 2004), would have transitioned to new ways of eating and managing weight, and would be able to reflect upon the process of change and make comparisons between pre-surgery and post-surgery experiences.

Sixteen participants (13 female, 3 male) were recruited from three different bariatric support groups in Upstate New York. With permission of the group leader, the researcher also observed the support group meetings. The first wave of recruitment in 2006 yielded ten participants from support groups associated with two regional hospitals. Six more participants were recruited in 2009 from a third support group that met as part of a work-site wellness program. These additional participants were recruited to confirm findings from preliminary analysis of the initial interviews and to

expand diversity of experiences. By the 16th participant, no new information emerged that added to the existing categories and themes. It was believed theoretical saturation was achieved and recruitment efforts ended (Glaser and Strauss, 1967). All study procedures were approved by Cornell University's institutional review board. Study purpose, procedures, and risks/benefits were explained to the participants both verbally and through a written consent form. Written informed consent was obtained prior to the start of the first interview.

Participant characteristics are summarized in Table 1. Participants ranged in age from 32 to 63 years. Fourteen participants lived with spouses or partners, one participant lived with children, and one participant lived alone. Time since surgery ranged from 14 months to 10 years, with an average of three years, eight months. Fifteen participants had gastric bypass surgery as their first bariatric surgery and one had a revision to gastric bypass due to complications from a previous bariatric procedure. All participants' surgeries were covered by insurance.

Semi-structured interviews were used to elicit detailed descriptions of participants' experiences. Interview questions were developed using the Food Choice Process Model (Sobal and Bisogni, 2009) as a guide to uncover participants' present and past food selection and eating behaviors and to understand the influences and rationales for their decisions. Questions also covered the topics of pre-surgery weight and dieting history, post-surgery weight loss, health, and surgical experiences. Each participant was interviewed twice, with approximately one month between interviews, to allow time to review transcripts. The first interview focused on dietary behaviors and the second on weight and post-surgery experiences. Two interviews allowed for in-depth, detailed exploration of topics while reducing participant and interviewer fatigue. These multiple contacts promoted rapport and provided the researcher with the opportunity to clarify details and confirm interpretations from the previous interview.

The interview guide was pilot tested with an individual meeting the criteria for the study. As no major changes were made to the

Table 1
Participant characteristics.

	Count
Marital Status	
Married	12
Single	4
Household Composition	
Lives alone	1
Lives with spouse/significant other only	9
Lives with spouse and children	4
Other	2
Education Level	
High school diploma	1
Associates Degree	6
Trade School	2
Some College	5
Graduate or Advanced Degree	2
Employment	
Full-time	9
Part-time	3
Unemployed/Retired/Disability	4
Income^a	
\$10–19,000	1
\$20–29,000	1
\$30–39,000	1
\$40–49,000	1
\$50–59,000	3
>\$70,000	8
Time since surgery	
Less than 2 years (14–17 months)	5
2–4 years (2–3.75 years)	5
5–10 years (5–10 years)	6

^a One person did not report their income.

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