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A complex relationship with food

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Submitted in fulfillment of the requirements for the degree

of:

Doctor of Psychology

Department of Psychology

City University, London

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Table of contents

Table of contents 2
City University Declaration 9
I. Sections of the portfolio 10
II. Reflections on my professional development 11
III. Central theme permeating throughout the portfolio 12
IV. Reflections on theory and practice in Counselling Psychology 13
Section A: The Research Study 15
Abstract 15
1.0 Literature 16
1. 1 Meaning and symbolism of food 16
1. 2 Why males? 20
1.3 What is obesity? 24
1.4 Aetiology of obesity 26
1.5 Stigma and obesity 29
1.6 Obesity, eating disorders and mental health 33
1.7 Weight loss surgery (WLS) 36
1.8 Pre-operative psychological assessment 41
1.9 The meaning of awaiting for weight loss surgery 43
1.10 Summary 46
2.0 Methodology 48
2.1 Research aims 48
2.2 Rationale for using a qualitative research paradigm 48
2.3 Rationale for using Interpretative Phenomenological Analysis (IPA) 51
2.4 Epistemological considerations 55
2.5 Ontological considerations 55
2.6 Interviews 56
2.7 Interview schedule 58

2.8 Sampling Considerations 59
2.9 Pilot interviews 61
2.10 Introduction of financial incentive 62
2.11 The participants 64
2.12 Reflexivity 65
2.13 Ethics and Permissions 70
2.14 Data Analysis 71
3.0 Analysis Chapter 75
3.1 Introduction 75
3.2 Superordinate theme 1 - Family milieu: past and present 76
3.3.1 Patriarchal family values 77
3.3.2 Adverse home life 78
3.3.3 Family rules around eating 79
3.4 Superordinate theme 2: Food as the self-soother 80
3.4.1 Trauma 80
3.4.2 Mourning the losses 86
3.4.2.1 Loss of physical function 86
3.4.2.2 Loss of a loved one 88
3.4.2.3 Loss of a job 90
3.4.3 Disordered eating 91
3.4.3.1 “Gorge ourselves” 91
3.4.3.2 Night eating 92
3.4.3.3 Emotional eating 92
3.5 Superordinate theme 3: Socio-cultural ramifications 93
3.5.1 Social versus private eating 93
3.5.2 Cultural identification with food 95
3.6 Superordinate theme 4: Food and self-identity 98
3.6.1 Competitive-self/alpha male 98

3.6.2 Body shame 101
3.6.2.1 Internal versus social stigma 102
3.6.3 Self-identity/merged identity with food 103
3.6.3.1 Food as an addiction 104
3.7 Superordinate theme 5: Food and weight-loss surgery expectations 106
3.7.1. Fear of complication/fear of mortality 106
3.7.2 Saviour/magic tool 108
3.7.3 High expectations in terms of weight loss 110
3.7.4 Being in limbo 111
3.7.5 Social support 113
3.8 Over-arching theme: Food and the masculine-self 114
3.9 Summary 117
4.0 Discussion 118
4.1 Research aims and summary of results 118
4.2 Discussion of analysis in context 118
4.2.1 Food and self-identity 118
4.2.2 Food as the self-soother 124
4.2.2.1 Disordered eating 124
4.2.2 Trauma 127
4.2.3 Losses 128
4.3 Family milieu: past and present 129
4.4 Food and weight loss surgery expectations 130
4.5 Socio-cultural ramifications 135
4.6 Evaluation of the research 138
4.6.1 Personal reflexive statement on the impact of the research 141
4.7 Contribution to counselling psychology 145
4.8 Limitations of the current study and ideas for further research 147
4.9 Implications for clinical practice 148

4.9.1 Bringing men's voices to the forefront of the obesity discourse..... 148
4.9.2 Engaging men in bariatric psychological provision 149
4.9.3 Psychological conceptualisation of the findings..... 152
4.10 Concluding thoughts 155
References 156
Contents of Appendices 183
Appendix A: Invitation to take part 184
Appendix B: Participant Information Sheet 185
Appendix C: Consent form..... 190
Appendix D: Demographic sheet 191
Appendix E: Debrief sheet 192
Appendix F: Interview schedule 194
Appendix G: Participant information and reflective notes 196
Appendix H: Copy of ethics form 202
Appendix I: from stage two and three of the analysis process 207
Appendix J: Exemplar from stage four of the analysis process 211
Appendix K: Exemplar from stage 6 of analysis process..... 222
Appendix L: Appearance of superordinate and cluster themes for each participant 230
Section B: The Journal Article..... **Error! Bookmark not defined.**
Introduction ..... **Error! Bookmark not defined.**
What is obesity? ..... **Error! Bookmark not defined.**
Why males? ..... **Error! Bookmark not defined.**
Weight loss surgery (WLS) ..... **Error! Bookmark not defined.**
Aims..... **Error! Bookmark not defined.**
Methods ..... **Error! Bookmark not defined.**
Design..... **Error! Bookmark not defined.**
Participants ..... **Error! Bookmark not defined.**

Procedure ..... **Error! Bookmark not defined.**

Data analysis ..... **Error! Bookmark not defined.**

Analysis and discussion..... **Error! Bookmark not defined.**

Food and self-identity ..... **Error! Bookmark not defined.**

Competitive-self/alpha male ..... **Error! Bookmark not defined.**

Body shame..... **Error! Bookmark not defined.**

Self-identity/merged identity with food..... **Error! Bookmark not defined.**

Limitations of the current study and ideas for further research..... **Error! Bookmark not defined.**

Clinical implications ..... **Error! Bookmark not defined.**

Conclusions ..... **Error! Bookmark not defined.**

References ..... **Error! Bookmark not defined.**

Appendix N: Author's guideline for the British Journal of Health Psychology ..... **Error! Bookmark not defined.**

Section C: "Food as my friend, food as my enemy: A client case study".... **Error! Bookmark not defined.**

Part 1: Introduction to the therapeutic work..... **Error! Bookmark not defined.**

Introduction..... **Error! Bookmark not defined.**

1.1 Summary of theoretical orientation..... **Error! Bookmark not defined.**

1.2 The referral and context of the work..... **Error! Bookmark not defined.**

1.3 Initial assessment and formulation of the problem ... **Error! Bookmark not defined.**

1.4 Negotiating a contract and therapeutic aims ..... **Error! Bookmark not defined.**

1.5 Summary of biographical details of client .. **Error! Bookmark not defined.**

Part 2: The development of the therapy ..... **Error! Bookmark not defined.**

The pattern of therapy ..... **Error! Bookmark not defined.**

Beginning stages of therapy (sessions 1-5)..... **Error! Bookmark not defined.**

The sixth session: an unexpected visitor..... **Error! Bookmark not defined.**

Middle stages of therapy (sessions 7-11)..... **Error! Bookmark not defined.**

End of work (sessions 12-16) ..... **Error! Bookmark not defined.**

Making use of supervision ..... **Error! Bookmark not defined.**

Part 3: The conclusion of the therapy and the review..... **Error! Bookmark not defined.**

What you learnt about psychotherapeutic practice and theory..... **Error! Bookmark not defined.**

Learning from the case about yourself as a therapist..... **Error! Bookmark not defined.**

Appendix M: Sara's initial cognitive behavioural formulation. **Error! Bookmark not defined.**

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Lastly, I would like to thank my husband, family and friends for their unconditional love and support through my Doctorate training and for braving through by my side throughout the joys and hurdles of the research venture.

I would like to dedicate this thesis to the memory of my father, Robert Abrami, whose health had been very poorly throughout this project. He has never ceased to believe in me and showered me with love and praise. I miss him deeply. I also would like to dedicate this thesis to my daughter, Noa Bluestone, who came into this world during this project and has been the light of our life and symbol of hope for a better tomorrow

City University Declaration

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Preface

This portfolio is about people's complex relationship with food from a counselling psychology framework. It combines both evidence-based research as well practice-based research, which embodies the underlying ethos of counselling psychology. I will start by presenting the three main sections of the portfolio, reflections on my professional development, the central theme connecting the various sections and reflections on theory and practice in counselling psychology.

I. Sections of the portfolio

This portfolio comprises of three main sections:

1. Section A: Firstly, I will present the research study, which explores men who are classified as 'obese' and their relationship with food prior to undergoing bariatric surgery. This research is based on the lived experience on eight men who are waiting to have weight loss surgery.

2. Section B: Secondly, I will present a journal article that is fit for publication according to the author's guidelines. (Please refer to Appendix N.) The journal article is an abridged version of the research study from section A and will demonstrate some aspects of the findings. I aim to publish in the British Journal of Health Psychology, which is edited by Professor Alison Wearden and Professor David French and has a high impact factor of 2.895. The empirical research component of this portfolio is primarily concerned with eating behaviours and health, which

would be of particular relevance and interest to the readership of this journal.

3. Section C: Lastly, I will present a clinical case study of my work with a client diagnosed with bulimia nervosa. The case study ties in with key aspects of my research literature and findings from section A. The case study examines theoretical background and clinical work as well as reflexive practice, use of supervision and areas of professional development.

II. Reflections on my professional development

Throughout my training as a budding counselling psychologist, I have learned to be mindful and attuned to the use of language employed by clients when describing their inner turmoil and physical embodiment and to move away from the prevailing biomedical rhetoric that typifies human distress according to diagnostic labels and symptom classification. Instead, I embrace and value a person's subjective inner experience as I have found that no two people with the same diagnosis or referral share the same needs, aspirations, readiness for change or use of the therapeutic encounter.

I feel deeply moved and privileged to be able work as a psychologist and share morsels of my clients lives. As Kottler (2010) justly said: "Being a therapist affords us the opportunity for continual spiritual, intellectual, and emotional growth" (p.68). The therapeutic relationship is intimate, collaborative and dynamic. Clients show different willingness to engage and have their own pace. I like to draw on 'third wave" cognitive behavioural therapies in my therapeutic practice, especially from compassion-focused and acceptance-commitment therapies, and remind clients that we are all '*imperfect human beings'* and that being able to be vulnerable in the presence of another person is a sign of great

courage, strength and venerability and not a sign of weakness, capitulation and shame.

III. Central theme permeating throughout the portfolio

The prevailing theme throughout this research portfolio is tied in with people's complex relationship with food. This complexity can manifest itself in an individual being incongruent and/or lacking authenticity. I borrow here Rogers' (1961) operationalisation of congruence whereby a person's needs are "matching of experience, awareness, and communication" in order to allow learning and growth to take place (p.339). Mearns and Thorne (1988) extend the definition of congruence by encompassing elements of authenticity, realness, transparency and genuineness. In other words, at times people exhibit an incongruent relationship with food whereby they are not being self-reflective, truthful and self-aware of the true dynamics that unfolds, and why they misuse food to cope with other problems of daily living. Whether people are diagnosed with an eating disorder (such as the young woman in my case study) or are classified as obese (such as the men in my research study), food can often be used and abused as a means of affect management. In a therapeutic relationship, as psychologists we encourage our clients to relinquish any incongruent façades and explore the role and functions that they subserve.

Food goes beyond the simple function of physical sustenance and reaching one's satiety level. It extends to further roles such as substituting for a lack of emotional nourishment (i.e.: affection, validation, reward, etc.) and/or fulfilling existential voids permeating someone's intrapersonal and interpersonal world. In those instances, food becomes a symbol of identity and communication. The act of eating is laden with cognitive-affective, socio-cultural, behavioural, physiological and relational meaning. The reasons and functions behind why

people eat what they eat are vast and manifold. For example, someone might eat a particular type of food to conform to an acceptable social norm, to attain a certain physicality, to contain painful feelings or to experience a culinary dish with gusto (Bryant-Jefferies, 2005). This portfolio invites the readers to reflect on their own relationship with food and what it symbolises for them.

IV. Reflections on theory and practice in Counselling Psychology

One of the foundations of counselling psychology is its relational focus, which leans towards a phenomenological mode of enquiry and advocates for an individualised formulation of the client's source of distress and to collaboratively explore the meaning and intricacies ascribed to their psychological ailments. The therapeutic relationship is the driving force and determinant of any foreseeable change that would lead a client to amelioration in their daily functioning. As an existential psychiatrist, Irvin Yalom (2001) astutely said: "Each individual has a different internal world and the stimulus has a different meaning to each" (p.50). I share the belief that the therapeutic relationship overrides any alignment to a single theoretical paradigm to conceptualise an individual's pain and suffering.

An important tenet of counselling psychology that encompasses the ethical, research, therapeutic and philosophical arenas is the recognition that individuals are '*relational beings'* (Milton, 2010). As a counselling psychologist, I embrace a holistic depiction of my clients' internal landscape which takes into account broader socio-cultural, political, economic drivers which colour the therapeutic relationship. I adopt a postmodernist epistemological stance in my practice that departs from the longstanding traditional Cartesian dualistic divide of the mind and body that has dominated the field of psychology, rendering it scientifically objectifiable, empirical and positivist. Instead of viewing human distress as pathological, reigning in the sphere of the '*mad, bad and sad'* and labelling it as '*mental disorder'* which still complies with a Cartesian binary perspective of the mind and body as separate entities; I value the underlying counselling psychology philosophy which strives towards giving our clients' their

own sense of agency, empowerment and responsibility towards their well-being, and places emphasis on the importance of the intersubjective, relational and embodied experiences (Appignanesi, 2008; Manafi, 2010; Finlay, 2011). As du Plock (2006) advocates, counselling psychologists are not anchored in illness and disease models, but rather on what defines us as human beings.

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Section A: The Research Study

Men classified as 'obese' and their relationship with food prior to undergoing bariatric surgery

Abstract

Eating from birth onwards is closely connected with interpersonal and emotional experiences and, therefore, its psychological and physiological dimensions cannot be strictly differentiated. This research aims to gain an in-depth understanding of obese men's relationship with food prior to having weight loss surgery, as there is a paucity of studies solely representing men's idiosyncratic views and opinions.

This research adopts a qualitative design and uses interpretative phenomenological analysis (IPA) to analyse the data as it has been shown to be an effective approach when little is known on a topic, there is novelty and complexity, and there are issues relating to identity and sense making.

Eight participants have been recruited through two well renowned charities: (1) the British Obesity Surgery Patient Association (BOSPA and (2) Weight Loss Surgery Information and Support (WLSinfo). Participants were invited to take part in a 60 minute face-to-face semi-structured interview and asked questions regarding their relationship with food prior to receiving bariatric surgery.

The over-arching theme of 'Food and the masculine-self' emerged with five interrelated superordinate themes: (1) 'Family milieu: past and present', (2) 'Food as the self-soother', (3) 'Socio-cultural ramifications', (4) ' Food and self-identity', and (5) ' Food and weight loss surgery expectations'. These results represent my interpretation of my participants' interpretation of their lived experience.

The findings increase our understanding and knowledge on how best to support men psychologically prior to undergoing bariatric surgery. Additionally, it gives men a voice in a field where the preponderance of the literature in qualitative research has solely focused on women's narratives.

1.0 Literature

> "*Food is a metonym of the mortality of human flesh, the inevitable entropy of living matter. Food is therefore a source of great ambivalence; it forever threatens contamination and bodily impurity, but is necessary for survival and is the source of great pleasure and contentment" (Lupton, 1996, p.3)*

1. 1 Meaning and symbolism of food

Eating from birth onwards is closely connected with interpersonal and emotional experiences and, therefore, its psychological and physiological dimensions cannot be strictly differentiated (Bruch, 1973). Food acts as the medium between the mother and her infant and symbolises emotional nurturance, comfort, protection and, most importantly, love and affection. According to Freud (1905), a child sucking on his mother's breast behaves like an erotogenic zone and the accompanying pleasurable sensation fulfils his need to be nourished (in Gay, 1995). It is through the mother's breast that there is that first dyadic relationship that starts to flourish (Gerhardt, 2004). Bowlby (1958) calls this the theory of Secondary Drive when a child learns to attach to his mother as his source of gratification because she meets his physiological needs for food and warmth. If there is a synchronous feeding relationship, this will support the child's developmental need as well as fostering positive attitudes about self and the world (Satter, 1986). The parent-child relationship is characterised by a power struggle in terms of the bodily habits of the child (Lupton, 1994).

I was always fascinated by the meaning, nature and symbolism that food represents for people- how food could act as a basic element for man's survival but could also take on a very different meaning that goes far beyond just the act of feeding and meeting a primary physiological need. Food takes on varying representations from symbolic interpersonal acceptance, trust, connectedness,

motherliness, friendliness, sociability and warmth (Moore, 1957). A mother teaches her children what foods, when, how much, why, and the associated feelings experienced when they eat (Moore, 1957). The function of food is not strictly related to its biological function but incorporates a complex value and ideology system as well. “Religious beliefs, rituals, prestige systems, etiquette, social organisation and group unity are related to food” (Powdermaker, 1960, p.287).

Food and eating are vital to our sense of self, our experience of embodiment and subjectivity (Lupton, 1996). Food consumption is not only tied into our physiological need for survival, because without it human bodies do not exist, but it also extends into socio-cultural rituals, traditions, genders, spirituality, professional and developmental realms of meanings (Lupton, 1996). People turn to food for emotional regulation and this can be communicative of feelings of comfort, boredom, pleasure, guilt, anger, treat and celebration among a few (Ogden, 2008).

Buckroyd (1994) states that people misuse food “instead of feeling or knowing, or understanding something that feels too difficult or frightening or unacceptable” to articulate (p.13). It is not solely individuals who are classified as “obese” or suffering from an eating disorder that turn to food for emotional nourishment, but, in fact, research indicates that most people do (Ogden, 2008). These messages are learned from early childhood onwards through associative and social learning processes, which build a rich repertoire of cognitions around food (Ogden, 2008). Ogden (2008) discusses the many arrays of meanings that food can hold in terms of emotional, conflictual, social, communicative roles and index of health and physical well-being.

In terms of the emotional roles, food is often embedded with sources of conflict such as eating versus denial, guilt versus pleasure, self-control or lack of control and food being perceived as healthy or not (Ogden, 2008). A healthy diet is often perceived as more moral, intelligent and attractive, and some foods have

historically been classified as more gendered. For example, meat has been strongly connected with cultural notions of masculinity and power (Ruby & Heine, 2011). Ruby and Heine (2011) have carried out a study in Canada (n=273) to assess how people perceive a “good” versus “bad” diet. Interestingly, the male participants in the study perceived vegetarians as less masculine than their omnivorous counterparts as meat is viewed as a symbol of power and status (Ruby & Heine, 2011). People tend to eat what is linked with social norms, cultural beliefs and some foods are coded as more in the masculine realm such as consumption of meat and alcohol (Roos, Prättälä & Koski, 2001).

With regards to self-control and lack of control over eating, Western values embrace a person who exhibits self-restraint, thus bodies become physical symbols of how much their “owners” exert self-control (Lupton, 1996). Hence, an overweight body might be evaluated as gluttonous, self-indulgent, hedonistic, lacking self-discipline, shameful, and not conforming to social standards of attractiveness and acceptability (Lupton, 1996). Indeed, this dichotomy of food being fundamentally fun as it is an intimate exchange between the self and other (environment) through the orifice of the mouth brings both feelings of pleasure and fear, especially in a day and age where we are socio-culturally bombarded by ambivalently laden messages about “good” versus “bad” foods from our parents, teachers, peers, teaches and the media (Rozin, 1999).

The principle of incorporation becomes fraught with anxiety as we become what we eat and this, in turn, forms the basis of our self-identity (Fischler, 1988). Fischler (1988) describes man’s omnivorous paradox, meaning that as omnivores we have autonomy, freedom, adaptability to thrive on a multitude of food sources and diets, be flexible in accordance with our environment. However, we need variety in our nutrients (carbohydrates, proteins, fats, vitamins, minerals, etc.) for our survival unlike specialised eaters who obtain all their nutrients from one food. The paradox resides in the oscillation between the two “poles of neophobia (prudence, fear of the unknown, resistance to change)

and neophilia (the tendency to explore, the need for change, novelty, variety)" (Fischler, 1988, p.278).

Furthermore, food symbolises self-identity in terms of gender, sexuality, self-control, social identity with issues of power and love, and cultural identity with regards to religion and social power (Ogden, 2010). Food is also central to our sense of collective, cultural belonging and *otherness* (Fischler, 1988). Starr Sered (1988) conducted a study among elderly pious Middle-Eastern Jewish women (n=100) and found that for them cooking was about caring for their families' physical, cultural, spiritual needs and was embodied and ritualised in the traditional aspect of Jewish dietary law, the *Kashrut.*

Human beings delineate their cultural group membership by asserting the specificity of what they eat or don't eat, symbolising their differences from *others* (Fischler, 1988). Food becomes the epicentre of family interaction around the dinner table, a means of welcoming others through the offer and sharing of food as a form of hospitality, which establishes and maintains interpersonal intimacy (Rozin, 1999). The meaning of "*company*" originates from the Latin for "*com*" meaning "*together"* and "*panis*" which means "*bread*", in other words eating is a socially intertwined behaviour and an invitation to break "bread together". As Rozin (1999) says, eating is "essential, elating, emotional and expansive" (p.28).

This project focuses on men who are classified as obese and their relationship with food prior to having weight loss surgery. This is an area of great importance to Counselling Psychology as most professionals working with obese clients have leaned towards a biomedical and behavioural model, which neglects the importance of the subjective experience of the clients and engaging with them as collaborators seeking to understand their inner world. Counselling Psychology is drawn from humanistic values from the 1960's which put forward three core conditions when working with clients: empathy, acceptance and authenticity, and the emphasis is placed on being with the

clients, rather than doing something to them (Woolfe, Strawbridge, Douglas, & Dryden, 2010). Humanistic values hold a largely phenomenological viewpoint of the therapeutic relationship as our search for knowledge comes from a desire to understand our clients' perceptions of the world, what is means to them, to unravel their stories and to focus on their lived experience (Langdridge, 2007).

1. 2 Why males?

At first I had a predilection to focus my project on women as I was drawn to feminist psychoanalytic theories (Orbach, 1978; Chernin, 1985; Lawrence, 1987; Williams, 1997), and I wanted to explore women's experiences of being obese who were on a waiting list for weight loss surgery. Feminist scholars were the first to theorise about body image and weight issues from the late 1970s to the mid-1990s and they linked the construct of fear of fatness with femininity and patriarchy (Bell & McNaughton, 2007). Orbach (2006) has stated that fat is a feminist issue, a social disease and is about mothering, rage, nurturance, sex and assertion (p.15). But what about men in the equation, why are their voices not heard?

Chernin (1985) stipulates that men express their mother-separation struggle through a preoccupation with sexuality as opposed to eating. It has been posited that men's disregard for their health has been attributed to the male role expectation and that masculinity has been connected with risk-taking behaviours, aggressiveness, a denial of weakness and a reluctance to seek help (De Souza & Ciclitira, 2005). However, men are not immune to concerns about their body and weight and, as far back as the 19th century, men were archetypal dieters. However, today they are exposed to similar body image concerns and unrealistic body ideals to strive for as women (Bell & McNaughton, 2007). There has been a dramatic rise in the perception of the male body as a desirable sexual object, eroticised in fashion, culture and media which points to an idealised masculinity (Gill, Henwood & McClean, 2005). There has been a paradigm shift in the last decade that place the male body as

the object of gaze rather than the bearer of the look, and this has taken a toll on men by creating increasing anxiety about their health, self-esteem and body image (Gill, Henwood & McClean, 2005).

The muscular mesomorph has been considered to be the male body ideal as it ties in with cultural views of masculinity which prescribe men as authoritative, efficacious,even domineering and destructive (Mischkind, Rodin, Silberstein & Striegel-Moore, 1986). Monaghan (2005) carried out a virtual ethnographic study exploring fat male embodiment from participants who have been clinically categorised as overweight or obese and stipulated that in the context of bodyism, fatness has been "used to emasculate male bodies or render them subordinate on masculine hierarchies" (p.97). Bodyism refers to a prejudicial cultural belief that the whole body more so than the face reflects someone's individual character (Monaghan, 2005). In present-day Anglophone culture, fatness symbolises lack of self-discipline and adherence to essential masculine traits such as being active and in control (Monaghan, 2005). When examining men's talk about physical exercise and the obesity discourse, Monaghan (2008) employs Bourdieu's (2001) notion of "symbolic violence" in a field of "masculine domination" whereby society's portrayal of fatness is imbued in the realm of the feminine and often seen as immoral and pathological in accordance with a society that renders fatphobic and sizist norms.

One recent Australian study conducted by Thomas, Hyde, Castle and Komesaroff (2011) examined obese men's experience with their weight and strategies for change, and the results demonstrated that men felt responsible for their obesity. The study also showed that there was stigma and self-blame concomitant with the barriers of weight change (Thomas et al., 2011). A possible assumption could be that men have tended to be positioned in society as resistant to disease; concern for health has been portrayed as a feminine behaviour (De Souza & Ciclitira, 2005). Gender is socially constructed and negotiated through relationships of power, which have portrayed men as reliant, independent, robust and strong (Courtenay, 2000).

Men have been shown to adopt health beliefs and behaviours that conform to hegemonic masculine ideals which depict them as more powerful and less vulnerable than their female counterparts, and that asking and seeking help for one's health is viewed in the feminine realm (Courtenay, 2000). The growing body of gender specific studies that has examined the reasons why men are more reluctant to seek help for their health has been attributed it to the fact that they adopt a "*traditional masculine behaviour*" when it comes to their physical well-being (Galdas, Cheater & Marshall, 2005). However, men are not a homogenous group. More research is needed, especially qualitative enquiries, to gain a greater understanding of the barriers linked with the decision making process of why men are reluctant to seek help when they experience illness (mental and/or physical) and to pay closer attention to factors such as ethnicity, age, socio-economic status and cultural beliefs which will modulate the findings (Galdas et al., 2005). Sex-difference studies do not account for within-group and person variability and the fact that not all men will behave in a similar fashion when it comes to help-seeking context (Addis & Mahalik, 2003).

In the United Kingdom, death rates from all major causes (cardiovascular, respiratory diseases and cancer) are higher for men than women (Office of National Statistics, 2012). This is not only due to biological predispositions but also to social factors such as men's perception of their masculinity and the health beliefs they uphold. Sloan, Gough and Conner (2010) carried out a qualitative study to examine healthy men's (n=10) descriptions of their masculine identity and health behaviours and found corresponding themes of hegemonic masculinity, such as a focus on their bodily functionality, autonomy and rationality and that talking and thinking about their health was construed as feminine. O'Brien, Hunt and Hart (2005) conducted focus groups with men (n=55) from very diverse background in terms of age, occupation, socio-economic status (SES) and health status and asked them questions regarding their help seeking behaviours and masculinity. Their findings predominantly endorsed the hegemonic view of masculinity. However, there were instances where help-seeking was perceived as a restorative and preservative function of

masculinity (i.e.: maintaining a sexual performance function) (O'Brien et al., 2005).

Men's help seeking behaviour is a product of masculine gender role socialisation whereby men learn gendered attitudes, norms, cultural values and ideologies about what it means to be a man. They emphasize the importance of self-reliance and emotional control (Addis & Mahalik, 2003). Men's health behaviours are embedded and influenced by the social context in which they live in (Mahalik, Burns & Szydek, 2007).

When it comes to men's physical health, a policy report commissioned by the Men's Health Forum (a charity founded in 2001 and dedicated to the promotion of health and well-being of men and boys in the UK) cautioned that men were more at risk of developing weight-related diseases due to the fact that two thirds of men in England and Wales are overweight or obese compared to just over half of women (Wilkins, 2005). Men tend to accumulate weight at a faster rate than women across Europe which could be partially attributed to societal changes where men work less in manual work, have an increasingly sedentary lifestyle, reduced physical activity, longer working hours and consume more alcohol (White & Cash, 2003). Overweight men tend to accumulate fat around the abdomen which has been linked with a higher risk of developing metabolic syndrome (i.e.: central obesity, type 2 diabetes, high blood pressure and cholesterol). However, most men are often "in denial" about their weight, and gender stereotypes of "*bigness*" in men tend to translate into messages of health and physical attractiveness (Wilkins, 2005). Hence, the Men's Health Forum has urged politicians, policy makers, journalists, healthcare professionals and educators to recognise and shift their attention to recognise that weight issues are a male as well as female matter (Haslam, 2012; Wilkins, 2005). More recently, increasing attention is shifting to include male psychology since 70-85% of the psychological provisions are currently given by women across the National Health Service (NHS), which might be seen as 'off-putting' for some men trying to access help (Morison, Trigeorgis & John, 2014). Furthermore, an awareness that gender socialisation places greater burden on men to achieve

power and ascribe to masculine ideals that portray feelings of shame, fear, sadness and vulnerability as "*unmanly*" explains why men are more at risk of suffering from depression, psychosis, substance-related and addictive disorders and committing suicide (Williams, Stephenson & Keating, 2014).

1.3 What is obesity?

Obesity appears as a medical category of diagnosis and is characterised by an excess of body fat where an individual has a body mass index (BMI) greater than 30kg/m² and results from a disparity between energy intake and expenditure (Devlin, 2007; Marcus & Wildes, 2009). This is the most commonly used definition of obesity but does not allow for discrepancies in weight between muscle and fat; hence a bodybuilder would be classified as obese (Ogden, 2010). The development of the BMI was put forward by Louis Dublin in 1942, a statistician and epidemiologist, who worked for the Metropolitan Life Company examining the association between weight and mortality among millions of people insured by his company (Gilman, 2010). Dublin's population was, however, biased and consisted predominantly of white, middle-class, urban males (Gilman, 2010). Although the BMI is used as an indicator of health, risk of mortality and morbidity, it is frowned upon and viewed as a Western model of risk by scientists in Asia who claim that the ranges do not transpose onto an Asian population (Gilman, 2010).

Alternatives such as waist circumference are often deemed a better measure for the analysis of the location of the fat since diabetes has been linked with abdominal fat (Ogden, 2010). Males with a waist circumference greater than 40 inches would be at a greatest risk of developing comorbidities such as cardiovascular disease, type 2 diabetes and hypertension (Gilman, 2010).

Obese men are considered to be at greater risk for health complications than women as they store their excess weight in their upper body (Ogden, 2000). According to the World Health Organisation (WHO), in 2008 there were over 200 million men worldwide who were classified as obese. These figures have

more than doubled since 1980 and keep rising (2012). These figures should be taken seriously as obesity has been classified as the fifth leading cause of death and it is preventable (WHO, 2012). There have been numerous studies showing the link between obesity and impaired quality of life, which refers to an individual's level of satisfaction with the physical, psychological and social aspects of their life (Mitchell & De Zwaan, 2005). Obesity is also associated with many comorbid disorders such as hypertension, sleep apnoea, cardiovascular diseases, diabetes, kidney disease and obesity-related cancers (Eckel, 2008). Studies indicate that obese individuals have a greater mortality due to their elevated BMI and predisposition to cardiovascular diseases, diabetes and kidney disease (Flegal, Graubard, Williamson, & Gail, 2007).

The term "*globesity*" (global obesity) was coined in 2001 by the WHO, but that nomenclature remains contested since we can conceptualise it as a disease or a phenomenological category that holds multiple causes, such as underlining physiological, psychological ailments or environment factors (Gilman, 2010). Obesity has triggered a state of moral panic with political, social implications and has become the new public health epidemic of the twenty-first century (Gilman, 2010). Strong (1990) named this state of social anguish "*epidemic psychology*" when there are waves of fear, emotional maelstrom, stigma and a moralising call to action that seems concomitant to the HIV/AIDS reactions in the 1980's. With the emergence of the "*obesity epidemic*" and biomedical discourse that equate fatness with badness and sickness, comes another viewpoint from the critical weight/fat studies that question these medicalised, pathologising typifications and healthiest claims (Campos, 2004; Lupton, 2013; Monaghan, 2007). For example, Gard and Wright (2005) and Monaghan (2007) suggest that agencies such as the WHO conflate overweight (BMI 25–29.9 kg/m2) and obesity (BMI≥30 kg/m2) figures in order to escalate the level of perceived seriousness and state of alarm that suggests that everyone is ill, diseased or at risk because of their weight.

Furthermore, Gard and Wright (2005) question the notion that obesity confers illness and disease and highlight the fact that many fat people live healthy, active lives and live beyond the lifespan of their thinner counterparts.

In terms of terminology employed for describing individuals with excess weight, a study was carried out by Volger et al. (2012) to explore obese individuals' preferred term at a primary care unit in Philadelphia, Pennsylvania. The study found that words such as "obesity" and "fatness" provoked distress, offence and acted as a barricade in terms of facilitating a dialogue regarding their weight. Instead, individuals preferred terms such as "weight", "weight problem" or "BMI", which was perceived as less judgmental and imposing less self-blame (Volger, 2012). Conversely, Piggin and Lee (2011) take a critical health psychology viewpoint and examine the "*Change4Life*" health promotion campaign in the United Kingdom, which abstains from utilising words such as "*obesity, overweight and fat*" and where the visual imagery and marketing strategy show the logo of little people symbolising humanity with no reference to gender, ethnicity, age or weight status. Piggin and Lee (2011) argue that while the Change4Life programme omits use of such terminology in their campaign in order to dampen existing stigma, it stifles understanding and acceptance in terms of body weight diversity within the population and fails to address the relationship between weight and health. Lastly, Piggin and Lee (2011) suggests that changing the term "*obesity*" in clinical settings within health promotions and common vernacular should only be put forth if there is widespread support for it and a more legitimate clinical term comes into place which aims to suppress any oppression and/or discrimination associated with it.

1.4 Aetiology of obesity

The word "*obesity*" derives from the Latin prefix "*ob*" which means "*over*" and "*edere*" which means, "to eat" (Wolman, 1982). However, this definition is inaccurate, as some individuals classified as obese eat less and have lower metabolic resting states than their peers (Wolman, 1982). Historically, the ancient Greeks saw control over body weight as part of the relationship between food, the body, and the gods and "*fatness*" as a pathological result of bodily imbalances (Gilman, 2010). However, during medieval times, in a period of impoverishment, obesity was perceived as a sign of power, ascendancy,

wealth, social privilege, vigour and opulence (Vigarello, 2013). Nonetheless, from the Renaissance until contemporary times, the obese person was vilified and seen as lazy, ignorant, slow, the subject of medical scrutiny. Today, obesity is judged as a "*social malady*" and public disturbance that emanates from a person's lack of self-will (Monaghan, 2008; Vigarello, 2013).

Obesity is a heterogeneous condition of multifactorial aetiology. Psychoanalytical theories in the 1950s have posited that it stemmed from a personality problem and acting out of unconscious conflicts and problems from the oral stage of psychosexual development that leads to unresolved dependency needs (Jones, 1953). Hilde Bruch (1958) discussed two types of obesity: (1) developmental and (2) reactive. Developmental obesity is conceptualised as beginning in infancy and is caused by a feeling of rejection by the mother toward her child, which leads her to compensate by overprotective behaviours, such as excessive feeding (Bruch, 1958). This leads the child to be unable to be attuned to his/her bodily urges and needs and a lack of body identity (Bruch, 1958). On the other hand, reactive obesity is seen as primarily taking place in adults in response to a traumatic event, which leads Bruch (1958) to encourage therapists to deal with the underlying cause of the disorder instead of focusing solely on symptom removal. Psychoanalysts have traditionally theorised that obesity stemmed from a somatic representation of an emotional turmoil and that therapy should focus on unravelling psychic conflicts as opposed to weight (Bychowski, 1950).

Later on, in the late 1960s, behaviour therapists stipulated that the causal explanation was due to failed conditioning that led to overeating and could be rectified by learning theory (Brownell & Wadden, 1992). Behaviourism is founded on the principles of classical conditioning, which stipulates that eating is often prompted by antecedent events that lead to inappropriate eating. Thus, behavioural therapy would enable clients to identify the cues and would reinforce new responses to them that are more adaptive (Fosters, Makris & Bailer, 2005). For many years obesity was believed to be a metabolic disorder since energy intake was lower in obese individuals than in their lean counterparts (Jebb & Prentice, 1996).

The psychosomatic theory of obesity puts forward that eating reduces anxiety and discomfort and that obese individuals are orally fixated and respond to negative emotional stimuli by excessive eating (Canetti, Bachar & Berry, 2002; Allison & Heschka, 1993; Geliebter & Aversa, 2003). Hamburger (1997) discussed his long-term clinical work, undertaken in the 1940's, to explore the emotional role of overeating with eighteen of his obese clients who he had seen both in psychiatric clinics and his private practice (some up to 398 hours). Hamburger (1997) concluded that clients overeat as a substitute gratification for love and security in response to difficult life situations, as an addiction to food, or/and as a response to depression or what used to be called "*hysteria*", which would translate as somatisation or dissociative disorder in modern parlance. The psychosomatic theory suggests that obesity is a result of an individual's mechanism of coping with fear, anxiety and emotional disturbances. Abramson and Wunderlich (1972) put this theory to test, and the results were insignificant which poses doubt to this model. The types of food people consume have been shown to vary according to people's mood, with women found to consume more fat-rich foods following a sad and depressing event compared to men (Christensen & Brooks, 2006).

These theories were proven to be erroneous as obesity cannot be pinpointed to a single source. There has been research based on family, twin and adoption studies suggesting a strong genetic heritability of up to 80% and a model of inheritance for obesity phenotypes (Friedman, 2009; Winchester & Collier, 2003). While we are only in the infancy of understanding the complex gene-to-gene and gene-to-environment interactions, obesity is largely exacerbated by non-genetic environmental factors such as dietary habits (level of fat consumption), eating behaviours, lack of physical activity and sedentary lifestyles (Vögele, 2005).

Although obesity has often been linked with the medical discourse in the literature, its psychological component is undoubtedly a cornerstone in the

understanding of why, when and how people become obese and in shedding light on its developmental trajectory. Bruch (1973) suggested that obesity was related to "*faulty hunger awareness*" and that learning was necessary for creating familiar patterns (p.5). Food could be symbolically used to camouflage uneasy emotions such as unrequited love, rage, anger a substitute for sexual gratification, comfort, pleasure, boredom, sadness, control, need of interconnectedness, celebration, denial, guilt, power, abuse, etc. (Bruch, 1973; Buckroyd & Rother, 2008; Goodspeed Grant & Boersma, 2005). Eating is connected with complex social, cultural and emotional ties and often abused as a means of affect management (Buckroyd & Rother, 2008).

Recently, Owen-Smith, Donovan and Coast (2014) conducted qualitative studies on the lived experience of participants (n=31) classified as "*morbidly obese*" living in the UK and asked them questions regarding the development and aetiology of their larger physical embodiment. The themes that arose from their work was that participants described their obesity as stemming from (1) a personal responsibility and morality towards their health (i.e.: working patterns, familiar traits and genetic disposition, physical and mental illness, etc.), (2) the role of family structure and importance of gender (i.e.: child bearing, childhood traumas, workplace responsibilities, etc.), (3) the role of emotional distress and the impact on the body, and 4) vicious circles and downwards spirals of weight gains (Owen-Smith, Donavan & Coast, 2014). Unfortunately, participants reported feeling shamed, stigmatised and discriminated against when accessing care, which suggests that additional training is vital to demonstrate a more compassionate, holistic and inclusive approach to health care provision (Owen-Smith, Donavan & Coast, 2014).

1.5 Stigma and obesity

Individuals living with obesity are not only deemed at higher risk in terms of suffering from potential health ailments and psychological malaise (depression, anxiety, self-esteem and body image), but are continuing to be vilified and

stigmatised in the press, employment, education, and, most perturbing, in healthcare settings (Ogden & Clementi, 2010; Puhl & Brownell, 2001). Widely held beliefs that obesity is caused by two of the deadly sins: (1) sloth and (2) gluttony still dominate common discourse (Fairburn & Brownell, 2002). Brown, Thompson, Tod and Jones (2006) conducted a qualitative study and interviewed obese patients (n=28) in five different general practices in the North East of England to see how they perceive and experience a sense of support in primary care settings. They found that usually patients felt reluctant to discuss issues relating to their weight and displayed a strong sense of personal responsibility and "*stigma-related cognitions*" for their weight (Brown, Thompson & Jones, 2006). Nonetheless, when good supportive relationships were forged with primary care professionals, these reservations subsided (Brown, Thompson & Jones, 2006).

Unfortunately, GP's and even health professionals specialising in obesity have been shown to share some prejudice in thinking that obesity is the responsibility of the patient, and they have felt sceptical towards the success of any treatment or available interventions (Schwartz, Chamblis, Brownell, Hair & Billinton, 2003; Epstein & Ogden, 2005). This aspect of ridicule and moral censure has often been more salient with people who are about to have WLS because of their significantly larger size (Throsby, 2007). Even among obesity researchers researching anti-fat attitudes and wounding stereotypes, they were shown not to be immune to their own biases and stigmatising comments as evidenced by comments at a conference, where a well-respected academician stated that if people living with obesity lost weight, "they would have a lot of sex, which is probably good as they won't have had it for a while" (Fling & Reale, p. 1925, 2014). Furthermore, in the press, daily articles worldwide, publish conflicting messages around *fat-shaming* being necessary to promote motivation to change and lead 'healthier' and 'happier' lives which feeds into further stigmatisation and a panic-stricken and fearful society that is informed to view obesity as an epidemic disease that might come knocking on their front door if they don't take necessary action and preventative measures.

Some weight loss advocates who frequently feature in the media, such as Steve Miller who works as a clinical hypnotherapist and motivational speaker, promote "*fat-shaming*" behaviour by encouraging people to be "anti-fat", "proactive in delivering fat warnings", "observe "fat" people's habits and create an aversion to them." In my opinion, this type of abusive and discriminatory behaviour could potentially lead to even greater feelings of shame for the person deemed "too fat" (Miller, 2015).

Individuals classified as "obese" have often been classified as self-indulgent, impulsive, lazy, gluttonous and lacking in discipline and have often been stigmatised (Throsby, 2007; Bidgood & Buckroyd, 2005). Ogden and Clementi (2010) conducted a qualitative study exploring how *enacted stigma* impacts upon an obese person's *felt stigma* and how that plays in terms of motivation for behavioural change. Participants interviewed were either classified as "obese" or had been and had lost weight through behavioural, pharmaceutical or surgical means and the main themes that emerged from their narratives were threefold: (1) the impact of obesity, (2) the meaning of food and (3) the role of their social context in terms of being obese (Ogen & Clementi, 2010). The results indicated how eating was rarely used solely in response to a physiological need, but as a means of emotional regulation, social behaviour, linked with issues of control, and in some participants referred to as an addictive behaviour (Ogen & Clementi, 2010). Largely, obesity was conceptualised as a negative and socially stigmatising experience impacting on individual's sense of self-identity and motivational level to change (Ogen & Clementi, 2010).

Stigma is a socio-cultural phenomenon that has damaging psychological repercussions such as a stigmatised person becoming avoidant, feeling rejected, and worthless in social contexts. Puhl and Brownell (2003) studied how "obese" individuals manage stigma and examined which coping strategies they used and found that self-blame, isolation and avoidance was linked with low self-esteem, low body satisfaction and low psychological well-being; whereas using self-acceptance and positive self-talk were connected to an ameliorated psychological adjustment.

Although more research is needed to address gender difference in terms of coping with weight stigma, men tend to use more aggressive and antisocial responses compared to women who rely more on emotional ones (Puhl & Brownell, 2003). While most of the literature has predominantly focused on weight stigma in women, Hebl and Turchin (2005) have tested an all-male American student sample of both Black and White students (n=68) and found that men too are stigmatised across a number of evaluative measures based on their physicality (for example, larger men rated as less attractive, popular, happy socially, social, professional and intelligent than their thinner counterparts).

When looking more globally at the public's opinion of international public health campaigns focusing on obesity-related messages, people viewed more favourably and motivational messages that did not contain the word "*obesity*" or references to body weight, but instead focused on encouraging healthy behavioural changes which was seen as less stigmatising (Puhl, Peterson & Luedicke, 2012). These findings have significant wider implications in terms of carefully framing public health messages and avoiding language that conjures shame and blame which are experienced as stigmatising as it only further alienates the audience they intend to motivate in the first place (Puhl, Peterson & Luedicke, 2012). On a wider level, we should be concerned about the persistence of "*fat stigma*" as it conjures the idea of the "*civilised body*" to continue unabated (Erdman Farrell, 2011). As Erdman Farrell (2011) justly illuminates: "reinforcing the dangerous idea of the "*civilised body*", fat denigration intersects with and exacerbates racism, sexism, classism, and homophobia, and all the other means by which our culture classifies and oppresses people based on their bodily attributes and social standing" (p.176).

1.6 Obesity, eating disorders and mental health

According to the National Obesity Observatory (NOO) the bi-directional association between obesity and mental health disorders is complex and multi-factorial as obesity is a highly heterogeneous condition with a myriad of features such as: gender, age, socio-economic status (SES), education, ethnicity, behavioural, social, biological and psychological factors that all play a role in moderating this relationship (Gatineau & Dent, 2011).

Recent research investigated whether obesity could be classified as a mental disorder and included in the new Diagnostic Statistical Manual of Mental Disorders (DSM-V) (Devlin, 2007). Some neurocircuitry of energy balance (homeostatic control of eating behaviour and non-homeostatic eating) has suggested that some obesity phenotypes might be associated with mental dysfunction, but these findings are too recent to suggest that obesity can be classified as a mental disorder (Marcus & Wildes, 2009).

Increasing attention has been vested in developing an addiction model to both eating disorders and obesity. However, according to epidemiological, genetic and familial research, laboratory feeding studies, psychopathological mechanisms of addiction as a brain disease, the results have shown discrepancies in the clinical validity of an addiction model of eating disorders (Wilson, 2010).

Non-homeostatic eating and substance use disorder models have been put forth suggesting the role of the dopaminergic reward pathway involved in terms of providing motivation and incentive for a person to overeat and develop a "*food addiction*" which would lead to their obesity (Devlin, 2007). Parallel symptoms to those found in the substance abuse scholarship have been reported and a "*food addiction*" model has been proposed such as a person experiencing cravings, tolerance and withdrawal behaviours. The construct of

"*food addiction*" has been contentious and widely debated in the scientific community, although popularised in the lay population. According to some authors such as Corsica and Pelchat (2010), they postulated that underlining neurobiological, neurochemical (endogenous opioids), neuroanatomical (limbic system) and self-medication findings supports the hypothesis of a "*food addiction*" model and link it with a putative causal factor of chronic overeating, binge eating and, most importantly, obesity.

A psychometrically validated measurement tool, the Yale Food Addiction Scale (YFAS), was devised by Gearhardt, Corbin and Brownell (2009) to identify individuals exhibiting signs of addictions towards certain food groups (i.e.: foods high in fat and sugar content) and used as a prediction of binge-eating propensity. The YFAS has a good internal reliability, convergent and discriminant validity, and has been shown to be a comprehensive tool for identifying eating patterns that are analogous to the addiction field (Gearhardt, Corbin & Brownell, 2009). Davies et al., (2011) have concurred that food addiction is a valid phenotype of obesity in a case-control design study using the YFAS and found that the participants who met the diagnostic criteria for a food addiction had a significantly higher comorbidity with BED, depression and attention-deficit hyperactivity disorder (ADHD), were more impulsive and had an inclination to self-soothe with food compared to their age and weight counterparts.

However, taking the view that "*food addiction*" is a behavioural phenotype present in a subgroup of people with obesity and akin to the addiction model has been proven to be flawed by Ziauddeen, Farooqi and Fletcher (2012) who showed that it may be a consequence or comorbidity of obesity as "*food addiction*" can be present in non-obese individuals. Furthermore, the criteria in the Diagnostic and Statistical Manual of Mental Disorders IV (DSM-IV) for substance dependence have poorly translated into food-related addictions and future research is necessary in order to create a more accurate nosological framework that captures the neurobehavioural definition of "*food addiction*" as so far it has put primary impetus on binge eating (American Psychiatric

Association, 1994; Ziauddeen et al., 2012). The food-addiction phenotype has been associated with individuals with binge eating disorder (BED) (Corwin & Grigson, 2009).

Binge eating disorder (307.51) is a diagnostic criteria that has been assigned to an individual who eats in a discrete period of time (less than two hours), an amount of food that is definitely larger than most people would eat in a similar time-frame, experiences a lack of control and marked distress with regards to their eating, eats faster than usual, larger amounts of food even when not feeling physically hungry, feeling depressed, embarrassed, guilty about the amount of food consumed and eating alone because of the shame associated with the binge episode (American Psychiatric Association, 2013).

Although BED has been linked to be associated with obesity, only 2-5% of obese individuals in the community meet criteria for BED and 30% of those seeking weight-loss treatment (De Zwaan, 2001). Furthermore, a study has measured participants' level of eating pathology and psychological distress and found that binge eating pathology was independent of weight status (Didier & Fitzgibbon, 2005). Hence, less emphasis should be placed on the body mass index (BMI) as a benchmark used to assess the presence of BED. More research is warranted as there is a lack of knowledge regarding the prevalence of BED and its relationship with obesity in UK samples (Hill, 2007).

Hebebrand et al., (2014) have also shared their criticism of the "*food addiction*" model and suggested that the term "*eating addiction*" or "*addictive eating disorder*" is more applicable as it avoids claiming that food can lead to the development of a substance dependence disorder which is a diagnosis which has been removed from the DSM-V and replaced by substance-related and addictive disorders (American Psychiatric Association, 2000). Employing a definition of an "*eating addiction*" puts more emphasis on the behavioural component compared to "*food addiction*" which appears to be a more passive

process and could be perceived as an excuse that befalls an individual because of our modern "*obesogenic*" and globalised food environment where the availability of highly palatable, energy dense and inexpensive food is omnipresent (Hebebrand et al., 2014). Although the notion of an "*eating addiction*" is in its infancy, Hedebrand et al. (2014) encourage future research into differentiating between an "*eating addiction*" with or without obesity and to unravel the biological, physiological and psychological mechanisms that differentiate the two categories which would, in turn, have a large public health impact on preventative measures and treatment availability

1.7 Weight loss surgery (WLS)

Weight loss surgery (WLS) is referred interchangeably and is also known as bariatric surgery which originates from the word "Bari" meaning *weight* or *pressure* in ancient and modern Greek and *obese* in biblical Hebrew (Deitel & Melissas, 2005). Bariatric operations or WLS are key gastrointestinal interventions, which aim to restrict the body's ability to consume and absorb food by altering the anatomy of the digestive tract (Waumsley, 2011).

According to the National Institute for Health and Clinical Excellence (NICE), WLS should be considered for individuals with a BMI of 40kg/m² or more who are classified as morbidly obese, or for individuals with a BMI of 35kg/m² or more who have other comorbidities such as diabetes, obstructive sleep apnoea and hypertension, have received intensive specialist management, are prepared for long-term follow-up, and have failed to maintain weight loss through non-surgical measures (2006). The registry of UK bariatric surgery found that a quarter of all bariatric surgery patients had higher levels of comorbidities (i.e.: sleep apnoea and type 2 diabetes, etc.), that three-quarters had impairment in their daily functioning prior to surgery and that these were resolved for around half of all patients one year post-surgery (Radcliffe, 2013; Welbourn, Fiennes, Kinsman & Walton, 2011). Given the emotional, physical and social strain of morbid obesity, it is understandable that an increasing number of people are turning to weight loss surgery (Radcliffe, 2013).

Bariatric operations are classified according two categories, either restrictive or malabsorptive. In restrictive procedures there is a limit of food intake because there is a small gastric pouch that is created which enables a delay in emptying. On the other hand, in malabsorptive procedures there is a bypass in terms of varying portions of the small intestine where nutrient absorption normally occurs (DeMaria, 2007). The two most common types of WLS used in the UK are (1) restrictive surgery-laparoscopic adjustable gastric band (LAGB) and (2) combined restrictive and malabsorption surgery,a Roux-en-Y gastric bypass (Waumsley, 2011).

The laparoscopic adjustable gastric banding is one of the most frequently used bariatric procedures and involves fitting an inflatable silicone band around the upper part of the stomach (please refer to Figure 1.1) (Stevens, Spavin, Scholtz & McClelland, 2012). The gastric band works by reducing the amount of food a person eats by increasing satiety signals as the food that passes more slowly stimulating the nerves at the top of the stomach and giving the person a feeling of fullness more rapidly and enabling them to eat smaller portions of food (Efthimiou, 2011). The band usually needs to be adjusted (inflated or deflated) numerous times via an access port to regulate the level of restriction and find an optimal balance between reducing any undesirable side-effects such as vomiting and dysphagia, and attaining successful weight loss (0.5-1kg per week) (Radcliffe, 2013). As for all surgical procedures, this comes with numerous benefits and risks to bear in mind. In terms of advantages, the band enables individuals to lose up to 50-60% of their excess body weight after two years post-surgery if they adhere to dietary advice (Efthimiou, 2011). Furthermore, the band is adjustable, reversible and less invasive than other bariatric procedures and permits a person to resume their daily activities sooner after the operation in comparison to other operations (Radcliffe, 2013).

In terms of disadvantages, a person fitted with a gastric band might experience some serious complications such as the port or band leaking, deflating, eroding (1% of cases), slipping (2-5% of cases), twisting or becoming infecting which

would necessitate further operations to rectify the problem (Efthimiou, 2011). Weight loss is slower than with other bariatric procedures, and some people find it harder to find the right balance between the correct point of restriction so it can take several repeated band fills to create that feeling of fullness without the accompanying unpleasant side-effects (Radcliffe, 2013). Lastly, fifteen per cent of people who have the gastric banding fail to lose the amount of weight expected (Efthimiou, 2011).

The Roux-en-Y gastric bypass is considered the “gold standard” of weight loss surgery as it brings an average of 70-80% of the excess body weight and is a restrictive procedure that consists of the stomach being stapled to enable the formation of a smaller pouch (please refer to Figure 1.2) (Stevens, Spavin, Scholtz & McClelland, 2012). Food bypasses the main area of the stomach as it is stapled off and passes through the oesophagus into this newly developed stomach pouch and then into the small intestine (Radcliffe, 2013). The main result is that the amount of food an individual is able to eat is considerably reduced, appetite is suppressed as well as feelings of fullness (Efthimiou, 2011). The advantages of this procedure is that weight loss starts from the time of surgery, weight loss is faster than with the gastric band, has shown to be effective in the resolution of symptoms of patients with diabetes, hypertension, sleep apnoea, and to ameliorate levels of social functioning and energy levels (Radcliffe, 2013).

However, the disadvantages and risks of the gastric bypass are not to be taken lightly. Gastric surgery poses a greater surgical risk as the stomach and intestines are cut, and the associated mortality risk is 0.7% compared to 0.1% for other surgical procedures (Efthimiou, 2011). Individuals will need to take multivitamins, mineral supplements, and be followed up for life as a portion of their stomach has been bypassed which affects the absorption of protein, vitamins and minerals (Efthimiou, 2011). It is possible that patients might develop gallstones as a result of the rapid weight loss, which might require a further operation to remove the gallbladder (Radcliffe, 2013). A hernia can

develop inside the abdomen as a result of the reconfiguration of the gastrointestinal tract, and patients might experience “dumping syndrome” which is a condition patients develop if they consume foods high in fat, sugar and carbohydrates which causes dizziness, nausea, vomiting, diarrhoea, sweating, heart palpitations and faintness (Efthimiou, 2011; Radcliffe, 2013). The “dumping syndrome” occurs as a reaction of the small intestine to sugar that has not been processed through the stomach, and this tends to reinforce which foods should be avoided in people’s diet due to their disagreeable side-effects (Radcliffe, 2013).

Figure 1.1:

Diagram of a Gastric Bypass*

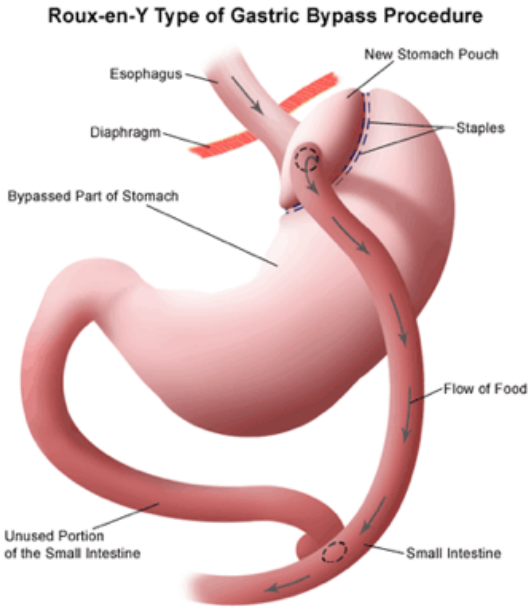
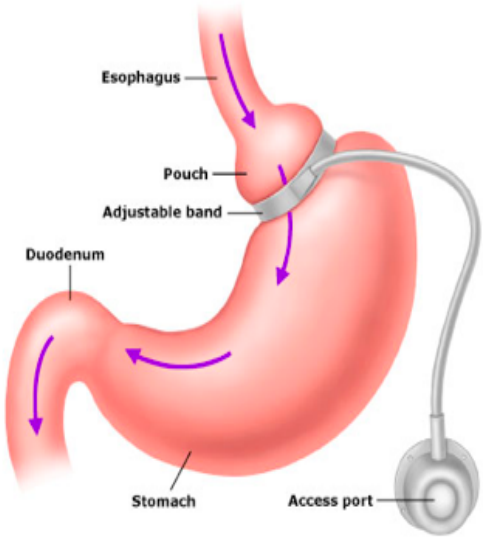


Figure 1.2:

Diagram of a Gastric Band*



* Reproduced with permission from Mr Evangelos Efthimiou

A large randomised-controlled trial found that the Roux-en-Y gastric bypass had a superior weight loss pattern when it was compared to vertical gastroplasty and gastrogastronomy (Hall et al., 1990). Overall, bariatric surgery has been shown to ameliorate and, in some cases, eliminate diabetes, hypertension and sleep apnoea (Buchwald et al., 2004). Moreover, Moldovan and David (2011) conducted a systemic review of eighteen studies to explore the effects of

psychosocial versus surgical intervention on eating behaviour post-treatment and found that weight loss surgery had greater result in terms of weight loss and eating behaviour.

Sjöström et al. (2004) carried out one of the few longitudinal studies entitled the Swedish Obese Subjects (SOS) whereby they followed up on 2000 patients who had undergone bariatric surgery at two and then ten years and another 2000 matched control subjects who had not undergone surgery but received nonsurgical treatment. They found that the patients who had undergone bariatric surgery had a greater long-term weight loss, were more physically active and had a considerable amelioration in their diabetes, hypertension and overall cardiovascular risks (Sjöström et al., 2004). However, two main limitations of the SOS study were that the two groups were not randomised as the ethics review board deemed it too risky due to higher rates of mortality following gastric surgery in the 1980's. Secondly the nonsurgical treatment offered to the second group was not standardised; hence, some candidates might have received some psychoeducation and behavioural therapy, while others received no treatment at all (Sjöström et al., 2004).

Furthermore, Kwok et al., (2014) conducted a systematic review and meta-analysis of randomised trials and controlled observational studies appraising the link between bariatric surgery and clinical outcomes and also found that patients who had undergone bariatric surgery had lower rates of mortality, cardiovascular complications and stroke in comparison to matched nonsurgical controls. This study further reinforces the manifold benefits for morbidly obese patients with a risk of cardiovascular events to elect weight loss surgery (Kwok et al., 2014).

Nevertheless, WLS comes at a high cost as there are some risks associated with having the surgery such as digestive and intestinal complications, respiratory failure, pulmonary embolism and sometimes mortality. The severity

of these side effects will be dependent on the patient's level of obesity, age and other medical conditions (Steinbrook, 2004; Throsby, 2007).

1.8 Pre-operative psychological assessment

According to the commissioning guide for weight assessment and management clinics put forward by the Royal College of Surgeons (RCS) and British Obesity and Metabolic Surgery Society (BOMSS) (2014), a patient can be referred for bariatric surgery if they fully understand and have realistic expectations of the surgery, are motivated and engaged with the team, comprehend the necessity of complying with the nutritional requirements pre and post-operatively and, most importantly, there are no medical, psychological, and/or social contraindications.

Patients are deemed ineligible for bariatric surgery if they cannot understand the dietary and lifestyle changes they need to make post-surgery. Also, if the patients are elderly, have untreated medical conditions and active addictions, they will be unable to have the procedure done (Mitchell & De Zwaan, 2005). There are ethical dimensions to consider preceding WLS, and psychologists play a crucial part in the screening element of treatment (making sure clients have no psychopathology) and deciding who is a good match for surgery based on the client's degree of cognitive, emotional and behavioural motivation for weight loss over the long-term (Bauchowitz et al., 2005; Waumsley, 2011).

Stevens, Spavin, Scholtz & McClelland (2012) have devised a traffic light system for psychological preparedness for bariatric surgery that consists of the red, amber and green category for risk assessment. Candidates fall into the red category if they are actively psychotic, have a drug and alcohol dependence, have a moderate to severe learning disability, dementia, a severe personality disorder, have self-harmed in the last year, have an active diagnosis of bulimia nervosa and are currently non-compliant to treatment and, therefore, will not be suitable for surgery at this stage (Stevens et al., 2012). In the amber group, candidates are classified as higher risk, although still deemed suitable for

surgery. This can be patients who have a history of a severe mental health conditions such as a substance misuse or who have displayed self-harming behaviours but have had no relapse in the past 12 months, who don't demonstrate strong motivation, treatment adherence, and poor insight into their eating behaviour (Stevens et al., 2012). Lastly, patients in the green traffic light are suitable for surgery straight away as they exhibit a good level of understanding, adherence, insight and motivation to go forward with surgery (Stevens et al., 2012).

However, as Franks and Kaser (2008) have justly pointed out in their review of preoperative psychological evaluations, the fact that bariatric candidates are a psychologically heterogeneous group makes it harder to pinpoint the most accurate pre-surgical characteristics that will lead to the best postsurgical outcomes. For example, there are conflicting findings in the literature regarding patients who present with binge eating disorder (BED) in terms of post-surgery weight loss (Franks & Kaser, 2008). Therefore, psychologists must congregate multiple factors and work in a client-centred manner in order to determine both pre and post treatment recommendations that will maximize long-term outcomes (Franks & Kaiser, 2008).

In terms of psychosocial standardisation of weight loss surgery assessment, there have been a few put forward, most notably, in the United States. The Boston Interview for Bariatric Surgery (BIBS) was developed and revised by Sogg and Mori (2004; 2008; 2009) in order to enhance the safety and efficacy of surgery, dampen any potential risk factors that might arise and generate an individual tailored program. The BIBS assesses weight, diet and nutrition history, eating behaviour, medical and psychiatric history, understanding of the surgical procedure as well as associated risks, motivation, surgical expectation, relationships and support system and has been recommended as an assessment tool by the American Society for Metabolic and Bariatric Surgery (Sogg & Mori, 2004; 2008; 2009). At the Ochsner Medical Centre, they also devised a bespoke psychological assessment comprising a clinical interview that includes the same rubric of assessment as the BIBS, and psychological testing (the Minnesota Multiphasic Personality Inventory–2 and the Millon

Behavioural Medicine Diagnostic) (Snyder, 2009). Heinberg, Ashton and Windover (2010) developed the Cleveland Clinic Behavioural Rating System (CCBRS) for weight loss surgery which demonstrated to be a reliable multidimensional measure with high internal consistency, that evaluates candidates on eight psychosocial domain (consent, surgical expectations, social support, mental health history, chemical and alcohol abuse, eating behaviours, treatment adherence and current stressors).

Nevertheless, one reason why there is still no clear consensus on any standardised psychosocial pre-surgical assessment, whether in North America, or in the United Kingdom, is that the empirical data of efficacious long-term surgical outcomes remains inconclusive (Sogg & Mori, 2009). Ratcliffe et al. (2014) explored bariatric psychologists' role within the UK NHS through the use of surveys and found a significant variation in the provision of bariatric psychological treatment offered to patients across the country which further reinforces the strong necessity and urgency of standardising and offering the same standard of care to patients opting for weight loss surgery.

A key issue lies in the fact that there is currently no consensus screening tool used by psychologists to evaluate which client would best benefit from bariatric surgery (Bauchowitz et al., 2005). Although research has not come up with consistent guidelines for clinicians in pre-surgical psychological assessment, it does suggest that individuals should not be denied surgery if they have a psychiatric diagnosis, but rather to identify possible areas of challenge and make recommendations for additional treatment (Mitchell & De Zwaan, 2005).

1.9 The meaning of awaiting for weight loss surgery

Among qualitative studies that have explored the phenomenon of waiting for bariatric surgery, Wysoker (2005) conducted a phenomenological study in the United States and asked eight participants who had undergone bariatric surgery one year prior to the interview what their experience of choosing bariatric

surgery to lose weight had been. Four themes emerged which were that participants viewed weight loss surgery as a last resort, the surgery provides structure, they felt positive about their decision to have surgery and that reality sets in and they are more aware of the behavioural and lifestyle changes needed to maintain their weight loss (Wysoker, 2005). This study drew on clinical implications for psychiatric nurses working with this client group. However, one limitation that is apparent is that the author asked participants retrospectively, one-year post-surgery, questions regarding their choice of opting for bariatric surgery and to recount their lived-experience both pre and post-op.

Engström, Wiklund, Olsén, Lönroth, and Forsberg (2011) carried out another study addressed to nursing professionals exploring the meaning of awaiting bariatric surgery due to morbid obesity, but this time using a larger sample (n=23) and the participants had not had their surgery yet. The study took place in Sweden and was analysed using hermeneutic phenomenology which led to six themes which were the following: (1) experiencing food as a complex element in life, (2) feeling hopeless regarding weight loss, (3) living in fear of future illness and death, (4) living a restricted life, (5) being ignored by health care professionals, and (6) hoping for control and opportunities (Engström et al., 2011). Informants in this study described their relationship to food as abusive and as an addiction; they also experienced feeling helpless when it came to changing their current eating behaviour and saw the surgery as being the solution to enable them to regain their sense of empowerment and control over their eating (Engström et al., 2011).

Concurrent with Engström et al. (2011) findings, Da Silva and Da Costa (2012) conducted a qualitative study in a Portuguese sample (n=30) looking at how morbidly obese candidates conceptualise their obesity, treatment, beliefs and expectations of their upcoming bariatric surgery. The results were analysed using grounded theory and they found that surgery candidates see themselves as passive in their treatment, that their eating behaviour is difficult to change, that they see surgery as a miracle that will change their lives without any active role on their behalf (Da Silva & Da Costa, 2012). Therefore, it is vital to increase

knowledge of the bariatric pathway and weight loss journey to patients and make them more empowered about their own responsibility in the process to ensure the best long-term outcomes post-surgery.

Pfeil, Pulford, Mahon, Ferguson and Lewis (2013) investigated the views of people who were going to undergo laparoscopic gastric banding (LAGB) in a British sample (n=23) and, using thematic analysis, found three overarching themes: (1) living with obesity, (2) desire to change and (3) expectations towards surgery. Participants in this study described the myriad of psycho-social and physical challenges of living with obesity and, echoing the Engström et al. (2011) study, also described feelings of powerlessness to control their food intake and achieve weight loss through other means than surgery, having a negative body image and being fearful of ill health as a consequence of their physicality (Pfeil et al., 2013). However, unlike the results found by Engström et al. (2011), the participants in the current study were more active in their care, knowledgeable in their decision to proceed and have surgery and, most notably, viewed weight loss surgery as renewed hope instead of a state of hopelessness (Pfeil et al., 2013).

Gregory, Newhook and Twells (2013) studied the meaning and experience of waiting for bariatric surgery in a sample of twenty-seven patients as the waiting lists for WLS are especially long in Canada (more than five years on average). The results were analysed using grounded theory and the authors found three themes of inequity as a barrier to accessing bariatric surgery: (1) socio-economic, (2) regional and (3) inequality relating to waitlist prioritisation (Gregory et al., 2013). In this study a long waiting list impedes upon surgical candidates mental well-being and adds to their feelings of frustration and anxiety. Hence, there needs to be more support and resources put in place to ensure that the waiting experience is as containing and positive as it can be (Gregory et al., 2013). Luckily, in the UK, bariatric surgery is funded through the NHS although waiting lists can be longer for some, which means that the results of this study would not necessarily be transposable on a UK sample. Lastly,

most of the participants who took part in this study were female (n=21) which negates the voice of men and the authors pointed out that men tended to be underrepresented in terms of those deemed eligible for bariatric surgery (Gregory et al., 2013).

1.10 Summary

As I read the literature on qualitative studies examining the construct of obesity and being male on a waiting list for weight loss surgery, I soon realised that the preponderance of studies have focused predominantly on women's narratives. Brown and Gould (2013) reviewed qualitative studies pertaining to obesity and found out that out of 31 qualitative studies researching obesity, women accounted for 78.8% of the extant samples compared to men that represented the remaining 21.2%. Furthermore, Natvik, Gjengedal, Moltu and Raheim (2015) also highlighted the lack of studies targeting male bariatric surgery participants and indicated that some qualitative studies remain predominantly female (see Ogden, Clementi & Aylwin, 2006; Bocchieri, Meana & Fisher, 2002). Men's accounts remain virtually invisible.

However, it is not solely the stigma of female "fatness" that is despised; men are equally at risk of social censure as Monaghan (2008) points out. Furthermore, necessary weight loss is often associated with a culture of shame and blame where fatness is equated with emasculated sickness (Monaghan, 2007). Bringing in men's voices and lived experience and how they relate to food prior to undergoing bariatric surgery is filling a knowledge gap as more men are classified as 'obese' in the UK with fewer of them likely to perceive their weight as problematic and to engage in weight-loss services (Robertson et al., 2014). Robertson et al. (2014) have shown that weight reduction for men is best achieved and maintained with a combination of physical activity guidance, behavioural change techniques and diet. However, more research that is attuned to issues surrounding the socio-cultural context and individual content is needed. As fewer men seek bariatric surgery, with most studies comprising only 13-50% of men in their patient population, more research is also needed to

identify men's obstacles to engaging in a more timely manner with weight-loss services that would lead to better surgical outcomes and to understand the role health care professionals and especially psychologists can play in helping to overcome these obstacles. (Farinholt, Carr, Jin Chang & Ali, 2013). It is my objective to capture men's narratives of their relationship to food —both past and present — to explore how their expectations of that relationship will change as they proceed with bariatric surgery and to question their expectations, hopes and fears of having the surgery.

2.0 Methodology

"Nothing would be more tiresome than eating and drinking if God had not made them a pleasure as well as a necessity". Voltaire

2.1 Research aims

This study seeks to gain an in-depth understanding of the relationship with food of men who are placed on a waiting list for WLS because of their obesity and related comorbidities using an Interpretative Phenomenological Analysis (IPA) and conducting semi-structured interviews (Smith & Osborn, 2008). My aim is to understand and encapsulate men's experience and relationship with food prior to having weight loss surgery. My research questions are grounded in my epistemological position which is constructivist-interpretivist (see below) and interested in people's sense-making and lived-experience of being male, classified as obese and about to have weight loss surgery (Smith, Flowers, & Larkin, 2009).

2.2 Rationale for using a qualitative research paradigm

Most of the literature that has looked at obesity and WLS has used quantitative measures such as questionnaires and psychiatric assessments (for example, the Diagnostic Statistical Manual for Mental Health, the Beck's Depression Inventory, the Structured Clinical Interview for DSM Disorders, etc.) (See Fabricatore, Crerand, Wadden, Sarwer & Krasucki, 2006; Walfish, Vance & Fabricatore, 2007; Franks & Kaiser, 2008; Heinberg, 2013). However, this approach limits the development of new insights and directions, especially since this project is interested in bringing forward the voices of men classified as 'obese' and their experiences with food prior to WLS as there is a paucity of studies solely representing men's idiosyncratic views and opinions.

The debate between the quantitative and qualitative paradigms has been long-standing within psychology and social science as they hold two opposing epistemological positions: the positivist, hypothetico-deductive, experimental lens versus the naturalistic, contextual and interpretative approach (Henwood & Pidgeon, 1992). The experimental method has been the dominant paradigm in psychology with its emphasis on universal laws and explanatory framework drawing on a cause and effect relationship and adopting a realist ontological position which assumes that reality consists of a world of objectively defined "*truths*" (Henwood & Pidgeon, 1992). According to positivists, the world and science are deterministic, mechanistic and they lean on an empirical framework of deductive reasoning to put theories forward which can be tested, revised, observed and measured (Krauss, 2005). However, striving for "*objectivity*" and heuristic assumptions based on causality seems implausible in psychology as much of what we aim to do is to grasp "inner existential choices made by people" (Kirk & Miller, 1986, p.10).

For this project I have opted for a qualitative paradigm, which places emphasis on a constructivist, descriptive epistemology, where reality, meaning of experience and behaviour in context is represented through the eyes of my participants, with its full intricacies and minutiae (Henwood & Pidgeon, 1992). A qualitative paradigm seeks to gain the quality and texture of people's experience, instead of identifying the causal relationships of the experience that would be sought by quantitative researchers (Willig, 2008).

Mason (2002) defines qualitative research as a way of looking at how the social world is interpreted, experienced, formed and understood. Qualitative research plays an important role in understanding a wide variety of psychological constructs. Qualitative methods are descriptive and inferential in nature (Gillham, 2000). Different approaches in qualitative research focus on looking at various facets of the work, such as discourses, meanings and interpretations and this, in turn, is what will generate such a multifaceted and rich way of interpreting the social world (Gillham, 2000). Good qualitative data allows researchers to expand "beyond initial conceptions and to generate or revise a

conceptual framework" (Miles & Huberman, 1994, p.1). The great strength of qualitative data is that it can enlighten issues and extrapolate meaning out of the accounts of participants and come up with possible interpretations and explanations **(**Gillham, 2000). That is why some qualitative researchers view analysis as an art form that rests on intuitive approaches that have the aim of coming up with a classification system to draw meaning out of the collected data (Miles & Huberman, 1994).

Qualitative data provides richness with "*thick descriptions*" embedded in real context and conveys a strong impact to the reader (Miles & Huberman, 1994). Ponterotto (2006) defines "*thick descriptions*" as the researcher's role to describe and interpret the thoughts, feelings and behaviours of participants and ascribe "*thick meaning*" to the findings which will lead to a sense of verisimilitude where readers can cognitively and emotionally position themselves in the research context.

In addition, qualitative research is grounded in an interpretive philosophical position that looks at how the world is analysed, understood and experienced and highlights the multi-layered elements of our social world (Mason, 2002). Qualitative research is interested in meaning, how people make sense of and experience events in the world (Willig, 2008). Furthermore, as a counselling psychology practitioner, adopting a qualitative inquiry is more congruent with my professional identity where I engage with the narrative accounts of my clients (Morrow, 2007). Kasket (2012) argues that as counselling psychologists, we cultivate a '*negative capability*' meaning that we develop the ability to tolerate uncertainty and remain open to a phenomenon resisting an urge to reduce and categorise it, which might be, more concomitant with a quantitative lens. Furthermore, Kasket (2012) elucidates the five tenets of counselling psychologists, which are to (1) prioritise the client's subjective and inter-subjective experience, (2) facilitate growth and actualisation of the client's potential, (3) work towards empowering the client, (4) focus on establishing a non-hierarchical, collaborative relationship and (5) appreciate the unique idiosyncrasies of the client.

2.3 Rationale for using Interpretative Phenomenological Analysis (IPA)

I have chosen IPA as it has been shown to be an effective approach when little is known on a topic, there is novelty and complexity and issues relating to identity and sense making (Smith, 2004; Smith & Osborn 2008). IPA's theoretical underpinnings stem from Husserl's philosophy of phenomenological inquiry whereby we should go "back to the things themselves", in other words to the "experiential content of consciousness" and from symbolic interactionism which is the meaning that individual's ascribe to events and can only be obtained through the process of interpretation (Smith, 1996; Smith, Biggerstaff & Thompson, 2008; Flowers & Larkin, 2009, p.12). IPA established itself initially in the field of health psychology in the mid-1990 with particular concern for the lived experience of people living an illness. Hence, my research investigation is a natural topic for IPA inquiry (Smith, 2011).

IPA is a qualitative approach aimed at exploring how people make sense of their major life events, understanding their own meaning-making. The aim of an IPA study is to focus on the detailed exploration of a participant's experience and what it means to the researcher, without coming with a predetermined research hypothesis (Langdridge, 2007).

Although IPA shares with cognitive psychology and social cognition approaches an interest in mental processes, it diverges in its methodology and does not use quantitative experimental modes of inquiry, but instead uses an in-depth qualitative approach to examine how people think about their lifeworld (Smith, 2004). IPA is interested in all aspects of the participant's lived experience, "from the individuals wishes, desires, feelings, motivations, belief systems through to how these manifest themselves or not in behaviour and action" (Eatough & Smith, 2008, p.182). IPA encompasses not only the cognitive layers of a person's attitudes, but seeks to capture the meaning of the embodied, existential and cognitive-affective domains of an individual (Finlay, 2011). IPA contributes to the development of embodied active situated cognitions (EASC),

in other words recognition that '*thinking beings*' are '*acting and embodied beings*' foremost (Larkin, Eatough & Osborn, 2011).

IPA is a branch of a phenomenological approach, which means that the researcher is interested in the participant's personal experiences and perceptions instead of attempting to recreate an objective event (Smith, Flowers, & Larkin, 2009; Smith & Osborn, 2008). Phenomenology is a branch of philosophy which attempts to understand the hidden meanings and quintessence of an experience through the influence of a person's consciousness and with the researcher's own interpretations (Grbich, 2007). It involves exploring an experience in depth and filtering and clarifying its essence (Grbich, 2007). In a phenomenological project the researcher abstains from drawing any suppositions and focuses on the topic with a fresh look (Moustakas, 1994). Reflection through a phenomenological approach allows for a logical, methodical and coherent way of carrying out the analysis, synthesising and arriving at the essential descriptions of the narrative (Moustakas, 1994). Through a reflective process, the researcher constructs a full depiction of the participant's conscious experience. This is what is called a *textural description,* and it includes the participant's thoughts, emotions, ideas, examples and all the necessary ingredients that constitute an experience (Moustakas, 1994).

Overall, this project endeavours to understand the essence and meaning of the collected interviews by analysing the emerging patterns and relationships among them. The theoretical underpinnings of IPA are phenomenological, interpretative and idiographic whereby the unique intersubjective experiences of individuals are valued (Smith, Flowers, & Larkin, 2009). One of the characteristic features of IPA is its idiographic nature where the researcher is encouraged to examine in detail a single case until some degree of *gestalt* or closure has been achieved and then can move onto the second case and so on, exploring themes of convergence and divergence (Smith, Jarman, & Osborn, 1999; Smith, 2004).

IPA is influenced by hermeneutics, which means the art of interpretation. As researchers we are involved in a double hermeneutic: participants are trying to make sense of their experiences and the researcher is trying to make sense of what the participants are trying to make sense of (Smith & Osborn, 2008). The hermeneutic cycle comprises our fore-understanding, meeting a '*resistance'* when questioning experience and engaging in an interpretative revision of our initial fore-understanding (Finlay, 2003a). There is a balance between the '*emic*' (phenomenological insider position) and '*etic'* (interpretative outsider position) in IPA where as researchers we move from the participant's worldview and then move away and attempt to make sense of it in terms of the particular research question posed (Reid, Flowers & Larkin, 2005).

An IPA project is inductive, idiographic and grounded in the data rather than in the pre-existing theory (Langdridge, 2007). An inductive approach ('*bottom up'*) means that the research employs a certain degree of flexibility to allow unanticipated themes to emerge during the analysis that can generate broader research questions which might not have been established in the present literature (Smith, 2004).

IPA advocates a social constructionist position that claims that socio-cultural and historical processes are central to how we experience our lives and recount the stories of our lives (Eatough & Smith, 2008). IPA is idiographic in nature and is concerned with the particular and strives towards an in-depth analysis and understanding of experiential phenomena according to a person's individual's context (Smith, Flowers, & Larkin, 2009). The strength of an IPA as a '*stance*' or perspective lies in the fact that when the systematic layers of interpretation are carried out effectively, this enables a certain degree of rigour and robustness of the researcher's findings which will contribute to the wider evidence base of psychological and health care literature (Finlay, 2011).

IPA shares the aims of other descriptive phenomenological approaches in that it wishes to capture the quality of the participant's experience, but takes into

consideration that the process of unravelling the meaning of the texts from the transcripts will require interpretative engagement from the researcher (Willig, 2008). The interpretative phase of analysis affords the researcher the opportunity to unravel the data in a more speculative manner and to question '*what it means*' for the participants within their wider socio-cultural context and by looking at existing theoretical constructs of the research question (Larkin, Watts & Clifton, 2006).

Discourse analysis (DA) was considered as a possible approach, but was soon ruled out because it examines the role of language as a function in constructing social reality whereas IPA is concerned with the cognitive, linguistic and affective connection between what people say, think and how they assign meaning to their experiences (Smith, Flowers, & Larkin, 2009). Discourse analysts examine what people say in order to learn about how they construct their narratives (Smith, 2011). Discourse analysis evolved from linguistic studies and is interested in how the story is told and what identities, relationships and shared meaning are created through language (Starks & Trinidad, 2007). Grounded theory was also taken into consideration as a plausible methodology for this research project. Grounded theory originates from sociology, pragmatism and symbolic interactionism, and aims to develop an explanatory theory by looking at meaning and interactions of basic social processes. It uses the constant comparison method of open, axial and selective coding (Smith, Flowers & Larkin, 2009; Starks & Trinidad, 2007). Grounded theory aims to develop a well-integrated set of concepts that provide a comprehensive theoretical framework for a social phenomenon under study (Corbin & Strauss, 1990). However, unlike grounded theory, which utilises theoretical sampling and keeps collecting data such as exceptions throughout the analysis phase, until no new themes emerge as there is a level of saturation; IPA relies on a purposive and largely homogenous small sample size, which provides a adequate perspective in a given context, and is interested in shedding light on understanding personal lived-experiences rather than looking at wider social processes and generating claims for the broader population (Brocki & Wearden, 2006; Willig, 2008). I chose IPA as it seeks to produce an in-depth examination of the phenomenon under investigation and looks at the psychological

convergence and divergences between each participant (Pietkiewicz & Smith, 2012).

2.4 Epistemological considerations

Epistemology is the branch of philosophy concerned with knowledge, what we can say about the world, and examining the relationship between the knower and the known (Langdridge, 2007; Willig, 2008). The epistemological position taken in this project is housed in constructivism and interpretivism because the data is being interpreted, and knowledge is being reconstructed and disseminated to a larger audience. This epistemological position presupposes that there is no objective knowledge, that reality is socially embedded and that the dyadic interaction between the researcher and the participant are central in capturing the "*lived experience of the participant*" (Grbich, 2007; Pontorotto, 2008). Etherington (2004) suggests that the ideal attitude for researchers when conducting research is to adopt a 'not-knowing' frame of mind.

2.5 Ontological considerations

Ontology is defined as the nature of reality and being or existence (Langdridge, 2007). Ontology is concerned with what is the form and shape of reality and what we know about it (Ponterotto, 2005). Is social reality external to individuals and imposing on their consciousness or is it the product of their cognitions? (Cohen, Manion & Morrison, 2007). This project subscribes to a critical realist stance to knowledge which denies that there exists a "*naïve realist*" position to the world whereby we can have an objective certainty about knowledge in the world. Rather it stipulates that there exists an array of valid accounts regarding a particular phenomenon under investigation (Maxwell, 2012; Willig, 2008).

A critical realist approach retains an ontological realism in the sense that a real world exists independently from our theories, observations and constructions of

it, that there are underlying enduring structures such as social, economic, biological and cultural drivers, while adhering to a form of epistemological constructivism and relativism that postulates that our understanding of the world is constructed from our own perspectives and beliefs about it (Maxwell, 2012; Willig, 1999). The leading thinker behind critical realism philosophy, Roy Bhaskar, put forth three ontological conceptualisations of reality to explain the social structures that constitute the fabric of our social life: (1) the empirical (what we experience through our senses), (2) the actual (what happens regardless of our engagement with it) and (3) the causal (what holds meaning in our social life can be seen by an observer and exists at the empirical level of reality) (Houston, 2014). Critical realism rejects the notion of extreme relativism, that there are "*multiple realities*" independent of one another and that the data collected during the research endeavour acts a "*mirror image*" of reality. Instead, it assumes that the data needs to be interpreted to explore the underlining structures that lie beneath it and that people hold different valid perspectives on reality (Maxwell, 2012; Willig, 2012). A critical realist position sits mid-way between a *realist* and *relativist* standpoint arguing that while the experience that someone has is 'real' to them, it is, nevertheless, a product of their interpretation and construction, which ascribes with the phenomenological stance that this project takes (Willig, 2008).

2.6 Interviews

Interviews were the chosen method for gathering the data for this research project since they are a flexible tool for data collection, "enabling multi-sensory channels to be used: verbal, non-verbal, spoken and heard" (Cohen, Manion, & Morrison, 2007, p.349). They are based on the dyadic verbal interaction between the researcher and the interviewee. The interviews carried out for this project were thematic and topic-centred, with a set series of questions that I wished to examine on men's relationship with food prior to having bariatric surgery. The questions posed tapped into different aspects of the phenomenon being researched (Langdridge, 2007). For this project, the interviews used were semi-structured because I was framing specific research questions inspired

partly by research conducted by Ogden (2010) on the meaning and symbolic aspects of food.

The most commonly employed interview in phenomenological research is the semi-structured interview as it enables a careful balance between consistency and flexibility (Langdridge, 2007). An important consideration that took place in this project due to the nature of the topic was to reflect upon the phenomenological interview and the issues of embodiment that arose during the interview process (Langdridge, 2007).

Interviews have a fluid and flexible nature to them such that even with a fixed set of questions, unexpected themes can come to surface and thus generate greater richness in the data (Mason, 2002). When carrying out qualitative interviews, it is important to be aware of my role as researcher and my active and reflexive participation throughout the process, and that it is challenging to keep a neutral role in the generation of the data collection. Therefore, I kept a reflexive journal throughout the research endeavour where I explored personal thoughts, feelings and questions as well as my burgeoning identity as a researcher throughout the project (Roulston, 2010).

The interview is a co-construction of the interpersonal transaction between the interviewer and the interviewee (Cohen, Manion, & Morrison, 2007). Silverman (1993) described the active interview as being more attuned to ways in which knowledge is constructed, examining the 'How' in the meaning-making process unravels and looking at the interactional and narrative procedures and how the knowledge is produced. The 'What' questions pertain more to the content and interview schedule. In order for the interview to tap into the questions that I wished to explore in greater depth, there needs to be trust, empathy, a sense of safety, and the interviewee must know that his anonymity is respected. This was assured in the consent form that the participants received before the start of the interview (please refer to Appendix C.) I was also sensitive to both verbal and non-verbal communication, able to clarify questions that seemed unclear to the interviewee. For this I relied on my counselling psychology skills of active listening, congruence, immediacy, reflection, clarification, acceptance and effective questioning skills.

Kvale (2006) stipulates that we need to be mindful of the asymmetrical power relation that unfolds during a qualitative research interview and highlights the fact that it entails a hierarchical relationship whereby it is an instrumental one-way dialogue with a specific goal and purpose and the interviewer subsequently holds the monopoly of the interpretation of that conversation. Furthermore, Kvale (2006) reminds us that the interview is not a '*dominance-free*' dialogue as the interviewer rules the interview that is an instrumental and potentially manipulative conversation since there is often a hidden agenda. I am aware of these established power dynamics that places the researcher in the "*expert*" role; however, my primary objective is that the narratives of my participants will empower others who have shared similar experiences with regards to their relationship with food.

2.7 Interview schedule

1. **Can you describe the role that food had for you growing up?**

   Prompts
   -Did you eat as a family?
   -Who prepared the meals?

2. **Can you tell me about your relationship with food?**

   Prompts
   - When you think of food, what does it make you think of?
   -When you are eating food, what feelings does it evoke?
   -When you are preparing food, what thoughts, memories cross your mind?

3. **When do you eat?**

   Prompts
   -Any particular times, moments?
   -When you experience different emotions? (E.g.: sadness, anger, loneliness, joy, happiness, boredom, frustration, excitement, rejection, shame, etc.)

4. **Can you please describe what food means to you?**

   Prompts
   -To your self-identity?
   -To your social interaction?

-To your cultural identity?

5. **Have you changed the way you eat over time?**
   Prompts
   -When you left home?
   -Did you ever go on diets? If so, could you tell me more?

6. **What made you consider having bariatric surgery?**

   Prompts

   -Who advised you?
   -What is your understanding?

7. **What changes do you hope the surgery will have?**
   Prompts
   -What are your expectations?

Finally, one last question:

8. **If food could speak back to you what would it say?**

9. **Is there anything you would like to add?**

2.8 Sampling Considerations

IPA should use homogeneous and purposive samples because they offer the research project insight into a particular experience (Smith, Flowers, & Larkin, 2009). IPA emphasis is on its commitment to a detailed interpretative account of the narratives collected. Therefore, there are no ground rules in terms of sample size as the aim is to focus on depth versus breadth (Smith & Osborn, 2008). Although there are no prescribed numbers of participants, for a Professional Doctorate between four to ten interviews (rather than participants) are usually recommended (Smith, Flowers, & Larkin, 2009). It usually depends on the depth, richness of analysis of each case and how the researcher wants

to compare and contrast each case as the main focus in IPA should be on the depth rather than the breadth of the study (Pietkiewicz & Smith, 2012).

In this project, I recruited eight male participants (between June 2013 and January 2014) through two renowned charities: the British Obesity Surgery Patient Association (BOSPA) and Weight Loss Support Information (WSLinfo). I also placed a website advertisement with the Beating Eating Disorders (BEAT) charity in August 2013 as they were at the outset of conducting some research on obesity and setting up emotional overeating groups through the country. However, my criteria were too specific in terms of people needing to be on a waiting list for bariatric surgery, so none of the participants interviewed were referred through BEAT. I sent a flyer to the chairman of the board of trustees of BOSPA who disseminated my invitations to participate in the study to all the team leaders around the country. I contacted the team leader and committee members at WLSinfo who kindly posted my recruitment flyers on their web forum as well as their social media groups. I liaised with numerous team leaders who invited me to attend their support groups and discuss my research project with their members.

In terms of inclusion criteria, participants needed to be male, at least 18 years of age in order to gain informed consent, fluent in English (to be able to collect thick and rich narratives), of any nationality, ethnic background, sexual orientation and be on a waiting list for bariatric surgery. (Therefore, they must have a BMI of 35 or above and have another serious health condition that could improve if they lost weight, or have BMI of 40 or above.) There were no additional exclusion criteria for this study as the participants would have had a psychosocial assessment done in the referring bariatric surgery department that would have screened them for their cognitive, social functioning, motivation, eating and mood disorders, and any form of unstable psychopathology (Mitchell & De Zwaan, 2005).

2.9 Pilot interviews

I conducted two pilot interviews with male colleagues to evaluate my proposed interview schedule, practice my skills as a qualitative research interviewer and ascertain areas of future improvement with their feedback post-interview. Although neither of my pilot participants met my recruitment criteria in terms of being on a waiting list for weight loss surgery, both of them described their relationship with food in great detail and how it had been shaped by socio-cultural, biological and environmental factors and changed over time. The first pilot participant spoke about food and self-identity as being able to be "*in control*" and eats a healthy balanced diet which equates with respecting himself and being successful and mature. He mentioned that food at times was used as emotional regulation and to fill feelings such as boredom, comfort, depression and a myriad of negative emotions. He spoke about feelings of pride, strength, virility and manliness associated with being able to eat great quantities of food and having the physical capacity to do so, which I thought were very interesting in terms of elucidating further questions about what is it about eating as a man which might be experienced differently than eating as a woman. The second pilot interviewee spoke a lot about cross-cultural references and having a bi-cultural identity when it came to his relationship with food and that he changed his diet and rhythm of eating once he moved to a Western country. Interestingly, he stressed the importance of the greater amount of food on a plate the better, which he said he believed was gender-ingrained.

The feedback I received from both participants was that they enjoyed the interview experience and did not find the questions emotionally distressing. On the contrary, it made them ponder further on their own ways of relating to food and also brought up themes of body image and the social aspirations of male beauty norms. My second participant did not come from a psychology background and reminded me that I should emphasise from the beginning that there are no right or wrong answers that I am looking for as he felt at times that he was going off on a tangent and not providing me with the answers I might have been looking for. This was valuable feedback as I had failed to mention

that to him at the start of the interview after I explained the information sheet and ran over the consent form. Furthermore, I changed the sequence of my interview schedule after conducting my pilot interviews and started out by asking participants to describe their relationship with food and only later on asking them about describing what food means to them which seemed like a more approachable question to start the interview process.

2.10 Introduction of financial incentive

Embarking on my participant recruitment phase, I encountered various challenges along the way in terms of accessing the right participants sought for this study. I attended support groups affiliated with BOSPA and WLSinfo support groups across the South of England and had successfully interviewed one participant in the first four months of my recruitment process. This prompted me to think and reflect further on what I was doing in terms of my recruitment drive that was not effective and what I could do to get more people expressing interest and enthusiasm about the study. The first roadblock was that most service users attending weight loss surgery support groups were predominantly female, and I was only recruiting male participants for this study. The second roadblock was that I was seen as an outsider and people had formed supportive friendships through the support groups and had been attending for a few years after their bariatric surgery. Some of the service users reported that they had lost their jobs because of their excess weight and were made redundant and expressed anguish about how they were going to support their families. This made me consider the idea of offering a financial incentive to participants expressing an interest in taking part in the study and being interviewed. According to some researchers from the feminist tradition, omitting to pay participants is perceived as unethical and they argue that making payment is a means to equalise the uneven power relationship that exists between the researcher and their participants (Head, 2005). Furthermore, Goodman et al. (2004) stipulate that the research participants should be compensated for their time, since the researchers themselves are compensated

through external rewards or salaries. In my case, the reward was the completion of my Doctorate degree.

In other words, the introduction of payment would not only create a certain homeostasis in terms of a power relationship, but also be a sign of respect, recognition and appreciation towards my participants for their time in a period when they are often faced with financial hardship. I amended my information sheet and web advertisement and stated that £15 will be paid for each interview. The ethical guidelines state that a "fair return" should be made, although not quantified by other researchers, and that payment should not be set at "coercive" level (Head, 2005). I decided to give interviewees this amount for practical reasons as this met my research budget for this study, felt like a fair return as I was asking interviewees for 60-90 minutes of their time, and this amount was approved and deemed sensible by the research development manager and ethics committee at City University.

On the other hand, the use of payment raises ethical queries as some authors have suggested that it could be seen as exploitative when dealing with vulnerable client groups (Paradis, 2000). This could be perceived as coercion or undue inducement that could compromise a participant's informed consent, unless it is seen as reimbursement or compensation rather than as incentive to participate in the study (Largent, Grady, Miller, & Wertheimer, 2012). The debate remains contentious, and there are no clear guidelines on this topic. That is why I have given participants their payment at the beginning of the interview and emphasised that the payment was for their attendance only and told them that they could withdraw at any point in the interview (Head, 2005). Since then, I have interviewed seven more participants, but cannot be certain that their participation was linked in any way with the introduction of a financial incentive as some participants told me that they would have taken part regardless.

2.11 The participants

I will give the reader more in-depth information regarding each participant's experience as well as my own personal reflections that I gathered during each interview to help contextualise them (please refer to Appendix G). Pseudonyms have been used in order to protect the confidentiality of the participants.

Table of the participants: figure 2.11

Name	Age	Occupation	Family status	Ethnicity
Adam	51	Fire safety consultant	Living with daughter	White British
Peter	46	Driver	Married	White British
Jack	44	Sales and marketing	Living with partner	White other
Ross	31	Software engineer	Living with friends	White British
William	36	Taxi driver	Living with partner	White British
Alfred	58	Unemployed	Living alone	White British
John	40	Unemployed	Married	White British
Mark	59	Unemployed	Living alone	White British

2.12 Reflexivity

Reflexivity involves an explicit evaluation of the self and turning our gaze inwards (Shaw, 2010). Finlay (2002) defines reflexivity as: “thoughtful, conscious self-awareness” (p.532). Active reflexivity should involve critical self-scrutiny and being constantly aware of my role as the researcher throughout this project (Mason, 2002). It also entails reflexively judging what we consider ethical or moral in defending our research questions based on our own experiences, values, beliefs, culture, norms and professional code of ethical practice (British Psychological Society and Health Care Professions Council) (Mason, 2002). Reflexivity not only facilitates the rigour and quality of the research endeavour, but also casts a light on any relational and ethical dilemmas that might have permeated throughout the process (Finlay, 2012). Reflexivity is a skill that allows us to take notice in our responses to the people and the world that surrounds us (Etherington, 2004). As a reflexive interviewer, I must look at the research process with a critical lense and question the context and the findings of my research as my source of knowledge (Finlay, 2012).

As Heidegger (1962) postulated, people bring their own lived experiences, specific understanding, involvement and fore-understanding into research. Hence, another person might perceive the same phenomenon in a different manner. As researchers we should engage with a sense of wonder and empathic openness to the world, while at the same time holding off from any of our pre-existent knowledge (Finlay, 2008). Husserl (1970) suggests that as a phenomenological researcher we must “*bracket out*” these beliefs in order to attune authentically to the meaning and essence of the participant’s lived experience. Bracketing, also known as phenomenological reduction or *epoché*, means the process by which I will attempt to abstain from leaning on my own presuppositions and ideas I might hold about the topic I am investigating (Langdridge, 2007).

However, I should notice that at times my personal reactions and responses might guide me to make informed choices about the direction of the research. Our socio-cultural and personal context can similarly impact on the interpretation of our work (Etherington, 2004). Engaging in reflexivity allows a holistic approach to psychological research (Shaw, 2010). We develop this skill in our Counselling Psychology training and as future professionals. Reflexivity requires us to bring a sense of personal awareness of our contribution to the construction and interpretation of meaning throughout the research project and that it proves difficult to remain outside of the subject matter while conducting research (Willig, 2008). Finlay (2006) advises researchers to attend reflexively to the bodies and embodiment of their participants and to their own and to pay particular attention to bodily empathy (attention to participants' bodies), embodied self-awareness (reflection of our own embodied experience as researcher) and embodied intersubjectivity (both researcher and participant's embodied experiences interweaving in empathic association) as the body has often been absent from phenomenological research.

Merleau-Ponty (1962) accentuates the importance of the body in phenomenological research when he says: " to be a consciousness or rather *to be an experience* is to hold inner communication with the world, the body and other people, to be with them instead of being beside them" (p.111). As an interviewer and psychologist, I do not only have empathy at a cognitive and affective level for my participants, but also have bodily empathy, which is felt by my embodied experience (Finlay, 2012). For example, my participant might be discussing feeling paralyzed by physical pain following an injury and in that moment, this might bring awareness towards a particular area of my own body where I am currently experiencing discomfort and tension. Alternatively, my body might be communicating other physiological signals in response to the participant's narrative, such as tightness in my stomach when I hear about their current emotional distress. Therefore, bringing attention to the body is in important facet of the research process.

Willig (2008) discussed the two branches of epistemology that we need to give thought to: personal reflexivity and epistemological reflexivity. Personal reflexivity concerns reflecting upon our beliefs, values, experiences, motivation, culture, age and gender, social and spiritual identities, and how they shape us in relationship to our research (Finlay & Gough, 2003; Willig, 2008). As researchers we need to bring a critical self-awareness to our own subjectivity, predilections and beliefs and to be conscious of how these can impact on the research progression and outcomes (Finlay, 2009). Some questions that have been useful to reflect upon have been: “What do I hope to achieve with this research?”, “Who am I, and how might I influence the research I am conducting in terms of my age, gender, culture and physicality?” and “How might my outside world influence on the presentation of my findings?” (Langdridge, 2007, p.59).

2.12.1 Personal reflexivity

I am aware that I have been drawn to research men classified as ‘obese’ and their relationship to food from a both a personal and professional standpoint. I grew up in a family where my father was considerably older than me and was always very conscious of his body and shape. He was athletic, kept a healthy lifestyle and expressed disdain towards men who in his mind “*let themselves go*”, perhaps because for him he drew parallels to the war when he was severely emaciated because he had nothing to eat, while the soldiers and officers of Vichy France and Nazi Germany were well-nourished and did not suffer the same traumatic predicament. On the other hand, on my mother’s side of family, I have three relatives who are classified as ‘morbidly obese’ and have been diagnosed with type 2 diabetes from an early age onwards and suffer from health ailments as a consequence.

Growing up, my mother voiced ambivalent messages around food varying from it is frightening and needs to be controlled to the other extreme where it is there to nourish you, give you pleasure, and bring people together in celebration and

festive periods. I, therefore, grew up with conflicting thoughts about food which has been seen as the '*good*' versus the '*bad*' object, and have been fascinated by the topic ever since. I realise that when reflecting about my project, my own gender as a female researcher and physicality has played an important role in the contextual framework. Since I am researching men's experience with food prior to having bariatric surgery and I have not experienced weight loss surgery myself, I needed to be careful not to misrepresent and construct my topic to reflect my position as an outsider (Langdridge, 2007). I have attempted to bracket any assumptions, beliefs, and intuitions I may have had along the journey and continued interrogating myself and engaging in critical self-reflection, which enabled me to articulate ideas regarding both my ontological and epistemological position. My training as a counselling psychologist has enabled me to consolidate these skills. I subscribe to the belief held by existential phenomenologists that although researchers should achieve *epoché*, it is never truly possible to bracket off all our presuppositions (Langdridge, 2007). Through the use of personal reflexivity as well as keeping a reflexive journal, I documented how the research was affecting and changing my identity as a researcher (Ponterotto, 2005; Ortlipp, 2008).

While I did not experience bariatric surgery, during my last year of training, I did undergo back surgery (a laminectomy and discectomy), which was completely unexpected and as a result during my research analysis, I did echo greatly with some of my participants' narratives when it came to living with chronic pain. Furthermore, my own physicality shifted quite considerably for me, which did affect my own attunement to my body and brought about a range of unpleasant feelings. Aside from utilising my reflexive journal, I spoke to my research supervisor, who was very supportive, and also re-engaged with personal therapy to make sure I had a space to unravel these feelings and clearly demarcate my narratives from my participants' and to explore how the research experience was at times affecting me.

Professionally, during my last year of training, I worked in a Weight Loss Surgery Department in Psychological Medicine in a hospital in Central London and was responsible for providing specialist psychological assessments and evidence-based treatment to both pre-op and post-op patients who were referred to the bariatric team as a part of a multidisciplinary team. I learned tremendously from my time there and had the incredible opportunity of sitting in on two bariatric operations with a handful of trainee medics and nurses, with the surgeon and nurses explaining to me beforehand what I would be seeing on the screen during the laparoscopic operations. This helped me with my both my clinical and research work by providing a more holistic experience of the patient journey. However, this made my position as an "*outsider*" at times harder as I was conducting some of my research interviews during the same time that I was working in that placement, and I could feel at times my roles shifting from research scientist to clinical practitioner mode, especially when participants would at times ask questions about their treatment before and after the recording, and I would respond and sign post them to places I was familiar with (although most of the information was usually found on the debriefing form).

2.12.2 Epistemological reflexivity

Epistemological reflexivity on the other hand is concerned with questioning how the research question is defined and limited what data was found and generated (Willig, 2008). Furthermore, it requires us to think about the design of the study and how the method of analysis has moulded the findings of the study (Willig, 2008). How could the same construct be explored and studied differently and give rise to another understanding of the some phenomenon? This necessitates us to reflect upon the assumptions we have made about knowledge, the world in the course of the research and think about the implications that such assumptions will have on the research findings (Willig, 2008).

2.13 Ethics and Permissions

I followed the code of ethics and conduct put forth by the British Psychological Society (BPS) as well as abided by the code of human research ethics, which advocates the respect for the autonomy and dignity of persons, follows scientific values and social responsibility, maintains high standards of professional competence and maximises the benefit and minimises the harm to research participants (British Psychological Society, 2009; 2010; Silverman, 1993). Brinkmann and Kvale (2008) bring about valuable questions in terms of research ethics and recommend that we think carefully about the '*why*', in other words, why is the research project valuable to pursue, what does it bring to further knowledge and how the research activity carried out.

Interviews have an important ethical dimension since they involve interpersonal interaction with the human condition (Cohen, Manion, & Morrison, 2007). Since this project seeks to explore and examine questions which are psychological and emotional in nature, it involves ethical considerations such as making sure to obtain informed consent from the participants, respecting the confidentiality and anonymity of the data, avoiding discomfort, harm and deception and, lastly, giving more thought regarding the consequences of the interviews (Cohen, Manion, & Morrison, 2007; Langdridge, 2007). Among the various considerations of the researcher is: How much information should be disclosed to the participant prior to the interview as interviews are based on the assumption that the interviewers have insight into the cause of the interviewee's behaviour and the willingness to speak about it (Cohen, Manion, & Morrison, 2007). Another consideration is that the interview might enable a particularly vulnerable participant to feel more in touch and self-aware on certain issues, which potentially could have a psychologically harmful effect on him (Cohen, Manion, & Morrison, 2007). That is why the researcher needs to be very sensitive to the potential vulnerability that the questions might incite. The interviewee might be aware of his rights but lacks the confidence to ask the interviewer to stop or has difficulty articulating his feelings of discomfort or even of emotional distress (Olivier, 2003). Hence, it is critical to create a space of

safety, respect and confidentiality, where the participant is fully aware that any material disclosed will be kept completely anonymous.

However, since interviews entail a social relationship, this also implies a certain power relation where the interviewee could be seen as put in the "*hot seat*" as the interviewer defines the situation, the topics that will be covered and the course of the interview (Mason, 2002). The research participants may feel guarded and experience a certain trepidation or reservation to disclose sensitive material. If they are so concerned about their self-presentation, they might not disclose their thoughts and experiences truthfully because they might fear being evaluated and judged by the researcher (Mason, 2002). By the same token, the power-role could be inversed, whereby the interviewer feels passive, vulnerable, helpless and manipulated by the interviewee. As Cohen, Manion and Morrison (2007) stated: "Power is fluid and is discursively constructed through the interview" (p.152).

Ethics entails following certain rules of conduct and good practice and conforming to these guidelines (Robson, 2002). Research ethics are mainly concerned with the relationship between the researcher and the participants and the integrity of the contribution to knowledge. Research aims and objectives should always be morally and ethically backed up and justified (Olivier, 2003).

"The key issue is that in order to place research on a firm moral footing, there should at least be the *intent* to improve the human condition" (Olivier, 2003, p.12).

2.14 Data Analysis

The analytical procedure used for this project followed the six stages put forth by Smith, Flowers and Larkin (2009). The first stage comprises being immersed in the data and reading and re-reading interview transcript as well as listening to the audio-recording to recreate the moment I conducted the interview and imagine the voice of my participants and any powerful and significant memory

that unfolded during the interview. Smith, Flowers and Larkin (2009) advise, at this stage, to jot down in a research diary any initial preliminary impressions, observations, reactions I have as this will enable me to bracket them off. Actively re-reading the raw data enables the researcher to enter into the participant's lived world and get a feel for the flow of the narrative and also highlight richer sections of the interview or moments when there are contradictions and get an appreciation for how the interviewee develops trust and feels safer with me in the room.

I then collated the interviews into a three column excel table where on the right hand corner I started writing initial notes that were subdivided in three separate sections: (1) descriptive comments making annotation on the content of what the participants reported (i.e.: key experiences, words or expressions), (2) linguistic comments where I focused more on the semantic content and use of language (i.e.: repetition, laughter, tone of voice, etc.) and (3) conceptual comments which are more interpretative and abstract in nature and are drawn from my own experiential and professional context where I attempted to find hidden meaning and explanation behind what was explicitly stated by my participants (Smith, Flowers & Larkin, 2009). All the notes recorded at this stage of the analysis, whether in the form of queries, summary statements, questions regarding the participants' multiples selves, agency and identity, were my own initial encounter with the text and got more refined as I progressed through the next stages of analysis (Willig, 2008). Smith, Flowers and Larkin (2009) remind us that while we record conceptual comments, the interpretations should be inspired by the participant's words, not from the outside, and to bracket our own narratives.

The third stage of analysis is about developing emergent themes, which I wrote on the left hand margin of the table. During this stage, I attempted to synthesise, reduce and map the interrelationships of the initial notes I wrote on the right hand side while maintaining the complexity of the meaning of what the participants said. This process is a part of the hermeneutic circle as I am added my own interpretation to the data and "the part is interpreted in relation to the

whole; the whole is interpreted in relation to the part" (Smith, Flowers & Larkin, 2009, p.92). The emergent themes are sometimes noted as phrases and mirror both the psychological essence of the transcript and capture sufficient particularity to be grounded in the text and abstraction to be conceptual (Smith, Flowers & Larkin, 2009). My supervisor advised me during this stage to place a question mark next to emergent themes that were more interpretative and were less grounded in the text. Each emergent theme was supported by a few words or a phrase as well as the page and line number to enable me to remember the source of the theme and create a data audit of how I progressed from one stage to the next in my data analysis.

The fourth stage involves searching for connections across all the emergent themes per participant. I listed all the emergent themes chronologically and then for the first participant, I cut out each emergent theme, spread them all out on the floor and started to cluster them spatially, using abstraction which Smith, Flowers and Larkin (2009) refer to as identifying patterns across emergent themes and creating a 'superordinate theme, which I named 'cluster themes' in my data analysis (see Appendix J). However, this method of typing all the emergent themes, cutting them up and dispersing them on the floor soon felt overwhelming to me so I deferred to my preferred way of working which was to create a separate excel sheet where I grouped all the emergent themes in cluster themes (i.e.: family life: past and present, relationship with food, body shame: ideal and stigmatised bodies, weight loss surgery expectations, etc.) and used some of the recommended ways of looking for patterns among emergent themes put forward by Smith, Flowers and Larkin (2009) which are abstraction (putting the similar themes together and creating a new cluster theme name for them), polarization (examining themes that have an oppositional relationship to each other), subsumption (where an emergent themes acquires the cluster theme name) and numeration (taking into account the frequency that an emergent themes resurfaces). The fifth stage of analysis involved moving from one participant to the other, repeating the same steps and bracketing as much as possible any emerging ideas that arose and keeping with the idiosyncratic nature of IPA. The final sixth step of analysis comprises of

looking for patterns across cases and building the connections and relabeling themes accordingly.

This led to the production of a master table with all the cluster themes exemplified with key words from each participant and line number. The cluster themes were also branched into superordinate themes and I drew their relationship on a piece of paper before transposing them in a graphical display (please refer to the analysis chapter).

3.0 Analysis Chapter

"Part of the secret of a success in life is to eat what you like and let the food fight it out inside." Mark Twain

3.1 Introduction

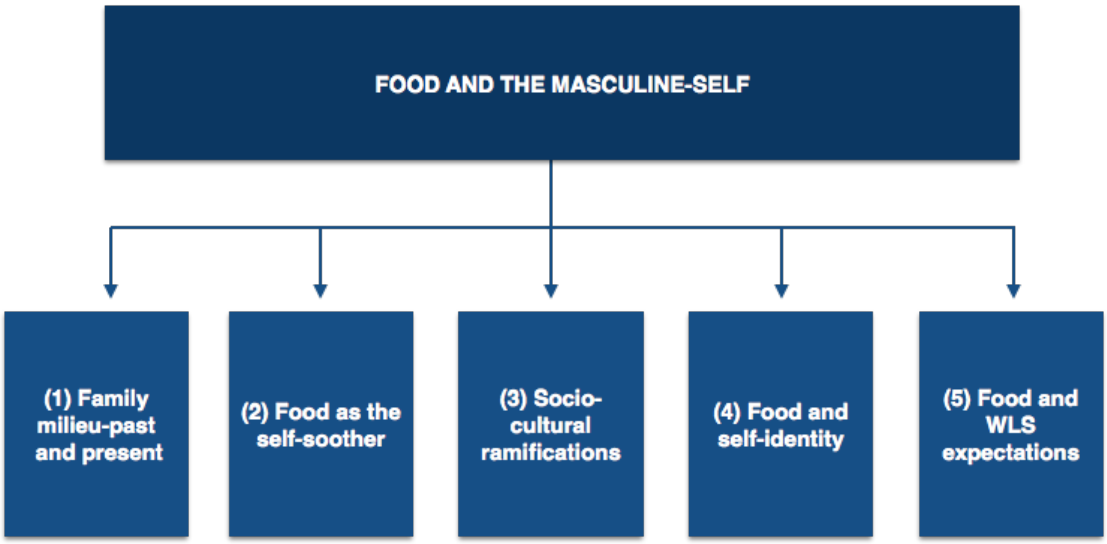
This chapter presents one over-arching theme and five interrelated superordinate themes derived from interpretative phenomenological analysis.

The over-arching theme is 'Food and the masculine-self'. The five interrelated superordinate themes are listed below:

1. Family milieu: past and present
2. Food as the self-soother
3. Socio-cultural ramifications
4. Food and self-identity
5. Food and weight loss surgery expectation

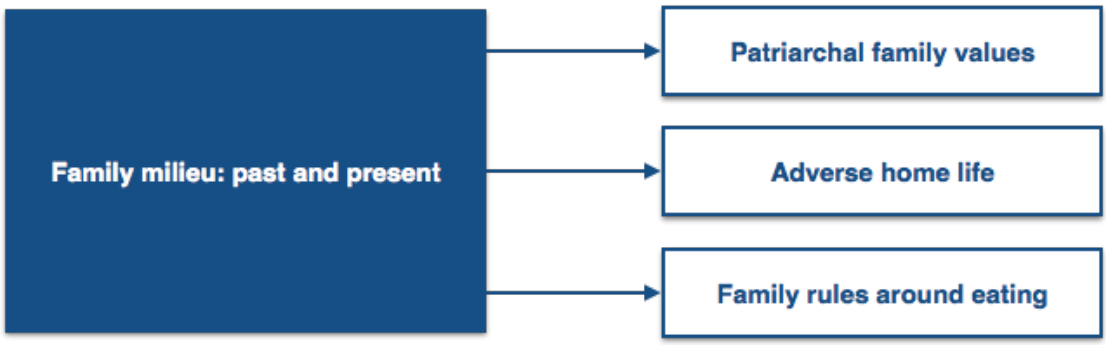
The following diagram illustrates the over-arching theme in relation to each of the superordinate themes. Each superordinate and cluster themes will be presented

Figure 3.1



3.2 Superordinate theme 1 - Family milieu: past and present

Figure 3.2



When unfolding the narratives of all the participants, one pivotal developmental starting point was exploring the role of the family milieu. Three central cluster themes appeared which are: (1) patriarchal family values, (2) adverse home life and (3) family rules around eating.

3.3.1 Patriarchal family values

The cluster theme of patriarchal family values was apparent for all participants as their mothers, current or past spouses were all described as the homemakers and in charge of any food preparation and domesticity.

Ross elucidates below how his mother likes to celebrate food and is referred to as a "*chronic over-caterer*". The use of superlatives such as "*far too much*" and "*huge*" emphasise the voluminous amount of food that is prepared for a congratulatory occasion in Ross's household. The fact that no one touched the food suggests excess, which might have been seen as normalcy for Ross growing up.

> *"My mum's a chronic over-caterer. I remember it was for my dad's 60th birthday, and we'd all organised to go to the pub for a meal, and at sundown or maybe two or so, then we came back, and we bought far too much food for everybody. There was, like, you know, a whole salmon, there were, like, three platters of sandwiches that she'd got from M&S, huge bowls of salad, and that kind of thing. Nobody even touched it, because we'd all just eaten." Ross, 68-74, 3*

William's father was the breadwinner like all the participants in this study, and his mother was the devoted housewife who prepared with love all the meals from scratch. William describes the early-onset of his burgeoning yearning for sugary food.

> *"My father worked and obviously she looked after us, she was a house mum and she cooked. Unfortunately, my desire for food from a young age stemmed and I had sweets and lots of biscuits and yeah..." William, 11-13,1*

Adam describes his ex-wife with whom he shared a lengthy marriage as a "*feeder*". She would feed him large portions of food and especially add "*lots of garlic or lots of chilli"* so he would not engage in flirtatious behaviour with other women. This could be seen as a means of control or distrust of her husband's whereabouts. Adam's laughter, in turn, conveys an underlining sense of anger and blame. He may perceive his ex-wife as one of the contributory factors to his current weight.

> *"So my wife of 21 years, I divorced a few years ago – I was a very young dad – she was a bit of a feeder, sort of thing, but I didn't know this until recently, I would go out down the pub on a Friday night, but she would feed me massive meals with lots of garlic or lots of chilli so that I wouldn't chat any women up (laugh)." Adam, 54-57, 2*

3.3.2 Adverse home life

Most of the participants (all of them except for Ross and Mark, please refer to Appendix L and M) spoke about growing up in financially deprived families and starting to work to earn money and become independent from a young age. Peter reminisces about his school dinners when he received free meals and did not share the same privileges as the other children in terms of food selections because he came from a less affluent background, and his mum was a single parent. He acknowledges that what he received might have been "*healthier*" than his peers because he didn't have the "*luxury of having chips*" or "*treats*", but there is a sense of loss. His childhood predated the processed food epoch of McDonald's. Though Peter employs the expression "*funnily enough*" on two occasions, it translates more into feelings of sadness and mourning at what could have been a different childhood. Perhaps this tells us why, later on, Peter turned towards unhealthy food options as a form of compensation for what he felt he was deprived of during his formative years.

"Funnily enough, my school dinners were probably healthier than the people...[1] *because obviously we had school free meals because of my mum being a single parent, so we couldn't have the luxury of having chips and things like that, so we had to have basically what was allowed on your ticket, sort of thing. So we actually ate more healthily than the other kids, funnily enough, because they could afford to have like, you know, the treats, you know, like the chips and all that. Yes, I think it does stem back, as I said, like, you know, to my mum not having a lot of money, so it was like you'd probably have the poorer foods, like, you know, not the leaner meats and things like that, it's like minced meat and... But then again, we didn't have pizzas then, you know, I don't think it was even heard of, having pizzas, you know. I mean, there wasn't McDonald's." Peter, 300-314, 6*

3.3.3 Family rules around eating

Social etiquettes around eating as well as family rules around food are taught and transmitted intergenerationally. Such was the case for Ross and Alfred. Ross did not grow up in a financially deprived environment, and food was never scarce. However, he was raised with the notion that he should be a "*member of the clean club plate*" and if he did, he would then be rewarded by dessert as recognition of his successful eating etiquette.

"The family wasn't short of money, and putting food on the table wasn't a big struggle, so it wasn't, you know, there wasn't pressure from that point of view. It was just, you know, that was the done thing. So if you did clean your plate and eat it all up, then, you'd done that, so you would be allowed pudding." Ross, 404-409, 12.

Alfred admits that he employs larger plates of food. Despite being self-aware that he might be physically full "*halfway through*", he still preservers and finishes the entire dish. Alfred's use of language, such as "*don't be an idiot*", is quite

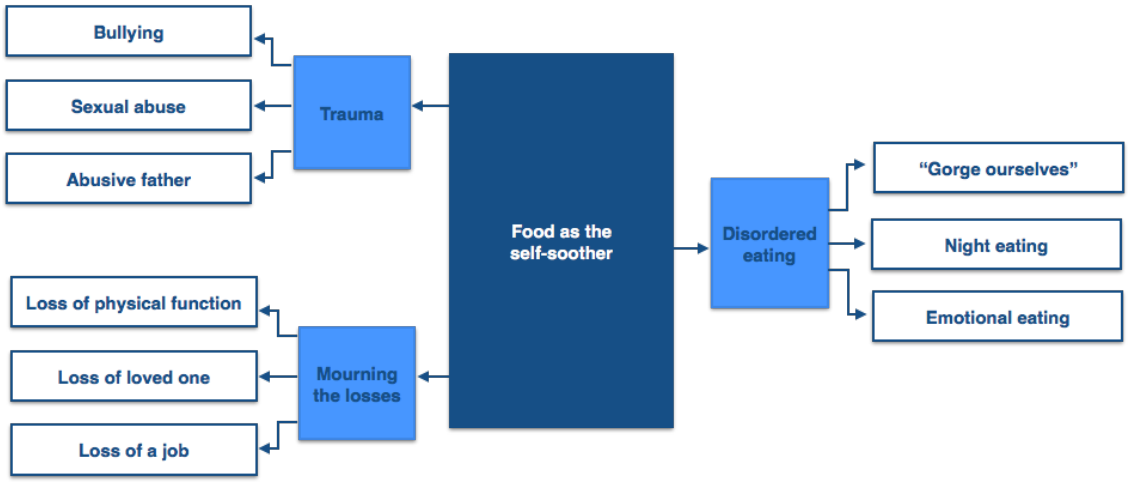
[1] … Indicates a pause in the speech

self-berating and self-critical. He attributes this eating behaviour to his parents' generation who lived on wartime rations.

> *"I'll tend to use a bit bigger plate, but I'll still eat it all, even though I can be full up halfway through, there's nothing there that says, don't be an idiot, leave the rest, throw it away. And it's just a thingy and I think it's... I don't know if it comes from the age I'm at or younger people might do it differently, but when your parents were brought up, you know, kind of, during the war..." Alfred, 218-222, 7*

3.4 Superordinate theme 2: Food as the self-soother

Figure 3.4



One central superordinate theme that transpired throughout all of the participants' narratives was the role of food as a self-soother. In other words, how food could be used and misused as a means of affect management (please refer to Figure 4.4). The three main clusters themes that arose from the data, was "trauma", "mourning the losses" and "disordered eating". Not all participants fell into each cluster themes (please refer to Appendix L for further information).

3.4.1 Trauma

Not all participants described traumatic incidents. Some still suffer the scars of their trauma to this day, while others are more preoccupied in terms of transgenerational pattern of transmission and having their children bear the same damaging consequences.

Peter discloses his experience of being sexually abused by a person that he trusted.

> "*It was a member of a junior football team I used to play with, and he used to…well, he used to sort of pay us to do, cleaning his windows and things, and one thing led to another, which you know, I was sexually abused, and didn't think there was anything wrong with it at the time. But it wasn't until sort of obviously later in life I was a bit confused about my sexuality, well, I know I wasn't gay, but it was like it affected me really bad. And I've had counselling over that, and I think I probably, if anything, had a lot due to that as well, I didn't realise it at the time, and I'm still on anti-depressants for it now". Peter, 68-77, 2*
>
> *"To deal with stress now, I have to try to find a different way to dealing with work stress, money stress, we've had trouble with our neighbours as well, with loud music (…)*[2] *I started eating again"* Peter*, 169-174, 4*

This passage brought up a range of difficult feelings. Peter was sexually abused by a person he knew and trusted, someone who had given him employment and a sense of responsibility and independence. His sense of disbelief, shock and fear is felt in his use of language and the way that he hesitates to articulate the events of what had happened. There are also feelings of shame and confusion regarding what the abuse symbolised and represented in terms of his sexual identity. The notion and meaning of temporal space *" it wasn't until sort of later in life"* has a lot of significance in terms of the aftermath of the event and how the abuse was emotionally processed later on and permeated until this day

[2] (…): Indicates that some words were removed.

on his psychological well-being. The subsequent quote exemplified his realisation that he tends to turn to food for emotional regulation, especially as a means to dampen his ongoing stressors.

Alfred, John, Adam and Peter all describe childhood experiences of being bullied due to their size and/or physical "otherness". Alfred recounts his very painful recollection of living with a physical disability that not only caused him great bodily discomfort, but for which he was also ridiculed and shamed for his visible difference.

> *"It sounds silly really but I was seriously knock-kneed so, you know, they tried with wedges on my shoes and all the horrible stuff like that so… Other kids would take the micky out of me but that's just the way it goes". Alfred, 23-26,1*

> *"Living on my own, it's been particularly difficult because you get…you get in that, can't be bothered cooking for one so you tend to cook, if you cook, you tend to cook a bit more and then it's that, if you excuse the expression, sod it, I'll eat that too because it's not too much, I'll have one and a bit portions. So you tend to overeat if anything" Alfred, 79-85, 3*

The use of his language suggests not only the gravity of the situation and the accentuation of his feelings of humiliation, but I felt that he might be reliving his fear of being judged or critiqued by me in the room. Perhaps he was seeking my approval by reinforcing his use of apologetic language "*it sounds silly really"* to convey his embodied shame. Having been diagnosed with knock-knee from the tender age of 12 years old has meant that he not only has struggled with his weight, but with long-standing physical pain in his knees.

In the subsequent passage, Alfred recounts how, aside from living with physical pain, he lives alone which acts as a roadblock in terms of motivating himself to

eat sensibly. This leads Alfred to overeat, as he tends to cook too much. Alfred's language is both hesitant and apologetic when he uses the expression "*sod it"* and repeats tentatively "*cooking*" as if he were seeking my approval for his transgressions. There is a sense of relinquishment and defeat in his narrative, as if he can no longer see the point and has given up. Alfred's pain and eating are intrinsically linked.

John described his experience of being bullied at school as being a significant contributor to his emotional relationship with food.

> *"R[3]: So, the bullying, was it related to your weight?*
>
> *P[4]: Yes, it was, and then when I got to secondary school I changed my way of thinking. I made myself think, you know, just ignore them, they're idiots, you know, because what they're doing is, they're bullying you to hurt you, but then you're going home and hurt yourself by eating, you know, what people do when they get bullied, so they win". John, 17-23, 1*

In this excerpt you sense John's internal battle between his emotional-self versus his rational-self. Although John is consciously aware that his bullies are trying to hurt him, he admits defeat and resorts to self-soothing with food. There is a sense of disconnection between his mind reassuring him that his bullies are only acting in order to hurt him, that they are "*idiots*", perhaps unworthy of his attention, and that he ought to stay strong on the exterior and demonstrate victory over his aggressors. Not only does this demonstrate a powerful cognitive coping tool, but an awareness of motivation of the "*other*" to attack him maliciously. However, his emotional self takes over, and the only way that he knows how to self-regulate from painful experiences is through food. He knows that, although food will ease his shame in the short-term, he is *"hurting"* himself by doing so and essentially going on a self-destructive path. John has lost in the face of his childhood aggressors.

[3] R denotes the researcher
[4] P denotes the participant

Furthermore, John fears a transgenerational pattern of eating and bullying with his son.

> *" I don't want him thinking because I'm overweight that's how you're supposed to be because it's not. I keep trying to tell him, I see a lot of me in him, you know, he gets bullied at school". John, 350-352, 10*

His son is like his mirror image and John wishes to break the cycle and become a better role model for his child. As a protective and caring parent, he wishes to show his son a better way of relating to his body and what he ought to consider a healthier physique. As an overweight parent, he does not wish to instil his physicality as the acceptable norm for his son. John must also somehow live vicariously through his son and relive his own experience of bullying all over again as he witnesses his son suffering from the same predicament.

Peter recounts his conflicting experience of childhood bullying especially with regards to his relationship with girls.

> *"They used to call me rubber man at school, because my skin used to stretch, but I played all sports at school, I even did gymnastics. I did everything, but I would still not lose any weight, I would still be plump. But it wasn't until I left school, when I was 16, and I started working before my apprenticeship started, and I started to lose it. And funnily, the girls that I went to school with, they said, oh Peter, I don't like you like this, and I said, what, all these years you've been calling me names (laughs) and now I've lost my weight you don't like me". Peter, 141-150, 3*

In this extract, Peter describes the shaming nature of being labelled "*rubber man*" despite being physically active and athletic. Despite continued efforts, it seems that his physicality still remained larger than that of his peers. He explains later on his bewilderment that when he later lost some of his body weight, girls commented that they preferred him as his old-self when they used to nickname him "*rubber man*". Peter's laughter is indicative of his state of

confusion that despite striving to be accepted, perhaps looked upon as an attractive young adolescent, he never seems to fit in nor be suitable enough for these young girls. His laughter also communicates sadness that no matter how he fluctuates in his physicality, he does not seem to be sexually desired.

William speaks about his father as an abusive figure whom he feared for most of his childhood. However, in the extract below this is where William reclaims his power.

> *" It is where I became a man. Because my father used to push me about to do what he used to do. And obviously at the gym he saw me turning from a boy to a man and in that predicament, I have gone from where he could push me and there was a punch bag. I said to my dad "hold the punch bag because I just want to punch". I put so much pressure into the punch that he knew that if I was going to punch him, I would hurt him so he left me alone from that point onwards and that was the breaking point for me." William, 508-515, 11*
>
> *"I was working very hard with my father. My father he lays the carpet, so you know we were always on our hands and feet and we were working hard and the calories you are burning". William, 493-496, 11*

This is where William turned from boyhood towards manhood and demonstrated his physical prowess in front of his father who no longer dared assumed the aggressor position. This passage not only communicates the protective value of his physical toughness, but that no one can hurt him physically anymore. Manhood symbolises power, physical strength and dominance in this context. The power game has reversed and from an "*abused"* position he can now become an "*abuser*" in the eyes of his father. His father should now fear his son. Furthermore, William worked very hard with his father during his early adulthood, which he described as strenuous physical labour, which facilitated, in terms of keeping him active, "burning calories" and maintaining a healthier relationship with food.

Furthermore, William draws a direct correlation between his weight difficulties and his childhood traumas. Food represents his means of cathartic release and to self-soothe.

> *"I have my weight problems because of my parents! My childhood was a very bad childhood, and obviously the only way I had comfort was to eat". William, 389-391, 9*

Although there is an accusatory tone in his comment, one could imagine that food, in this instance, takes on a parental function, a consoling nurturing substitute that whispers in his ears "*Eat me and all will be fine, I am here to look after you and appease you".*

3.4.2 Mourning the losses

Experience of loss was a significant cluster theme that transpired in most of the participants' narratives. Any change in life entails a loss and I will be exploring their associated meanings. For this cluster theme, I will be focusing on three specific losses: (1) loss of physical function, (2) loss of a loved one and (3) loss of a job. The theme of loss will also become apparent when we will look at participants' expectations of weight loss surgery.

3.4.2.1 Loss of physical function

John describes a terrible accident he faced that had a devastating impact on his mobility and emotional well-being.

" I was rushing to work and I fell down the stairs and I must have knocked myself out, and when I came round I tried getting up and I couldn't move (…) It took two ambulance crew three hours to get me out of the house (…) I've never experienced worse pain that I'm in anyways and I'll do anything to get rid of it (…) It's like everything that's happening with my life has got to a point where I'm depressed most of the time (…) They couldn't put me in the machine because over the years I've put the weight back on and more, you know, since I fell because [of][5] what I was doing. I stopped doing Taekwondo because I couldn't do it. I don't like walking because I'm in pain more when I walk. I'm supposed to use two sticks and I don't like using them, I feel like an old man, you know". John, 134-224, 5-7

The velocity in which John was going about his daily routine, propelled him to have an accident that left him paralysed with pain. When he describes the fact that it took two-ambulance crew to take him out of his house, I felt as though he was conveying his sense of body shame because he needed more than one ambulance crew to assist him and it was a rather lengthy process to get him out of his house. John describes the unbearable intensity and chronic nature of his pain and his aspired wish to live a pain-free existence. He elaborates on his state of despair due to the severity of his pain and the loss of his physically able body.

There is a direct correlation between the pain impacting on his emotional and physical well-being. John states that medical health professionals were unable to fit him in the MRI machine due to his size as he accumulated weight since his fall. It became a vicious cycle whereby the pain prevented him to resume his physical activity and pleasurable hobbies. His use of language such as "*couldn't*" reinforces this cycle of learned helplessness. John no longer enjoys walking as he is supposed to use walking sticks, which make him feel emasculated and could be seen as a direct attack on his manhood. Lastly, over

[5] [ ]: Denotes an added word.

the years John described gaining weight and "*putting it back on"*, which suggests that he attenuates his physical pain by turning to food.

Alfred also mourns the loss of his physical function.

> *"But I suppose because of the problems I've had with my knees it's been like a... It's taken... It's taken the focus off the weight loss really whereas I was doing okay but it's just... it's just got... I don't know, it's just silly the way it is at the moment (…) As regards to food it's a, kind of…it's difficult. It's that, when you can be bothered and then sometimes you tend to overeat because you're bothered…" Alfred, 179-194, 6*

In this passage, Alfred struggles to articulate his ideas and the repetition of *"it's taken"* indicates perhaps his frustration and impotence at moving forward due to his pain. I also felt as though there was an underlying feeling of anger at himself when he said "*it's just silly the way it is at the moment*". Living with pain is creating an obstacle for him in terms of his weight loss goal and he communicates his feelings of shame and criticism. For Alfred it's a question of juggling what are his most pressing needs —between having bariatric and having knee surgery —in terms of ameliorating his daily functioning. When it comes to his relationship with food, it seems to be both perplexing and ambivalent as he describes his difficulty in trying to uphold both his enthusiasm to eat well and not to overeat. It seems that self-soothing with food is his preferred avenue.

3.4.2.2 Loss of a loved one

Peter spoke of his grief when he lost his grandfather whom he considered his paternal protective figure. At only 37 years old Peter suffered from a heart attack, which frightened him greatly as his grandfather died of heart failure.

"My grandfather he had a triple heart bypass, but he was the first person in this country who had to have a pig's valve put in his heart… I was 14, so obviously he died over a heart. And obviously I was so close, and he was close to me as well, even though he had another grandson, he was a bit younger, he was like, we had quite a big bond, and actually my cousin was a little bit jealous sometimes, because we had that special bond, sort of thing." Peter, 984-993,19

"After that scare I had last month, where I thought, God please don't let it be this again, so that's even putting me in a more positive mind of having the surgery done, and I need that help." Peter, 1018-1021, 19

When Peter describes his grandfather as being the first in the country to have had a pig's valve put in his heart, he conveys his sense of pride. Peter mourns the loss of his grandfather. He was quite young when he lost him, and there is a fear of repetition as he himself is now a grandfather and fears his own mortality following his sudden heart attack and leaving his own grandchildren behind. Peter's repetition of the word "*obviously*" conveys that there is an assumed common knowledge and/or perhaps lingering feelings of anger at losing his beloved grandfather so prematurely. Peter emphasises the "*special bond"* he shared with his grandfather that was envied by his other grandchildren. Peter fears having another heart attack and following the same predicament as his grandfather and not being able to see his grandchildren grow up. This has only made him more determined and instilled a "*positive mind*" in terms of proceeding ahead with his decision to have bariatric surgery to regulate his relationship with food.

Mark described how painful it was when he buried his mother and how it affected him emotionally and existentially.

" We'd had the stone setting for my mother (…), and I was very, very, very low, really, really low. I don't cry an awful lot, but I was on the

phone to my son, and I was just sobbing, that I feel so low (…). We'd put the stone on my mother's grave, next to my father, who was my best, best friend, and I think everything just welled up. My weight, my situation, the fact I was on my own, my kids were living away (changed word), and I was on the phone to my son and I just lost it. I just started crying" Mark, 946-956, 22

In this passage, Mark's repeated use of superlatives such as "*very*" and "*best*", his accentuation of certain words like "*really*" suggest his feelings of deep sadness, loss of his sense of self, and, at the same time, reliving the loss of his father who was not only his best friend but also his confident. Mark emphasises that he usually does not cry, but on this occasion, he was not just crying, but sobbing and *losing it*. What did those tears and "*losing it"* mean to him in terms of his masculinity, and for those around him to witness his vulnerability and fragility so transparently? Tears might have symbolised a sign of weakness for him in the past. Mark speaks about feeling low in affect following the death of his mother and questioning his existence, most notably his weight, his loneliness, and what brings meaning to his life.

3.4.2.3 Loss of a job

Alfred, John and Mark lost their jobs due to their complex relationship with food which rendered them physically limited. John mourns the loss of his job following his accident.

" Since I fell that day, I lost my job, a job I loved (…). I loved it because you get to talk to the kids, you know, they're all, like, in wheelchairs, or you know, and lovely kids that wanted to help me fix stuff around the school and stuff, you know, I miss that." John, 636-644,18

John worked with disabled children and loved his job because of the relationship he built with them. The repetition of "*you know*" and "*stuff*" indicates a shared familiarity and a degree of abstract cluster of activities. Sadly and paradoxically, John lost his job that was more than his professional identity to him, and became like the children he worked for disabled.

3.4.3 Disordered eating

Disordered eating was one of the cornerstone cluster themes of the participants' narratives. In this section I will be exploring participants' eating patterns, most specifically, episodes of binge eating, night eating and emotional eating.

3.4.3.1 "Gorge ourselves"

All the participants in the study described episodes akin to binge eating. Ross describes an early memory and reference to a binge-eating episode.

> *" Me and my friend we would always go off to the local shop and buy as many sweets and chocolates, and then we'd just immediately gorge ourselves on that kind of thing (…) We would sort of, buy, like, a litre tub of ice cream, or something like that [laughing] and then just feel really quite ill [laughing and smiling]. So we would have to find somewhere to lie down and recover from that." Ross, 8-16, 1*

This passage suggests that Ross's binging was habitual and shared with his childhood friend. He accentuates that he would buy a voluminous amount of sweets, "*as many*", and "*immediately gorge*" on them which suggests an inability to delay gratification and an aspect of self-indulgence in his eating. Ross would only cease to eat with his friend once he felt physically ill. His

laughter could be indicative of feelings of shame and guilt associated with his binge episodes.

3.4.3.2 Night eating

Jack and Alfred both discuss irregular patterns of eating and eating specifically during the night.

> *"P: My routine is not to eat during the day, early, and then stuff myself at night. So I probably… I might go until two or three o'clock with no food at all.*
>
> *R: So, no breakfast?*
>
> *P: No. I found the earlier I ate, the more I ate." Jack, 490-494, 10*

Jack's description of his eating habits and routine consists of skipping breakfast and then '*stuffing*' himself at night because by that time he is famished. His justification of not having regular meals throughout the day is that if he did so it would lead him to eating more. In other words, in his experience, his night eating is a means to regulate and cut down on his eating intake.

3.4.3.3 Emotional eating

All the participants discussed how their eating was emotionally driven at times. William speaks about feeling depressed about his physicality and suffers, in turn, from a poor body image. The only way that is familiar to him to self-soothe is to turn to food for emotional solace.

> *"It depresses me the way I keep looking at myself and I think to myself: "Wow, I am in a state. I am the size of a bus, but why?" It is always why, why, why because I get myself in a state. I need to go and get myself a*

donut makes me happy again. You know that's my downfall." William, 592-596, 13

William's use of metaphor, that he believes he is "*the size of a bus"* accentuates how large and all encompassing he feels. His repetition of "*why*" and continued self-questioning exemplifies his state of rumination and despair. There is a demand to seek a justification for his physicality, but at the same time, a harsh and critical internal voice that will dampen as he resumes his self-sabotaging cycle of emotional eating (i.e.: eating the donut) and seeking a short-lived gratification. He is cognitively aware of his self-perpetuating cycle.

3.5 Superordinate theme 3: Socio-cultural ramifications

Figure 3.5



The third superordinate theme that surfaced from participants' accounts was the socio-cultural ramification of men's relationship with food (please refer to Figure 4.5). The two cluster themes were the "social versus private eating" and "cultural identification with food".

3.5.1 Social versus private eating

Participants described a discrepancy in terms of their social and private eating behaviours. Depending on whom they were eating with during social outings, their eating would fluctuate.

Alfred explains that he would not like attending weddings or being in large crowds as he would feel self-conscious of his corporeality. His reiteration of "*I don't know*" indicates that he is seeking meaning behind this divide between his private and social eating. He found open buffets especially difficult, an internal battle in terms of being mindful of his portion size. There is a conflict between two voices, one inciting voice inviting him for more food and the other one being wise and indicating that he does not have to pile up his plate.

> *" I don't know and I think it's because I've been embarrassed about my size, possibly, I don't know. But I also find that, you know, when there is an open buffet, I have to really fight with myself not to overload my plate (…) You know, get some more on that plate, there's a space on that plate, fill it (…) If I'm at home, most times I'll be fairly sensible with food (…) But, yes, when you're out it's…it's a different ball game definitely". Alfred, 660-679, 21*

For Adam, there is not a significant divergence between his social and private eating. However, interestingly, the presence of the "*other*" will mediate his food intake and reinforce his internal regulatory voice telling him when to cease eating. There may be an element of shame when he utters that people "*expect him to have more*" due to his size. Adam speaks about food being incessantly on his mind and when the eye of the "*other*" has vanished, he acts like a "*rebellious child*" and there is no one to say, "*stop*" or to look over his shoulder.

> *"If I'm going out for a meal with friends, I will not eat as much as I would do if I was on my own, but it's not a huge difference, it's not like, you know, double or anything like that. I guess people expect me to have more, but remember I said about it's always on my mind, and when I'm eating when I'm out, it's there to say stop. Yes, it's there to say stop, even if I still feel hungry, I will stop, yes. But if I'm on my own, yes, there's that nagging voice, it comes in, and a lot of the time I go, oh sod it, and be the rebellious child, as such. " Adam, 298-304, 9*

3.5.2 Cultural identification with food

All participants gave detailed accounts of their cultural identification with food, whether it was tied in more with the particular such as with their spiritual upbringing, a patriotic sentiment, a fondness for certain holidays and associated cultural celebrations, or an observation of the macro-layer of society in a day and age of globalised food markets.

For William, proposing food to people entering his home environment, is more than being hospitable, it is part of his Irish cultural heritage. He explains that feeding others extends further than a learned social behaviour, it is part of his genetic makeup when he says "*it's kind of in the blood*" and "*my ancestors did*", implying that he is following in their footsteps. Food is associated with helping people and being a provider.

> *"Whenever people come into the door like you for example, I offer you coffee, biscuits, sandwich, breakfast, that's what I do. That's what my family does, my ancestors did, all my aunts, uncles, cousins they do that. So whenever I go on holiday to Ireland the first thing I do is I walk in the door, cup of tea, biscuits, cakes, bread, sandwiches, you know have this, have that...They go out of their way to cook for people that is us, that is our culture. So whenever, my family are coming today. I am putting pizza and chicken for them. But that is what we do, so… It's a culture thing, yeah. It's kind of in the blood, yeah to cook and provide and just help everybody out." William, 148-154,4*

Mark grew up in a strictly kosher household where he was taught to conform to the regulation of Jewish dietary law. He sheepishly recounts a memory he had of eating his first non-kosher meal with a school friend and expecting the "*sky to part*" and a "*lightening bolt to hit*" him. This powerful metaphor symbolises his fear and belief that a divine almighty being would come to punish him for his

transgression. His laughter conveys his sense of victory that no one witnessed his indiscretion, and he relished and discovered a new gastronomical world.

> *"As I say, I'd grown up kosher, and my buddy, Alex, said I'm going to go to Wimpy, and I looked at my other pal Gary who was also kosher, and we didn't know what to do. I bought a Wimpy, and I stood outside, and I took my first bite, and I looked up at the sky, actually expecting it to sort of part and a lightening bolt to hit me, and it didn't. And I thoroughly enjoyed (laughing) the Wimpy, and that was it." Mark, 136-143, 4*

Ross looks forward to Christmas as this represents a cultural celebratory holiday when the whole family is united and will eat a large "*Beef Wellington*" which is one of Ross's all- time treasured meals.

> *"Christmas is certainly a big family food event at home. We've got various traditions. My dad will buy a nice, big bit of fillet steak, and we'll do a Beef Wellington out of that. That is always one of my favourites going back home that I quite look forward to. " Ross, 64-67, 2*

For Peter, he examined the wider socio-cultural implication of food in a growing multi-cultural society where there is a plenitude of choice as a consumer. He is astounded at the innumerable food options that he is now exposed to and developing new budding palates for novel foods such as his "*chillies*". On the downside, this diverts him from making healthier purchasing choices because, as he recollects, a few decades ago, he would have only been able to buy fresh produce. Living in a globalised era also hinders Peter's sense of individual cultural identity when it comes to food.

> *"It's so mixed now, you know, ethnic groups and all that, it's... I mean, food, the difference to what it was years ago is that you go in the*

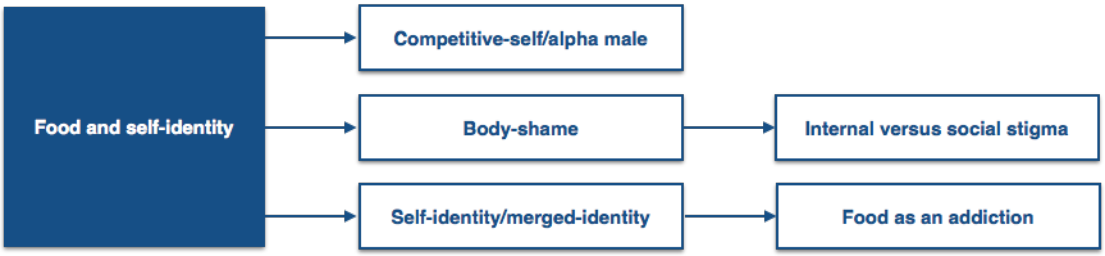
supermarkets now and you can get anything you want from any part of the world, so that eating has changed, you know. As I said about my chillies, you know, I mean, even ten years ago, it wasn't even in our foods, and now it's just taking our country by storm, quite literally everything, you know, but yes, you know, I love my Indian food, which we didn't have 20 years ago, so I think the availability of food, all different foods in the supermarket and all that, has definitely, probably made it worse. Where going back, you were limited to what you could buy, and it'd probably be more fresh vegetables, because that would only be what's in the shop, you know, basically." Peter, 779-792, 15

Jack argues that the problem with British cultural identity emanates from a lack of knowledge in cookery and dietary education, which stems from a shattered family and socio-cultural ecosystem. The cost-effectiveness of fast-food and processed cuisines is more appealing, although nutritionally health hazardous in terms of quality and added sugar and salt content. On the other hand, there is an underlining sense of blame towards English culture in Jack's narrative, which might act as a protective mechanism in terms of shifting responsibility for his current weight on the '*other*' instead of assuming more ownership for his past and current food purchasing decisions.

"The trouble is the family environment in England has broken down. People don't know how to cook. Their relationship with food is slightly askew with how it should be. The food you get isn't always great quality. Takeaway food can be too cheap —too much fat, too much sugar, too cheap. Chickens are 21-days-old when you eat them takeaways." Jack, 1152-1157, 22

3.6 Superordinate theme 4: Food and self-identity

Figure 3.6



The fourth superordinate theme that emerged throughout most all of the narratives was the role of food and participants' self-identity (please refer to Figure 4.6). The three main clusters themes that arose from the data, was the "competitive-self/alpha male", "body shame" and "self-identity/merged identity". Not all participants fell into each cluster themes (please refer to Appendix L for further information).

3.6.1 Competitive-self/alpha male

The role of competition and a self-questioning alpha male identity in relation to participants' eating patterns was apparent most prominently for Ross and Adam, although all participants described competitive features except for Alfred and John (Please refer to Appendix L).

Ross describes the role of competition, conforming to a social group, and how it ties in with the construct of masculinity.

> *"Certainly, these days, even if you're out at a steak restaurant there's still a bit of competition amongst the guys of, oh, I'm going to have the 400-gram steak. I'm going to have the 500. I'll go for the 600 (…) I don't know*

what it means. It's just, you know, competition for the sake of male competitiveness. You know, guys are like that. Whatever you find, they'll just go, well, anything you can do, I can do one more of. It's like, be it, you know, a drinking contest or an eating contest, and even though it's not, you know, they're no prize, or nothing at stake, it's just, you know, men are defining who is the alpha male here, in this group, and it's like, well, clearly the best way to determine that is who can eat the biggest steak." Ross, 256-269, 8

He especially illustrates the symbol of steak which one could consider as an emblem of manliness in today's society. Men competing with each other to see who can consume the largest quantity of meat or alcohol for that matter will be crowned the victorious alpha male of the group. Winning the competition does not grant you a tangible reward, but a social status of being nominated the alpha male, which indicates dominance, physical capacity and respect within the social group. When Ross says: " *you know guys are like that*", I felt that he was emphasising the gender divide between me as the female *outsider* and including himself within this group dynamic.

Adam speaks about being brought up with an attitude that he should eat what he can. In other words, there is no restriction on the limits of his food intake.

" I guess, being brought up it was eat what you can, and it was, yes, it's just a testosterone-filled environment, the Forces, you know, it is, and you eat as much as you can, because you're using it, you're expelling it, you're running around, you know, absolutely. And then afterwards, when I left I was married, and I'm not one of these kind of... do I think I'm an alpha male. Do I think I'm an alpha male? I've seen and done it, and I've bought the T-shirt. I've been to war, I'm not aggressive in the slightest, I don't like guns, because I've seen what they can do, and a lot of these, you know... I never, ever get drunk and out of control, I don't, it's not me, but I'm also kind of masculine enough to stand my ground,

I'm not a weak person. I don't know if that helps in any way? But I mean, you look at these idiots at the pub and you just think, oh, why don't they grow up, you know? Have I ever had a one to one fight? No, it's not me. I'm a big, cuddly teddy bear. But I'll protect you, and if there are any baddies, I'll protect you (laugh)." Adam, 620-636,16

Adam later on joined the Military, which he describes as a "*testosterone-filled environment*" where food was seen as necessary fuel that needs to be consumed in order to keep his energy level up to par. His use of language "*using it"*, "*expelling*" and "*running around*" underlines the mechanical and more physiological drive of the eating function. Adam hesitates in his speech and then questions himself twice on whether or not he believes he would label himself as an "*alpha male"*. He conjures it up himself and makes reference to the fact that it was a behaviour that he had witnessed and was part of his old-self, but far removed from his current self.

Adam's portrayal of alpha maleness is fourfold: (1) a material representation such as a T-shirt which could be seen as a membership to a group identity; (2) war and what it entails, with the use of arms and lingering thoughts of death; (3) being part of the drinking culture and (4) being masculine and physically strong. There is some ambivalence in his response. Adam wants to convey his *otherness* from these "*idiots*" who supposedly engage in pointless fighting. He describes himself as a" *big, cuddly teddy bear*", drawing attention to his softness, warmth and approachability. Nonetheless, he still wants me to know that he can act as a *protector* when need be by stating that he would be capable of protecting *me* against "*baddies*". His laughter might suggest his surprise that he brought my gender in his narrative and assumed the dominant position, reminding me that, despite the contradiction, he still displays alpha maleness features.

3.6.2 Body shame

All the men in this project spoke about feelings of body shame and a sense of divide between the stigmatised versus the idealised male body. A strong longing to be accepted, seen for their *real self* and not for their physicality were also important themes that were highlighted by a few of the participants.

> *"I'm aware as to what I am, but it is somewhat strange when you sometimes see somebody else in the mirror, and they go, oh, no, that is I, kind of thing. I think it's interesting and telling that I don't have a mirror in my bedroom or (…) I never bought mirrors other than the one in the bathroom. And I suppose it must have been a conscious decision. Well, not a conscious decision, but, you know, I think you should, you know, you've clearly gone to some lengths to avoid catching sight of yourself every day, for that kind of thing.*
>
> *R: What about if you shop or you catch a sight of your silhouette when you are out? Would that be fine?*
>
> *P: Yes, I mean, you… It's… Yes, I mean, you catch sight of yourself. I don't feel uncomfortable about it. It's just, you know, sort of, that's not who I am in my mind's eye, sort of, from when I had lost weight a bit, or something, you know, or my online profile pictures I tend to use one of those, even though it's like, from a time when I was 18, or something. Maybe that's not quite such a representative view who I am now, but in my mind that's who I am, not how I am when I see myself in the mirror, or something like that." Ross, 350-363, 11*

Ross describes a state of disbelief and dissociation between his imaged-self that he has in his mind's eye and his physical self. There is a split sense between his intellectual and physical awareness. When he says "*in my mind that's who I am*", he is mindful that placing an online picture of himself on a dating profile of a much younger *self* is far from accurate, but possibly less body shaming and more physically appealing to himself and his potential romantic

partners. Ross could be mourning his old physical self that he felt more connected to. The fact that Ross goes through extensive measures to avoid the use of mirrors and purposely does not have any in his home represents a conscious form of avoidance and denial of a body that he rejects. Mirror avoidance also serves as a defence mechanism that has short-lived functionality. Ross's hesitation in his speech might convey multifaceted elements of shame comprising internal self-evaluative, emotional and behavioural components.

3.6.2.1 Internal versus social stigma

All the participants described episodes of social stigma, while Adam and Jack discussed internalised stigmatised beliefs. Adam self-identifies as a *fatist* and speaks about his dislike of "*fat people*" which encapsulates an internal conflict as he recognises that he is fat which would suggest self-loathing and a prejudiced-self.

> *"P: I'm actually a bit fatist in some way. I don't actually like fat people, and yet I'm one myself. I would never date a fat girl; I couldn't. I don't like fat people (laughs).*
>
> *R: Why, what would be your thoughts towards fat people?*
>
> *P: I just don't know, I think they're kind of... I'm an absolute, what's the word, hypocrite, but I don't think they've got self-control, and I think they're kind of weak, and maybe that's mainly aimed at me – there you go, you might have found something there (laughs)." Adam, 254-260, 8*

Adam's tone of voice is cheerful and jokey, and he laughs which would suggest that he finds the subject matter quite light-hearted. However, underneath his robust external carapace, I could sense that he felt deeply shamed and realised that he was being a "*hypocrite*" in describing himself. In order to shield his ego,

he barricades himself and sees the "*fat people"* as "*weak" others* with *low "self-control"*, but soon discovers that this is his own lived-experience.

3.6.3 Self-identity/merged identity with food

William describes an enmeshed, long-standing, intense and intimate relationship with food. For him food is more than his mere merged identity, but he uses the metaphor of his love of food being like a marriage. There is an anthropomorphisation of food where it is depicted as his lover.

> *"P: Yeah, obviously my love of food I had for 25 years. You know I have loved food so much. But, like any relationship, after 25 years you get sick of it. Whether you are married for 25 years and you wake up every morning and you look at the same person, it's the same thing. I don't want that!*
>
> *R: You can still love food.*
>
> *P: Exactly, but I got to break away from my full relationship I have with food, and now I have to have the mindset to say there is us now and we are going to separate. "You are here, that's fine. I know you are there. But I am going to go this way. I am going to go to the gym. I want to go to swimming. I want to look at nice clothes and also be accepted. It's a big thing. You know being accepted within the society. I am a very bubbly character. I am very chirpy, I talk away to everybody, anybody. That is my business taxi driving and obviously you have to talk. But it's the thought that everybody knows me as "big William" you know, the cab driver, the "large man". I don't want that stigma no more. I want to able to say I am a healthy man, you know?" William, 221-232, 5*

William speaks about feeling tired and wishes to divorce from his kinship with food and "*break away from his full relationship*". His use of language sounds angry, as though he is fed up with the monotony and predictability of his daily

routine, especially when he says, "*you get sick of it*" and "*I don't want that!"* His desire for a sudden and clean break has transformative and existential components as he wishes to resume his physical activities, be accepted in society and break the cycle of social stigma where he is labelled as "*big William*" and "*the large man*".

There are dual identities between his aspired *athletic self* who strives to be accepted and can buy nice clothes, and his *big self* who everyone knows as the "large bubbly and chirpy character". William wants to be seen as his *authentic self*. My intervention could be seen as an indication of a moment where I oscillated away from being the researcher and back into my practitioner's role as I experienced William's desire for a radical separation from food as a form of *black and white* thinking with an absolute finality that I was perhaps unconsciously trying to salvage.

Another moment that captures the phenomenon of merging, albeit slightly differently, is when Adam speaks about his weight history and brought my own physicality into the discussion.

> *"I've got you to lose; I'm carrying you on my back, sort of thing, or in my belly." Adam, 155-156, 5*

In other words, "losing me" would be attaining his target weight. There is a merged sense of embodiment where my body is playing an instrumental role in terms of how he sees himself and what he no longer wishes to carry around. This also sounds like a form of splitting as he is talking to a part of himself as if it was not part of himself.

3.6.3.1 Food as an addiction

The construct of food addiction has been referred to by Adam, Jack and John, in common parlance, and is present in the scholarly literature. However, I don't share this conceptualisation and have placed this cluster theme as an extension

of participants' self-identity (For further discussion, please refer to the literature and discussion chapter).

For John, he uses the analogy of fast-food as resembling a "*drug addict*" in front of his drug of choice. It is challenging to overcome the enticements of McDonald's and veer away from it as his children share the same affinity and he wishes to please them.

> *"I like McDonalds (…) and it's hard because you try not having something like that but then your kids want it, and then you take your kids, you know, it's like putting, like a drug addict in front of a drug". John, 366-368, 11*

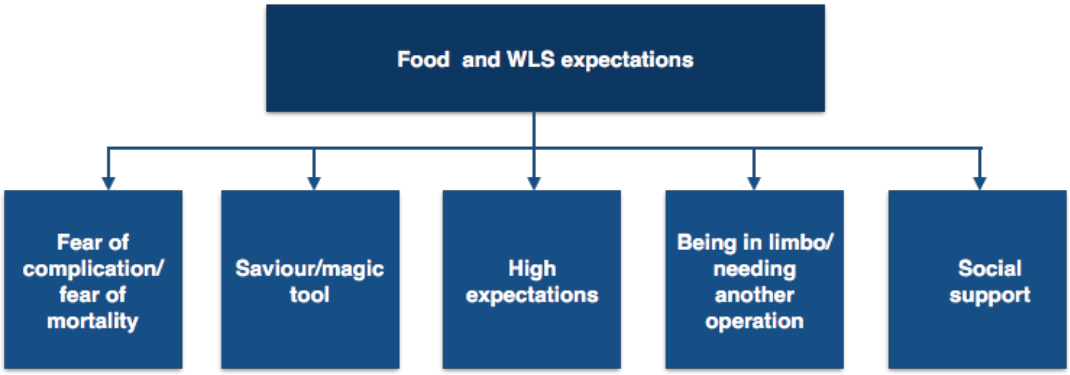
Furthermore, John describes his relationship with pop as a long-standing, toxic and addictive behaviour. He explicates that for him, it is similar to someone who has an addiction to alcohol; he suffers from daily cravings and it consumes his cognitive and affective functioning. When the doctor asked him to reduce this drinking intake, he suffered from physiological withdrawal symptoms, such as dizziness spells, and felt unwell.

> *"P: It's, like, with the Coca Cola, I've been drinking it every day since I was about ten, and it's got to a point where I'm drinking quite a lot of it, you know, like an alcoholic, but with the pop. I'll get up in the morning; first thing I want is a tin of pop. I'll drink it all day. Last thing I'll have is a tin of pop (…) It's like I told the doctor and he said I needed to stop doing that. So I stopped doing that, and I stopped smoking, and then I got really poorly and my doctor said it's because I've done too much at once (…) I went dizzy and I felt tired all the time and stuff, and what it was I was having withdrawal from the Coca Cola, you know, like alcoholics, I was shaking." John, 82-91, 3*

John's daily structure commences and terminates with his consumption of pop, which he views as his incessant need for gratification. There is also the reference to his smoking behaviour, which is indicative that there is a susceptibility of a cross-addiction. When John abstained completely from drinking and smoking, his body became fatigued.

3.7 Superordinate theme 5: Food and weight-loss surgery expectations

Figure 3.7



The fifth superordinate theme that arose for all of the participants was food and weight loss surgery expectations and imagining their future aspired physical self post-operatively (please refer to Figure 3.7). They all spoke about envisioning an ameliorated transformative-self as well as a strong desire to move away from their "*status quo*". The five main cluster themes that were strongly echoed were: (1) fear of complication/fear of death, (2) WLS as being a saviour/magic tool, (3) high expectations in terms of weight loss, (4) being in limbo and needing another operation and (5) having social support.

3.7.1. Fear of complication/fear of mortality

All participants discussed fear of surgical complications as well as death anxiety. Adam conveyed his raw and mixed emotions regarding his upcoming

operation. He is aware that if he does not take effective action and moves forward, his longevity will be drastically reduced.

> *"I'm scared. I don't want to die, but I'm going to die if I don't do something, and I'm also incredibly excited". Adam, 172-173, 5*

> *"I'm worried about the complications after, I'm worried about the surgery, I don't want to die on the table". Adam, 182-183, 6*

Adam's repetition of the word "*worried*" heightens his trepidation of dying and/or enduring probable post-operative surgical complications.

> *"'Unless I happen to be the one... the one in 200 that kicks the bucket".*
>
> *Alfred, 733, 22*

Alfred spoke about his desire to inspire other men with his narrative and become a motivational figure. However, he soon fears, as others, that he might be facing his imminent death. Although his tone of voice is buoyant, he speaks hesitantly about being the one that "*kicks the bucket*" and cites a statistic that is far from accurate in terms of the risk of mortality for bariatric surgery which suggests a heightened state of anxiety or that he is misinformed by the medical literature.

> *"I can't wait to have that done and it should start changing my life because if I don't I'm going to end up, I'll end up in heaven, won't I? If I carry on the way I'm doing I'm not going to be here much longer, you know." John, 283-285, 9*

For John, he communicates his eagerness of having surgery and the metamorphic aspects it will have on his life. His thinking is quite polarised and he envisions a spiritual departure and "*ending up in heaven*" if he doesn't proceed forward. I felt as though John was in the contemplation stage of change and evaluating the costs and benefits of adjusting his behaviour.

> *"I've got to change my lifestyle anyway, so if I have to give up certain stuff, then I'll have to, you know…. It's either that or have another heart attack and die, you know". Peter, 973—975, 18*

Peter is aware of lifestyle changes that he needs to implement in order to proceed to surgery and for it to be a long-term health benefit. Since he has suffered prior cardiovascular complications, he is more susceptible of experiencing another heart attack and looming death.

3.7.2 Saviour/magic tool

Participants, although anxious about potential unforeseeable side-effects, were equally hopeful that having bariatric surgery would not only cement the road to their new transformed-selves, but would also act as a form of saviour and magic tool.

> *"I saw the gastric band as the answer to all my problems, have this fitted and you will be thin for life". Adam, 81-82, 3*

Adam visualises having the gastric band as his saving grace and the miracle solver of all his day-to-day quandaries. Interestingly, Adam employs the past tense to describe his decision making process which is indicative that there is little room to manoeuvre. In his mind, the gastric band acts as the solution and recipe to being "*thin for life*"; theoretically, his ultimate ambition. Socio-culturally,

people continue associating thinness with happiness, success and physical attractiveness. In order words, Adam wishes to become the object of envy.

> *"P: So I'm going to have a different life afterwards, you know those adverts for razors, in fact, men and women, the Ladyshave where... that have (unclear word) roller-skating, where the women are roller-skating, (laughs) unashamed – that's going to be me, that's me, you know. I'm going to be climbing mountains and looking incredibly good-looking, even more good-looking than I am now, which I know is hard to...*
>
> *R: (Laughs) So you think it's going to make you... it frees you, kind of thing.*
>
> *P: It's a catalyst to kind of a, for want of a better phrase, a reboot of my life. Yes, and I've got a lot of support to do that." Adam, 196-203, 6.*

Furthermore, Adam fantasises about his future aspired life and new alluring physique. He uses the analogy of feeling like the "*Ladyshave"* commercials, where both men and women are roller-skating, "*unashamed*" and "*incredibly good-looking*". This idealised sensual, carefree, liberated image he has built up is what he is seeking. Surgery is not just going to be his saviour, but will be *"a reboot of his life",* meaning his opportunity to start his life on a clean slate. Adam's laughter, humour and body language appeared confident and slightly boastful. However, this might have been his means of deflecting his internal fears and low *amour-propre*.

> *"The surgery is going to remove the portion control. It takes care of that. So when I eat and I feel full, stop! If I don't stop, I am going to get sick and it is just a waste of time so there is no point. So it takes that portion control and with that I am going to feel more alive, more energetic. Instead of after a big dinner feeling "ouuuu", tired, sluggish and very slow and weak." William, 449-452, 10*

For William, bariatric surgery will act as a regulator in terms of his feelings of satiety and "*remove the portion control*". Instead of worrying about eating large quantities of food, his gastric anatomy will be reconfigured in a way that will warn him when he has reached his allocated threshold of food. That way, if William oversteps these boundaries and eats more, his body will respond and he will start feeling poorly. Weight loss surgery performs as a gastrointestinal gatekeeper and will permit William to feel more "*alive*" and "*energetic*" instead of feeling "*tired"* and "*very slow*" after consuming too much food, implying that he would lead a healthier and more spirited lifestyle.

3.7.3 High expectations in terms of weight loss

Quite a few participants expressed high expectations in terms of weight loss targets following bariatric surgery. This might be due to the fact that some of them had not yet had their pre-operative assessments.

> *"They've sent me a questionnaire that you have to fill in beforehand, and they say, you know, where do you…? What would you define as a failure of the procedure? What would you be satisfied with and what would you say is good?*
>
> *And I sort of sat and thought about it and came up and said, well, actually, if I only lost 50 kilos with weight loss surgery I'd actually still be fairly disappointed, because that would still leave me very much with an unhealthy BMI, and I'd feel that you'd done… effectively you'd played your last trump card. You know, there aren't many other options you have available left. You can have revisions to the surgery, but they're not as effective as the initial attempt. So, if after doing all of that I was still in an unhealthy BMI category I'd be fairly upset about that, I think, you know, it's a lot of things to go through for not much result, even though losing 50 kilos would be an incredible accomplishment, but it wouldn't really have done anything, I think, much for me." Ross, 511-521, 15*

His bariatric team asked Ross what he would consider a successful outcome with regards to surgery in order to gauge whether his expectations were realistic. Ross said that if he were to only lose 50 kilos, he would feel "*fairly disappointed*" which unfortunately might not coincide with his average excess weight loss following bariatric surgery. Depending on which procedure he elects, he should expect to lose a different percentage of his excess weight, which means that he might not attain a healthy body mass index post-operatively. When Ross says that proceeding ahead would be equivalent to playing "*his last trump card*", he is inferring that he is taking a gamble and this is his last resort, emphasising that he run out of other viable options. Ross is engaging in a pros and cons decision-making matrix and pondering on his long-term prognosis.

For Jack, he also spoke about his desire of attaining a benchmark weight of 17 stone, which would translate into losing half of his current body weight. Perhaps again, this is not setting realistic expectations in terms of desired weight loss.

> *"P: I feel like I've got to give this bariatric thing a chance. It would be nice in two years time for me to weigh ten stone less. It would be nice if I did it in a year's time.*
>
> *R: What's your goal, would it be ten stone less? Is that what you have…?*
>
> *P: I'd like to do more than that if I can, because 24 stone wouldn't be great. I'd like to be 18 stone, 17 stone, which would probably give me a BMI of 31, 32 roughly." Jack, 957-964, 18*

3.7.4 Being in limbo

Some participants discussed being in limbo when it came to knowing whether they were still going to have funding approved for their surgery and receive a due date. Others spoke about the delicate balance between bariatric versus other indispensable operations.

"The difficulty I have at the moment is that with the bariatric side, which I've been on that since March last year, I think I was accepted; that's still quite a long process. But with that, what I'm saying is, if I have the knees done first it will delay the bariatric side quite a while because the... the risk of poisoning or whatever would wind up in the joints. So, I'm in a, kind of, limbo at the moment because I need my knees doing urgently but obviously I want the bariatric surgery so... Just sooner we get the bariatric surgery done the better, but at the moment I'm struggling around the house and all sorts so... " Alfred, 29-39, 2

Alfred conveys his sense of daily struggle and physical hurdles in his discourse. He is at a crossroad and must choose between having his bariatric and knee surgery done and seeking the most plausible solution. He has been patient and has been waiting for over one year and feels powerless as his sense of urgency is beyond his control and time is lapsing by.

"They phoned me to say, we're terribly sorry, but you've lost your funding. So I had a year in limbo (…) I was buzzing because I'm now back in the system. I've seen the surgeon, he's told me this and then suddenly, because I hadn't attended two appointments (…) so I lost the funding again. So I mean, I just went, oh, to hell with it (…) Now I'm back on, so let's…as they say, third time is a charm." Mark, 1025-1030, 24.

The same applies to Mark who had lost his funding for bariatric surgery on numerous occasions and light-heartedly said that his "*third time is a charm*" suggesting that he is more hopeful on this occasion and feels more enthused about moving ahead. Initially, Mark felt despondent and exasperated when he said "*to hell with it*" and thought that this might not be the right avenue for him as he was repeatedly stricken out of the system.

3.7.5 Social support

In order for surgery to be successful in the long-term, one vital element is to forge strong social support. Fortunately, most participants expressed having support from their relatives and loved ones for electing bariatric surgery. On the other hand, other participants voiced concerns as they were either alone in the journey, or living with families who were sceptical and apprehensive about potential risks it might entail. I will be presenting two differing views in order to capture this theme.

Jack tells me how pleased he is that he has been attending the bariatric support groups offered through his hospital as this reinforces his desire to move ahead with surgery. Attending a local group and meeting people at various stages of their surgical path, alleviates his previous ambivalence. His presence in these monthly meetings has considerably shifted his perceptions as well as the merits of having bariatric surgery performed.

> *"I mean I'm really glad I went to that support group. It made a big difference; it made me far more keen do it, you know, and fill…The likelihood of me pulling out of the surgery is probably 80% less, before it was probably 50-50. I'll go to the other ones as well, keep myself ticking away." Jack, 1091-1096,21*

Contrariwise, John doesn't share the same experience as Jack and has been aggressively critiqued and had his sanity questioned for even pondering electing surgery. This is possibly coming from a place of fear that the risks of surgery outweigh the benefits.

> *"My next door neighbour knows and says I shouldn't have it done. Everybody you speak to don't want, they say you're crazy or you're nuts, or you don't know that, it's like…" John, 655-658, 18.*

3.8 Over-arching theme: Food and the masculine-self

This project sought to encapsulate men's relationship with food, especially preceding bariatric surgery, which will have a substantial impact on how that relationship will be altered once their gastric anatomy is reconfigured. All the superordinate themes overlapped with one another, especially with regards to how the participants defined their *masculine-selves*.

Whether this was conveyed through their past and current family environments, issues pertaining to body image concerns, private and social eating etiquettes, identity, weight loss surgery aspirations; all the superordinate themes tied in with participant's construction of their masculinity.

Peter, Mark and John describe some of the perils of adhering to a hegemonic form of masculinity, especially when it concerns help-seeking behaviour and showing signs of vulnerability such as crying due to their gender role socialisation.

> *"Some men put on a front on, there is like this hard man image (…), to be strong for his girls, sort of thing. I have broken down at work a few times, you know, and I feel really awful, had a few tears now and again. I don't like doing it, because it feels like, it's a thing a man shouldn't do." Peter, 693-705, 13*

Mark extends on his understanding of men's lack of help-seeking behaviour by suggesting that there are underlying genetic components as well as cultural variables that mediate this comportment.

> *"Guys are predominantly a single entity (…). We don't listen to people, we don't let people in on things when we hurt, we think we're okay, it'll get better. If we get a lump, for example, we really really loathe telling anyone (...). We are stupid, there is a design fault (…). We're far happier talking about sports or girls, or politics or anything but our foibles, failures, problems, because it doesn't seem manly to do so, because we don't want to appear weak. It's bloody stupidity and I'm speaking from experience." Mark, 1280-1302, 30-31*

Avoiding any social displays of weakness and frailty is an imperative that must be protected at all costs. John concurs and depicts this lack of help-seeking behaviour with macho attributes, which he normalises as an accepted social norm.

> *"You know if you've got something wrong with you below your waist, you don't want to go and see a doctor, even though you probably know it's something bad. I think a lot of men just don't want to do it because it's a man's thing." John, 803-807, 22-23*

Adam on the other hand embraces some of the hegemonic masculinity facets as well as his larger physical embodiment that enables him to assert his power, presence and virility in a professional context. This is his means to gain respect and show his authority. There seems to be an oxymoron though as he both '*likes his bigness, but dislikes his fatness'* which symbolises a sense of splitting or different configurations of himself. A part of himself that he approves off, while another one that he rejects and abhors.

> *" I like being big, I just don't like being fat. I enjoy being big, I like the presence, I do a lot of presenting, and I like to take control of a group and show who is the boss. Otherwise, they will walk all over you." Adam, 643-649, 16*

So, how can we change this dominant social discourse and facilitate men's weight loss journey prior to undergoing surgery? Jack suggests developing competitive sports courses solely for overweight men as a possible solution that would both feel motivating as well as a safe space.

> "*Men are competitive, possibly more so than woman. If there was some way that fat people could do a bit more sports and make it competitive,*

rather than fitness on referral, which I think is basically going to a gym. If you have a fat person basketball league, badminton or squash, I would be up for that, but it would have to be a place where you won't have the piss taken out of you (…). That would be great, that would help." Jack, 1008-1021, 19

William speaks about a key marker in shaping his sense of masculinity and burgeoning difficulties with food was his lack of an older male role model to mentor him and act as a true exemplar.

" I was looking at magazines and they were all muscle magazines. And each time I was reading it I was eating sweetie, sweetie [small childish voice]. So instead of me getting like this [points to smaller], I was getting like this [points to larger] and I was like this is not right because I did not have no one, no older man to look after me or help me, or guide me, that is where it went wrong! " William, 533-539, 12

Alfred describes being judged for his food choices by his brother-in-law because they are not considered very manly. Unfortunately, he soon rebels and relinquishes to his old unhealthier eating habits because it avoids having to defend himself and have his masculinity threatened and put in question.

"He will look at me as though I'm mad because sometimes it just might be a plate of salad with a bit of fish or something like that (…) Why are you eating that rubbish? You know it's just rabbit food sort of thing (…) You feel, of to hell with it, yes go on, I'll have something. And it's the pressure of it that does it. And it's a silly thing because you bend. Rather than start a conversation about why this and why that, you just think, of to hell with it and just have some" Alfred, 715-745, 22-23

All the men in this study shared their experiences of body shame which ties in with their *masculine-selves*. Ross longs for his upcoming bariatric surgery as a means to be seen for his *true self* instead of solely for his physicality.

> *"I wondered you know how many people get to know the actual face of somebody who's very overweight, or how many just remember the silhouette (…). What do other people think of me as? And I think other people think of me as the shape, and less of me as an individual." Ross, 733-743, 21*

3.9 Summary

This chapter presented one over-arching theme and five interrelated superordinate themes derived from the interpretative phenomenological analysis of the interview transcripts of eight men which comprised of one over-arching theme ('Food and the masculine-self') and five interrelated superordinate themes ('Family milieu: past and present', 'Food as the self-soother', 'Socio-cultural ramifications', 'Food and self-identity' and 'Food and weight loss surgery expectation'). What transpired from the analysis process is that men's relationship with food has manifold symbolic meanings ranging from intrapersonal to interpersonal functions encompassing wider socio-cultural implications.

4.0 Discussion

"Manliness consists not in bluff, bravado or loneliness. It consists in daring to do the right thing and facing consequences whether it is in matters social, political or other. It consists in deeds not words." Mahatma Gandhi

4.1 Research aims and summary of results

This study aimed to shed light on the lived experience of men's relationship with food prior to having weight loss surgery. What transpired from the analysis section was that their relationship is complex and imbued with rich meaning. All five superordinate themes overlap with each other and feed into one another. I will explain each superordinate theme embedded in the literature and link it with wider clinical implications.

4.2 Discussion of analysis in context

4.2.1 Food and self-identity

At the core of the phenomenon under investigation is how participants described food in terms of their self-identity, tapping into their intra-psychic processes. Food defines our sense of self-identity, not solely in terms of asserting our 'oneness', but also highlighting our 'otherness' by what we chose to incorporate. As Fischler (1988) points out, our relationship to food is entrenched in complex meaning and multidimensional in nature ranging from biological, behavioural and cognitive facets to psychological, cultural, individual and collective functions.

A central element of the participants' relationship with food and how it tied into their self-identity was anchored into their sense of masculinity and how they

displayed and exerted it. One of the cluster themes that arose from the data analysis and that was mostly apparent in both Ross and Adam's account was a form of hegemonic masculinity, the "competitive-self/alpha male".

Hegemonic masculinity, which was originally conceptualised by sociologist Connell in the 1980s, has had considerable influence in the field of men's studies, gender and social hierarchy, and refers to a dominant form of masculinity concurrent within a patriarchal culture which stipulates what it means to be a 'real' man and abide to an underlying idealised '*masculine script*' which emphasises men as being aggressive, emotionally contained, competitive, self-reliant and heterosexual (Connell & Messerschmidt, 2005; Farrimond, 2012). Although hegemonic masculinity symbolises power and authority and is the socially dominant gender construction that acts as a template to men's social relationships with women as well as other men, it remains socially constructed and embedded within cultural and relational context (Courtenay, 2000). Masculinity is socio-culturally constructed and in common parlance, we refer to '*male strength'* or even '*male virility'* and if over-exerted, becomes '*machismo*' which originates from the Greek word for '*battle*' so can become more threatening and fraught upon (Pittman, 1993).

Masculinity is a group activity that involves prescribing to a code of conduct that requires men to maintain masculine norms and social attitudes that will be critically examined and evaluated by other men (i.e.: friends, colleagues, family, ancestors, role-models and, most importantly, their father) in order to steer men to conform to the '*masculine ideal'* (Pittman, 1993). Furthermore, masculinity is passed onwards inter-generationally, but becomes problematic when men and women venerate and embellish it which Pittman (1993) coined the '*masculine mystique'*. Men without any male role models, may overdo their masculinity out of fear that they are not as '*powerful*' as they think they ought to be and fall into a array of masculopathy from being *philanders* (exerting sexual dominance over women out of possible fear of them), *contenders* (competing with other men to re-affirm their sense of being a man) and c*ontrollers* (keeping everything under control and rule bound) (Pittman, 1993).

Some of the men in this study have conformed to the hegemonic masculinity script, especially Adam and Ross. Adam's father left the family household when he was a young infant leaving him with no male role model until the arrival of his stepfather years later. He described his upbringing as '*disruptive*' and, therefore, left home as soon as he could to join the Armed Forces, which, he said, was a '*testosterone-filled environment'* and prescribed to the dominant masculine norms when he states that he is '*masculine enough to stand his ground*' reinforcing strength as a necessary ingredient.

When it comes to food and masculinity, Ross described competing with his male friends to see who can consume the largest portion of steak and the winner in turn gets to be ascribed the '*alpha male*' of the group. Meat and especially steak (red meat) has been codified as a gendered food in contemporary Western societies and belonging to the masculine realm in terms of nomenclature (Lupton, 1996). Bourdieu (1984) conducted an ethnographic study of French contemporary society in terms of food taste and preferences and described red meat as being reserved for men as he depicted the male body as strong, big and powerful and meat gives vigour, blood and health. Ruby and Heine (2011) conducted a study with a student population looking at the perceptions of omnivores and vegetarians in terms of morality and gender characteristics and found that although the men who abstained from eating meat were regarded as more virtuous and morale, they were equally perceived as less masculine than their omnivorous counterparts. As evidenced from Adam and Ross's lived experiences and suggested by the literature, '*manhood*' is recognised through social displays of competition and aggression, and is socially and culturally constructed rather than biologically defined (Ruby & Heine, 2011; Ross, Prättälä & Koski, 2001).

Another cluster theme linked with food and self-identity that was apparent and strongly present in all the participants' narratives was their sense of 'body shame', which has been further broken down into their 'internal and social stigma'. Every man in this study spoke very fervently, at times angrily,

sheepishly and transparently about feelings of shame surrounding their physical embodiment. Mark conveyed his feelings of anger towards his body size:

> "*I feel very, very pissed off that I am this size, which is alien to me, although obviously I have been big for the last 20-odd years…it really angers me* " (line 1213-1216, p.29).

This sense of an alien, discomforting body was evident for other men who expressed a disconnect between the image that they held in their mind's eye versus their actual physical selves. Some participants consciously expressed avoiding having mirrors in their home or being taken in photographs, which reinforced this split sense of self. This coincided with some of the findings from Adams, Turner and Bucks (2005) study exploring the experience of body dissatisfaction in a sample of fourteen men who found four main domains: (1) societal, (2) interpersonal, (3) intrapersonal and (4) social presentation. In terms of social presentation, some of the men in this study expressed harsh self-criticism, perhaps as a means to dampen the emotional impact of their internal stigma and as a coping mechanism in the face of daily stigma they encounter towards individuals of larger embodiment. Jack defined food in relation to his self-identity as a "*big fat slob*" (line 185, p.4) and Mark described feeling socially alienated and using a form of defence mechanism to buffer himself against fat shaming.

> "*You build a wall around yourself… You put yourself down; you get there before someone else. You will do the fat jokes about yourself because you know someone else is going to say it* " (line 1305-1308, p.31).

The fact that body shame was a vital element in the participants' interviews in terms of their relationship with food and self-identity countered the literature that has put an emphasis on 'being female' as being a greater risk factor in terms of developing poor body image with people classified as being 'obese' (Schwartz & Brownell, 2004). Cash and Roy (1999) postulate that women in general are

more dissatisfied with their physicalities and, hence, being female is a risk factor in itself in terms of body image disturbance. However, as Schwartz and Brownell (2004) rightly point out, most of the studies to date have been comprised of female participants because of the preponderance of females seeking treatment for obesity compared to their male counterparts. These, therefore, are not representative samples and leave us pondering about claims that reinforce the feminist scholarship in terms of body image and weight issues such as Orbach's (2006) seminal book, "*Fat is a feminist issue*".

Other feminist scholars, such as Wolf (1990) who wrote about the *beauty myth,* have stated that: " *Women must want to embody it and men must want to posses women who embody it. This embodiment is an imperative for women and not for men*..." (p.12). I would dispute these tenets as men are far from immune to issues surrounding body concerns as shown by the participants' narratives. For example, William's description of the perfect body was someone like "*Arnold Schwarzenegger, with lots of muscle and good definition…someone who looks like they care for their body*" (p.528-531, p.12). The desire to be accepted in society without feeling ostracised, denigrated and stigmatised for their physical embodiment was a strong driving force for most participants opting to having weight loss surgery. Fat embodiment in men defies hegemonic ideals of masculine bodies that are expected to be tightly contained, strong and muscular (Bell & McNaughton, 2007; Lupton, 2013). Monaghan (2007; 2008) writes about living in a shame and blame culture where fatness is often equated with immorality, emasculation and sickness. Fat oppression has often been tied in with feminine discourse, especially in a field of 'masculine domination', but men of larger corpulence might be portrayed as a symbol of 'failed manhood' (Bourdieu, 1998; Monaghan, 2008).

The last cluster theme was a sense of 'merged identity with food', which applied to Adam, Jack and John as far as describing 'food as an addiction'. Food was intrinsically linked to their self-identity, self-concept and embodied-selves. Adam stated that food was "*kind of part of who I am, it's there, it's always there"* (line, 36 p.1) and Jack stated that "*food is (his) identity*" (line 750, p.14).

There are nurturing, consoling and containing aspects in the narratives of the men in the study about food always being a constant, an enmeshed and symbiotic aspect of the relationship of food with their selfhood and how they cognitively define themselves as individuals. This parallels with what Ogden (2008; 2010) wrote about food representing a forum for communication about individuals' sense of self. Lupton (1996) and Fischler (1988) highlighted how, at the fundamental biological level, eating and absorption of food personifies that we become what we eat. Their research exemplifies a reciprocal connection between 'food making the eater' and the 'eater making himself by eating'. Furthermore, Adam discussed an addictive relationship with food and with fizzy drinks. "*I like McDonalds…it's hard because you try not having something like that…it's like a drug addict in front of a drug"* (line 491-495, p.14).

Meule (2015) conducted a narrative review on the history of food addiction research and pointed out that although it has recently gained more attention among scholarly circles as well as the media, the research and terminology of food addiction was already introduced as early as the 19th century, with specific references to 'chocolate addiction'. Even though there has been a growing interest in 'food addiction' research in the last decades within the scientific community, it remains a contentious topic and is still in its infancy (Meule, 2015). As discussed in the literature chapter, there has been increasing, buoyant attention focused on the development of a '*food addiction'* model, especially a quantifiable one such as the Yale Food Addiction Scale (YFAS) that might explicate and identify individuals at greater risk of developing 'obesity' given the rising prevalence rates (Gearhardt, Corbin & Brownell, 2009). The view that food addiction translates with models of substance addictions remains debatable, as food is essential to our survival and ubiquitous unlike drugs that have clear indicators of dependency such as tolerance and withdrawal symptoms (Ziauddeen & Fletcher, 2013). Furthermore, the YFAS scale seems to capture a behavioural phenotype concurrent with individuals meeting a binge eating disorders (BED) diagnosis which can be present in 'non-obese populations'. Ziauddeen, Farooqi and Fletcher (2012) have encouraged further neuroscientific data underpinning the neural mechanisms of the '*food addiction model*' in order to establish its validity. Therefore, Adam's description

of his relationship with food conforms to the food addiction narrative, which might give him a sense of solace in terms of the prevalent views portraying obesity as moral failure, but clinically it is perhaps not relevant as obesity is a highly heterogeneous condition that cannot be pinpointed to an addictive relationship with food as its sole aetiology.

4.2.2 Food as the self-soother

The second superordinate theme in this study is tied to participants' affective relationship with food and how food could act as a self-soother and be used and abused as a means of emotional regulation. All the men in this study described the act of eating laden with affect that took a function beyond the simple role of physiological sustenance, but also at times symbolised nurturance, affection and companionship, and filled other emotional voids that were present in their lives. For William, he described food as his '*lover, his soul mate'* (line 86, p.2) perhaps because food was his only constant and comfort in his life as he experienced a lot of conflict in his home environment. Food provides immediate gratification, attenuates painful feelings in the short-term, but can also act as an apprehensive source if consumed irregularly and to excess, which can lead to disordered eating —one of the cluster themes that will be explored. The two other cluster themes that emerged were participants using food as a self-soother in response to a trauma or to a loss.

4.2.2.1 Disordered eating

Disordered eating was one of the cornerstone cluster themes of the participants' narratives. Although no formal clinical assessments were carried out as part of this project and my objective was not to do so, most of the participants' descriptions of their relationship with food could coincide with that of an eating disorder, most specifically with binge eating disorder (BED) and night eating syndrome (NES). BED is characterised by recurrent episodes of eating significantly more food in a shorter time frame than most people would eat

under similar circumstances, and associated feelings of lack of control, guilt, shame, secretive eating, eating too rapidly and marked distress (American Psychiatric Association, 2013).

All participants have described elements coinciding with a diagnosis of BED, which is not a surprising finding as binge eating is present in more than one-third of individuals classified as 'obese' and undergoing bariatric surgery (Yanovski, 2002). In terms of long-term outcome of weight loss surgery, people presenting with BED tend to have an earlier onset of obesity, higher rates of psychopathology such as a depression, anxiety, low self-esteem and body image concerns (Radcliffe, 2013). The presence of BED does not pose a problem in terms of eligibility of having bariatric surgery and in the short-term could even act as a remedy as individuals are no longer able to consume large amounts of food due to the gastric reconfiguration (Mitchell, Devlin, de Zwaan, Crow & Peterson, 2008). Nevertheless, longitudinal follow-ups indicate that binge eating, especially associated loss of control, can resurface two years after surgery and can lead to more weight regain post-surgically (Mitchell et al., 2008; McAlpine et al., 2010).

Alfred was one of the participants who described his eating pattern more concomitant with night eating syndrome (NES) that is characterised by a delayed circadian rhythm of food intake. Individuals who display NES usually are not hungry in the morning, have difficulties sleeping or falling back to sleep and can have low affect (American Psychiatric Association, 2013). Individuals eat significant amounts of food during the evening or at night and are aware and distressed by the behaviour and present with distinctive behavioural and neuroendocrine characteristics in terms of plasma levels of leptin and cortisol (Stunkard & Allison, 2003; Radcliffe, 2013). An estimated 20-30 per cent of bariatric patients present with NES. Therefore candidates for surgery should be screened pre-operatively for both BED and NES and followed psychologically post-operatively to support them with regulating their eating habits (Allison et al., 2006; Radcliffe, 2013).

Although emotional eating is not an eating disorder, it can act as a common precipitant for an individual to have a binge episode. Almost all of the participants in this project described an emotional relationship to food. They spoke about turning to food when they felt bored, angry, sad, depressed, tired, elated and myriads of other emotional states. Jack spoke about food being his '*reward*'. John described associated feelings of '*guilt and hopelessness*' about his emotional eating. For Ross, William and Alfred, their mood acted as a driver to the degree of their emotional eating. As Hamburger (1997) writes, eating goes beyond the aesthetic and social dimensions and can be modulated according to an individual's daily emotional state.

Psychosomatic theories of obesity developed in the 1930-1950's posit that obesity is intrinsically linked to overeating as a response to emotional distress (Allison & Heshka, 1992). This theory was proven to be erroneous as emotional eating is present in non-obese, non-disordered eating populations as well, and most people at times eat to regulate their emotions (Allison & Heshka, 1992; Ogden, 2008).

However, Buckroyd and Rother (2008) point out that the literature over the past twenty years has identified a subgroup of as many as 45% of individuals classified as 'obese' who eat emotionally. For example, Walfish (2004) conducted a study with a sample of 122 female pre-surgical bariatric patients, examining especially emotional factors relating to their eating behaviour, and found that 40% of the sample were classified as 'emotional eaters' and recommended targeting negative emotions such as 'boredom, stress and depression' in order to adhere to long-term weight-loss maintenance post-surgery (Walfish, 2004). Since, this study only comprised a female sample, other studies, such as the one carried out by Larsen, van Strien and Engeles (2006), looked at gender differences in the association with alexithymia and emotional eating in individuals classified as 'obese'. Alexithymia is a term that was coined by psychotherapist Peter Sifneos in 1973 and refers to an

individual's lack of ability to find appropriate words to describe their emotions. The findings from Larsen, van Strien and Engeles (2006) found that alexithymia was more present in emotional eating by men classified as 'obese' than by women, which suggests that gender-specific treatments for men classified as emotional eaters should be designed.

4.2.2 Trauma

Turning to food as a means to self-soothe following a trauma is not an uncommon response (Brewerton, 2007). Food can act in those instances as a healer, dampening any uneasy emotions, turning pain into emotional nourishment. In terms of early childhood traumas, the themes of 'sexual abuse', 'abusive father' and 'bullying' appeared in the participants' narratives. Peter disclosed being sexually abused by a person he trusted and suffered for many years the damaging consequences, kept it a secret from his loved ones and suffered from depression as a result. Grilo et al. (2005) investigated rates of self-reported childhood maltreatment in male and female bariatric surgery candidates in a sample of 340 people and found that as many as 46% of the sample reported emotional abuse and 32% reported sexual abuse, which is two to three times higher than normative community samples and, in terms of psychological functioning, is linked with people suffering from higher rates of depression. Furthermore, emotional abuse was linked with people experiencing greater body dissatisfaction and lower self-esteem, which was evidenced by some of the participants in this study, such as William, describing having abusive father figures (Grilo et al., 2005).

Childhood bullying was another common theme in the study, where half the sample (Alfred, John, Adam and Peter) recounted experiences of being teased and made a social mockery due to their physical '*otherness*'. Studies have exemplified how children classified as 'obese' are often stigmatised by their peers, victims of verbal, physical and relational bullying which is as present in boys as girls and leads to lower self-esteem and feelings of victimisation (Janssen, Craig, Broyce & Pickett, 2004; Gatineau & Dent, 2011). 'Obese' children are exposed to greater harassment, ostracism, and prejudice than

other children and they are reinforced to feel that they are to blame for their 'fatness' and are fundamentally flawed, especially in a day and age of moral panic around fatness (Lupton, 2013; Rich, Monaghan & Aphramor, 2011).

4.2.3 Losses

The last cluster theme that related that food as the self-soother was participants' accounts of losses. These encompassed losses in terms of physical function and the associated loss from 'able-bodied' to 'disabled', the loss of a loved one and associated grief, and the loss of a job and professional identity. Both Alfred and John spoke about their physical disability and how it had acted as a vicious circle in terms of their weight fluctuations and relationship with food because of the associated feelings of being physically incapacitated which leaves them more frustrated, hopeless and stuck and leads them to turn to food as a source of comfort in those instances. Kai-Cheong Chang and Gillick (2009) conducted a qualitative study exploring fat individuals' construction of their identities and whether they identified as having a disability and whether they viewed fatness as a disability. Participants did not equate their fatness with a disability and instead associated disability with a physical and/or mental health ailment (i.e.: multiple sclerosis, schizophrenia, etc.). They indicated that this classification only generates further oppression and stigmatisation that could act as additional barriers to full acceptance in society and hinder identity formation, making people feel more invisible and isolated (Kai-Cheong Chang & Gillick, 2009). With regards to the loss of a loved one, suffering from a significant bereavement, like Mark and Peter did, can lead to symptoms similar to individuals diagnosed with major depressive episodes. Although not diagnostic criteria in itself, feelings of intense sadness, rumination about the loss and a significant change in appetite and weight gain can be apparent (American Psychiatric Association, 2013) which could explain the oscillation in their weight, according to the latest edition of the Diagnostic Statistical Manual (DSM-V).

4.3 Family milieu: past and present

The third superordinate theme was participants' family milieu and how that influenced and shaped their past and present relationship with food. The three cluster themes that emerged concerned patriarchal family values, adverse home lives and family rules around eating. All the men in this study described very defined gender roles whereby their mothers were responsible for preparing food and all domestic chores in their home, while their fathers (if present) were the primary breadwinners. For Jack food meant love as his mum prepared all the meals from scratch. Ross described his mum as a feeder while Mark portrayed his mother's feeding as culturally and religiously engrained when he depicted her as "*a typical Jewish mother…her child should eat*" (line 10, p.1).

As infants, our first relationship with our mother is a nutritive one, and the experience of suckling and eating on a mother's breast appears to be among the earliest sources of sensory pleasures which psychoanalysts have named the 'oral stage' of child development (Powdermaker, 1960). Developing an appropriate parent-child feeding relationship enables a child to develop a positive attitude about the self and the world (Satter, 1986). Satter (1986) explains that an asynchronous relationship can grow if the primary caregiver (in this instance we refer to the mother) is domineering regarding feeding which causes the child to become anxious and confused about his needs because his mother seems to override them with what she deems necessary, leaving the child unable to gain a sense of autonomy and effectiveness. We can hypothesise that this dyadic relationship might have been evident for Ross, Mark and Jack who portray their early feeding relationship as bountiful, abundant, excessive (in Ross's case) and perhaps not attuned to their physiological cues of hunger and satiety.

Furthermore, family eating practices and cultural beliefs and values in terms of food seem to override psychological factors according to research (Lupton, 1994). Dietary changes in the context of the nuclear family seem particularly

tough because of the expectations of family members and the need to conform to gender and familial roles, which, in this study, ascribes to a patriarchal framework (Lupton, 1994). Having a full stomach and eating well is one way of achieving a state of euphoria, and the family meal symbolises love, affection, communication and pleasure (Powdermaker, 1960; Odgen, 2010).

The family meal is the site of acculturation into the norms and behaviours around eating preferences and also the forum for the construction and model of the contemporary Western family to unfold with the emotional and power relations within the family (Lupton, 1996). The power dynamics do not only reside solely between women and men within the household, but there are also power struggles —between mother-child and at times father-child relationships (Lupton, 1994). For example, Jack spoke about surpassing his mother's cuisine and being a superior cook, and Mark described rebelling against his mother's regimented and unadventurous cooking and secretly bonding with his father over worldly gastronomies.

The role of food and eating in the context of the family is very often tied in with motherhood, nurturance and femininity in terms of the purchase and preparation of food, which remains in the sphere of women's domesticity in this study (Warin, Turner, Moore & Davies, 2008; Lupton, 1996). In terms of parental feeding and intergenerational transmission of obesity risk which has often been the focus of attention with overweight or 'obese' parents, Wardle, Sanderson, Guthrie, Rapoport and Plomin (2002) carried out a study with 214 families and found that 'obese' mothers were not more likely to use food to self-soothe their children as a form of reward or for emotional regulation than normal-weight mothers. However, 'obese' mothers were found to exert less 'control' over their children's food intake, which could explain a difference in terms of weight (Wardle et al., 2002).

4.4 Food and weight loss surgery expectations

The forth superordinate theme was participants' weight loss surgery expectations and their aspired future post-operative physical selves. Five main cluster themes that arose were: (1) participants' fear of surgical complications and fear of death, (2) surgery being their magic saviour and path to a new transformative-self, (3) unrealistic weight loss surgery expectations, (4) being in limbo as they require another surgical procedure and (5) having a social support network that aids them through the bariatric journey. These themes will be examined according to the literature.

All the participants in this study spoke about fears of death and surgical complications as well as communicated feelings of existential angst and of having bariatric surgery as their last resort or, as Ross phrased it, as playing "*your last trump card*" (line 516, p.15), implying that it is his last option in order to pursue daily living. According to Buchwald et al.'s systematic review and meta-analysis (2004), the operative mortality rate ranges (30 or less days) from 0.1% to 1.1%, depending on which bariatric procedure a patient undergoes. This is considerably lower than other major surgeries such as heart surgeries, which had a mortality rate of 2.98% recorded in 2012 in the blue book of the society for cardiothoracic surgery in Great Britain and Ireland. However, fear of death and surgical complications is not an uncommon response and was reported in Meana and Ricciardi's (2008) study when they interviewed 33 people who were going to have gastric bypass surgery. Meana and Ricciardi (2008) found that one of reasons that participants reported that they had decided to go forward with surgery is that they were confronted with their own mortality as a daily threat, that weight loss surgery had became their only chance to live, and that the power to make that decision and change lied in their hands.

In this study, participants expressed concerns regarding long-standing side effects they might incur from proceeding ahead with the surgery. William expressed trepidation based on accounts that he heard from other people who had had bariatric surgery and had to take medications for the rest of their lives in order to stay alive. Ross described a sense of finality and catastrophic

thinking when he discussed his surgical options and predicted some extreme physiological symptoms that might incur if he does not adhere to the necessary vitamin supplement regime required following his operation.

> *"Can I really say I will take four sets of vitamins every day for the next 40 years, without fail? Because if you do… if you don't, you know, your body starts leaching calcium out from the bones, your teeth turn to dust, and, you know, a lot of things that cannot be rectified start to happen, which sounds bad."* (Line 591-595, p.17)

On the other hand, participants expressed a strong sense of hope, revival and described bariatric surgery as their tool towards their new 'transformative-selves'. Adam described surgery as a '*reboot to his life'.* John spoke about looking forward to wearing new clothes and being able to be accepted and seen in society. Jack foresees a thinner future-self as 'happier' and Mark is already planning to resume his professional path and physical activity once he loses weight. These themes confirm what has been elucidated in the literature from other studies (see Throsby, 2008; Ogden, Clementi & Aylwin, 2006; Bocchieri, Meana & Fisher, 2002).

Throsby (2008) conducted a qualitative study interviewing 35 people who had either undergone bariatric surgery or were waiting to have surgery and she came across the term of "re-birth date" on weight loss forums highlighting this construct of a post-surgical 'new-self' which is often analogous with a person's reconciliation with their 'real and authentic-selves'. Throsby (2008) extends her understanding of the concept of 're-birth' and 'transformed body' not only to people being visibly different post-operatively, but also having a newly disciplined, responsible body and being able to exert control and restraint over their consumption. Research undertaken by Ogden, Clementi and Aylwin (2006) with 'obese' patients (n=15) who had undergone surgery paradoxically found that the patients wished to surrender control because their eating was "out of control." By reducing food intake and choice, patients felt they had achieved a

new liberated sense of self and an improved sense of control and relationship with food (Ogden, Clementi & Aylwin, 2006; Ogden, 2005). Furthermore, the notion of 'rebirth' was mentioned by participants in the study who described being able to feel less self-conscious, more empowered to take action and seize new opportunities (Ogden, Clementi & Aylwin, 2006). Bariatric surgery has also been shown to improve health status, self-esteem, body image confidence, mood, marital satisfaction and eating behaviour (Stunkard & Wadden, 1992; Bocchieri, Meana & Fisher, 2002; Ogden, Clementi, Aylwin & Patel, 2005).

Wood and Ogden (2015) conducted a qualitative study exploring the long-term consequences of having weight loss surgery in a sample of ten patients and one of the themes that transpired from their findings was participants' quality of life post-surgery. Some had revealed a sense of 'reinvention' and newly found identity (i.e.: thinner-self or new-self), which supports the collective aspirations of the men interviewed for this study.

However, another important aspect prior to having weight loss surgery is having realistic expectations and knowledge of the bariatric procedure selected and understanding of the anticipated excess weight loss (EWL) that a person can foresee based on their current height and weight. For example, if patients select to have a gastric band fitted, they should expect to lose 50 per cent of EWL which translates as 50 per cent of the difference between their current weight and ideal weight and does not always mean that attaining a normal BMI range is foreseeable (Radcliffe, 2013). Alternatively, if patients select other surgical procedures, such as a gastric bypass, they should expect to lose 60 per cent of EWL. Nonetheless, understanding the various procedures, their risks and benefits, both in the short-term and long-term, as well as having realistic weight loss expectations, are vital ingredients for people not to be set up for disappointment (Radcliffe, 2013). Bauchowitz et al., (2005) compiled a survey of the psychosocial evaluation of bariatric surgery candidates in present practices and found out that out of the 37 potential contraindications for surgery, lack of knowledge about surgery was a pivotal one that was rated 77.8% of the time as a definitive contraindication for surgery.

Some of the participants in this study did not seem to have realistic expectations regarding their EWL and target BMI post-surgery. This might be due to fact that they have not had their group education session yet as part of the assessment stage. A conversation needs to take place prior to surgery with the bariatric team informing them of what they might achieve based on the procedure they select and the calculation of their projected weight loss following weight loss surgery. Alfred and Mark both discussed feeling in limbo regarding their upcoming weight loss surgery. Alfred mentioned needing to have a knee surgery as well and that it was a pervasive vicious circle. Perhaps having the bariatric surgery first, might ease some tension and pressure on his knees if he is carrying less weight. Mark spoke about spending years in limbo as he was waiting to be placed on a waiting list again for surgery after he was discharged in the past for missed appointments. Engström et al., (2011) have documented in their qualitative study investigating the meaning of waiting for bariatric surgery, that over 50% of their participants reported suffering from pain in their feet, knees and/or hip. Furthermore, 17% of participants reported having heart failure or infarction and 21% experiencing back pain which suggests that this is a common shared experience which limits people's mobility in their daily lives (Engström et al., 2011).

Lastly, having a social support group can be greatly beneficial in terms of fostering greater motivation, understanding, success and outcomes before and after having bariatric surgery. Most of the participants in this study were fortunate and reported having support from their loved ones who supported their decision to proceed ahead and have surgery. However, a few others expressed being isolated in their preparation and readiness for change as they lived alone and/or expressed being criticized and judged for telling people that they were going to have bariatric surgery. They also reported that people hold stigmatising beliefs (see Puhl & Brownell, 2003; Ogden & Clementi, 2010).

Research conducted by Orth, Madan, Taddeuci, Coday and Tichansky (2008) has shown that patients who attend regular support group meetings prior to having undergone a bariatric procedure achieve greater weight loss compared

to patients who do not attend the support groups. Some of the topics discussed usually include information regarding nutrition, expectations of surgery, socio-cultural adjustments, exercise, dealing with plateaus, life after surgery and many other areas that participants find relevant to their experience (Orth et al., 2008).

Interestingly, Robertson et al., (2014) carried out a systematic review of the evidence-based management strategies employed for treating obesity in men and, more specifically, on how to engage men in obesity services as it is well documented that they are less likely to engage in weight-loss services. Robertson et al., (2014) found that group-based weight management programmes facilitated peer and social support and aided greatly in terms of meeting other men with similar health ailments. These programmes facilitated weight loss because men felt both accountable to other members of the group and to themselves, which ameliorated adherence and compliance.

4.5 Socio-cultural ramifications

The fifth superordinate theme was participants' accounts of the socio-cultural ramifications of their relationship with food. The two themes that appeared from this superordinate theme were men's (1) cultural identification with food and (2) social versus private eating, which will be grounded in the literature.

All the men in this study discussed their cultural identification with food. This was either linked with their religious upbringing and keenness for certain holidays, which are celebrated with special foods, or their reflection on their British identity and what it meant to them in terms of being drawn to certain foods. Additionally, participants discussed the greater macro-layers of society and how they experienced living in a globalised food market.

William, for example, describes cooking, providing for others and helping out as being '*in his blood*' and part of his Irish heritage. John refers to '*fish and chips*' as being an integral food that represents his cultural identity.

As Hamburg, Finkenauer and Schuengel (2014) state:

> "*People feel strongly about their individual food preferences and the food culture they were raised in (…) Food offering can be used to show affection to loved ones, to show hospitality to strangers, or to adhere to or express religious beliefs" (p.1)*

This demonstrates a shift from the commonly associated *intrapersonal* perspective of using food for emotional regulation towards an *interpersonal* regulatory process that symbolises comfort, reward, celebrations and rites (Hamburg, Finkenaeur & Schuengel, 2014; Goodspeed Grant, 2008). Food and eating are embedded in socio-cultural and symbolic meaning and passed down inter-generationally (Goodspeed Grant, 2008).

Peter alludes to the globalisation of the food industry and abundance of food choices, which makes it harder for him to associate with food in terms of a personal sense of cultural identity. According to the Lancet's first series on obesity (Swinburn et al., 2011; Roberto et al., 2015), the globalisation of food markets has been promoting overconsumption of energy-dense foods with poor nutritional content which has been recognised as one of the contributing factors of the current '*obesity pandemic'*. This has been executed by tapping into people's psychological vulnerabilities and creating a food choice infrastructure whereby product placements in supermarkets with poor nutritional content are frequently more cost-effective, bigger in size and, therefore, more desirable for the consumer to purchase (Roberto et al., 2015).

According to Dr Christina Roberto, Assistant Professor at Harvard University, appropriate food labelling and educational and public health campaigns are vital in creating changes in terms of promoting healthier eating, and she proposed to

break down complex food messages into a simple traffic light system indicating which options are healthier than others which would have significant impact on the consumer's behaviour and decision making process (Lane, 2015).

Regarding social versus private eating, Bisogni, Connors, Devine and Sobal (2002) conducted a qualitative study exploring identities in terms of food choice and one of the types identified was participants' identities related to their reference groups and social categories which defines their sense of '*normalcy*'. This was further broken down into interpersonal relationships and roles and group association as identity sources, which is also exemplified in this current study whereby participants, such as Adam and Alfred, reported that they were expected to eat more or less in social settings due to their corporeality (Bisogni, Connors, Devine & Sobal, 2002). De Castro (1994) carried out a study with 515 adults who were asked to record a 7-day diary of everything they ate, drank, who they were with and their relationship to them, their gender, their self-rated hunger, emotional state and the time of the day that they ate. The results of the study indicated that meals eaten socially were larger and longer in duration and were eaten more rapidly when in the presence of family and relatives, which suggests that social facilitation enables greater food consumption and disinhibition than when participants were eating alone (De Castro, 1994). However, De Castro's (1994) findings differed from the accounts of the participants in this current study who reported contrary relationships with food and tended to be more prudent with food choice and portion size in social settings because of fear of social appraisal and being stigmatised due to their *bigness.*

Green, Larking and Sullivan (2009) explored the phenomenon of repeated diet failures with self-reported dieters in order to further elucidate means for effective weight- loss interventions. One of the key themes found related to the challenges of emotional and social eating and participants talked about eating being context-dependent and rationalised overeating in terms of conforming to *social etiquettes* (i.e.: not being seen as being rude) which concurs with the findings of the present study (Green, Larking & Sullivan,2009).

4.6 Evaluation of the research

Assessing the validity of qualitative research remains a contested issue due to its relative novelty as a method of psychological research as opposed to quantitative research which has well-established guidelines such as evaluating the sample size and suitable use of appropriate statistical analysis, etc. (Yardley, 2000). This study adopts Yardley's (2000) four evaluative criteria for assessing validity in qualitative research, which are: (1) sensitivity to context, (2) commitment and rigour, (3) transparency and coherence and (4) the impact and importance of the research.

The sensitivity to context pertains to the study being anchored in the relevant theoretical and sociocultural context investigating a similar phenomenon or methodology, which has been demonstrated in my review of the literature. It also means sensitivity to the participants involved in the study as IPA entails a commitment to the idiographic principles and recruiting a purposive sample that share a common lived experience, which was the case in this study as all the men who partook in the study were on a waiting list for bariatric surgery (Smith, Flowers & Larkin, 2009; Shinebourne, 2011). Yardley (2000) alludes to being aware of the social context as well and looking beyond the participants' narratives in terms of being indicative of their internal feelings and thoughts, but also to be sensitive to the linguistic and dialogic context which gives the researcher central meaning. Furthermore, I was working in an NHS bariatric psychology service during the recruitment stage of this study, which I believe made me more attuned to participants' individual perspectives, and gave me greater insight into their current quandary and journey ahead (Yardley, 2008). I was equally mindful of the power imbalance, relational ethics and of my dual role of as a scientist-practitioner when I was conducting the interviews and, later, through the stages of analysis when I was deeply immersed in the data (Finlay, 2011; Langdridge, 2007; Shinebourne, 2011).

The commitment and rigour of this study has been demonstrated by my deep engagement with the research topic (as evidenced in the literature chapter), care and attentiveness to my participants prior to and during our interviews, and subsequently during the analysis stage as I was paying close attention to the intricacies and subtleties of their narratives (Yardley, 2000). Smith, Flowers and Larkin (2009) contend that in order for a study to be rigorous, it needs to be thorough in terms of an appropriate sample to be selected to explore the phenomenon under investigation (please refer to the methodology chapter in terms of the sample criteria for IPA), the quality of the interview conducted as well as the completeness of the analysis encompassing all the complexities and minutiae observed (Yardley, 2000). In order to achieve rigour in IPA, the analysis needs to move beyond the descriptive layers of the text and delve into more interpretative ones. Ricoeur (1973) writes about the metaphorical and double meaning of language, which is grounded in the theory of hermeneutics and puts forth that as a researcher I am deciphering the manifold layers of meaning and reminded that there will always be more than one way of construing a text. However, Ricoeur (1973) postulates that there are limited possible interpretations to the text and that validation enables us to stand by the interpretation put forward.

Reading Gee's (2011) experiential in-depth case study explicating the seven steps of the analytical process in IPA while disclosing her personal reflections of the whole research process enabled me to take a renewed perspective of my own analysis and to re-evaluate some of my initial conceptual comments and discuss them further with my research supervisor. My supervisor, in turn, provided feedback as a form of triangulation through the analytical stages, which increased the rigour of the study. Furthermore, Smith (2011) alludes to the concept of the '*gem*' when conducting IPA analysis which is defined as a segment that particularly stands out of the transcript and requires considerable analytic effort. Smith (2011) classifies gems according to a spectrum from "*shining*" (The meaning is clearly apparent). to "s*uggestive*" (The meaning needs some detective work on behalf of the researcher.) to "*secret*" (The meaning requires more peering through to uncover the hidden significance.) which all "shine light on the phenomenon…on the corpus as a whole" (p.7). The

notion of the '*gem*' enabled me to ameliorate the rigour of my analysis by scrutinising the text and giving it further analytical leverage.

Yardley's (2000) third criterion, transparency and coherence, refer to how clearly all the stages of the research process have been exemplified (Please refer to Appendices I-L for a detailed audit trail). In IPA this denotes being transparent about the specific details of the participants' selection and construction as well as conduction of the interview, which can be found in the methodology chapter of this thesis (Smith, Flowers & Larkin, 2009). Transparency also entails self-reflexivity about my motives, influences and impact throughout the research endeavour as well as bringing to my awareness the importance of the wider socio-cultural and political context in terms of where the study positions itself (Yardley, 2008) (Please refer to the methodology chapter). Coherence relates to an appropriate fit between the research questions, the underlying theoretical assumptions and the method employed. Coherence also insinuates presenting a clear and cogent argument and placing oneself in the 'reader's shoes' as an important facet of assessing validity is questioning whether the research tells us something novel, useful and important (Smith, Flowers & Larkin, 2009; Shinebourne, 2011).

This brings us to the last criterion, which concerns the impact and importance of the research and its wider utility, influence and applications on the community the findings were deemed relevant for (Yardley, 2000). The men in this study shared transparently, courageously and generously their lived experiences of their relationship with food prior to undergoing bariatric surgery. The aspirations of this study are two-fold: (1) to be able to publish the findings of the research in peer-reviewed bariatric and psychological journals to inform and advance clinical practice in the field and (2) to encourage other men who share similar journeys to come forward, dampen any associated reservations and stigma and engage with psychological and health care providers before considering weight loss surgery as a means of altering their relationships with food.

4.6.1 Personal reflexive statement on the impact of the research

Personal reflexivity is a pivotal process in qualitative research and involves reflecting upon my own values, beliefs, experiences and interests and taking a deeper look at how the research endeavour has both shaped and affected me as an individual and as a researcher (Willig, 2008). Unlike quantitative research that adopts an objective and positivist ontological stance whereby the researcher is seen as a detached observer, qualitative research recognises that the researcher acts as a co-constructor of the psychological knowledge produced (Langdridge, 2007). Personal reflexivity involves a metatheorised processing, where we retroactively reflect on past reflective moments and subject them to further conscious scrutiny based on theoretical knowledge in order to create meaning of what has been recollected (Stedmon & Dallos, 2009). Langdridge (2007) set out very key questions to encourage researchers to reflect on their relationship with their topic at hand and I will discuss two of them below:

1. *What is my relationship with the topic being investigated?*

Although I am an '*outsider*' in the sense that I am not on a waiting list for bariatric surgery and have not experienced a tempestuous relationship with food to the same extent as my participants, I do share some '*insider*' facets to the topic under investigation which I will discuss. During my Doctorate studies, I underwent back surgery due severe and persistent disabling pain. This experience left me feeling powerless, feeble and shocked as it all happened very suddenly. I felt incapacitated due to my reduced mobility at the time which persisted for months, and I was dependant on my loved ones and health professionals for everyday care and to be able to resume my daily functioning. During my data analysis, I felt at times a parallel process unfold as I could sense at times an over-identification with some of the salient themes of my participants' narratives such as their struggle to live with chronic pain and aspirations for what their lives might look like post-surgery. That is when the use of my research journal came in handy to record my initial and evolving thoughts,

emotions and challenges and to be able to discern and untangle my own narrative from those of my participants when I felt more drawn to certain aspects of their experiences.

Aside from undergoing surgery, my own physical embodiment went through several changes as I became pregnant and experienced psychological and physiological fluctuations as my body went through various stages of development all in preparation for my future identity as a mother. Smith (1999a, 1999b) discusses a theoretical model of the relational-self based on his qualitative research of women going through their first pregnancies. Smith (1999a, 1999b) found that symbiotic relations with key others and family during pregnancy can facilitate psychological preparation for mothering. I felt similarly during my pregnancy as attending antenatal classes, meeting expectant parents and receiving advice and counsel from family members, friends, professionals and strangers felt both anchoring and grounding as well as alienating and disparaging at other times. Lupton (1999) accurately describes the intense focus on the pregnant woman's body in Western societies in terms of being the subject of other people's gaze, appraisal as well as discourses that place a heavy emphasis on bodily surveillance and self-regulation. Pregnant women are also exposed to high 'risk' rhetoric in terms of insuring the well-being of the foetus as it is often depicted as fragile, vulnerable and susceptible to threats (Lupton, 1999).

In terms of how my evolving pregnant embodiment tied in with my research topic, I spent time pondering about my feeding relationship with my daughter. Would I be able to teach her long-term healthy eating habits to effectively self-regulate, or would she later turn to food to appease uneasy emotions? Would I breast feed or bottle feed? When would I start weaning her and which foods would I introduce first? I experienced a myriad of anxious thoughts about being a '*good enough'* parent and then strived to be more acceptant of any bumps that came along this novel journey. This internal dialogue brought me closer to my participants' narratives and thinking about their first experiences of being fed as infants as well as thoughts about inter-generational patterns of feeding and how they taught eating habits to their children if they were parents.

2. *Who am I and how might I influence the research I am conducting?*

I will answer this question by honing into my gender and professional identity, which I believe might have played a contributing role in terms of the data collected. I am a female Psychologist researching men's relationship with food prior to undergoing weight loss surgery. At times, I felt that my gender had an impact on the narratives that I collected. For example, Adam referred to himself as a '*big, cuddly teddy bear'* who would protect me if there were any '*baddies*' (line 636.p.16), reminding me of my '*outsider*' female position. I wonder if those same words would have been employed if I were a male researcher? Sallee and Harris (2011) conducted a qualitative study exploring how researchers' gender influence male participants in terms of exerting their masculinities and male gender identities. Sallee and Harris (2011) found that male participants presented themselves differently to male and female researchers and recommended to other researchers to become mindful of gender expectations as well as reflexive about gender performance in the research process. In other words, Adam might have been performing a certain gender identity and conforming to a culturally dominant notion of hegemonic masculinity that places men as heterosexual and dominant in their relationships with women. However, it is also possible that the men who partook in the study felt greater ease, transparency and fluidity in their narrative with a female researcher and that this facilitated greater rapport as I was seen as an '*outsider'*.

My professional identity as a Counselling Psychology Trainee working at the time of the data collection for his study in both a Bariatric Psychology as well as Community Eating Disorders NHS clinical settings had a personal as well as research influence at times in terms of building rapport with my participants. I felt that my dual role as a scientist-practitioner and reflective-practitioner overlapped, as I was mindful of similar difficult experiences that had been voiced by both my clients and research participants. Research participants sometimes (as mentioned in my methodology chapter) would ask me questions pertaining to their bariatric surgery after our interview since they were aware

that I worked in a bariatric psychology setting. I would signpost them to the debriefing form or to contact their local team for further information.

The research endeavour as well as my clinical work in both bariatric and eating disorders services made me reflect further on the resemblance of clinical themes that transpired in both settings. I noted that NHS bariatric surgery services are affiliated with specialities in nutrition, biological science, medicine and public health but there appears to be an inconsistency as well as insufficient psychological provisions across bariatric surgery services in the UK in comparison with eating disorders services that remain a specialty within mental health services (see Ratcliffe et al., 2014; Hill, 2007; Hill, 2015). Hill (2015) highlights from her own clinical experience that this conceptual division has meant that there is a lack of evidence-based research in terms of which therapeutic modality is most efficacious for individuals classified with '*severe obesity*' aside from behavioural approaches put forth by NICE (2006) and Cognitive-Behavioural Therapy (CBT) for binge eating disorders (NICE, 2004). This does not allow space for other therapeutic models to be employed such as Cognitive-Analytic Therapy (CAT) and Family Therapy (SFT), for example, that are in usage in eating disorders settings. I emailed psychologists belonging to the Clinical Health Faculty Obesity network branch of the British Psychological Society (BPS) who predominantly work in weight management NHS services (Tier 3) and/or bariatric psychology services (Tier 4) and asked them about psychological provision within their services and whether they noticed a problematic relationship with food resurfacing with their clients after two years post-surgery, when they are meant to discharge their clients from their care (refer to NICE, 2014). I received comments from clinical lead psychologists who mentioned that presently there is insufficient psychology input (mainly focused on pre and post-assessments) to be able to meet the needs of a growing client population, that their departments remained largely under-resourced and that they noticed that clients struggle with food around 18 months post-surgery. This made me reflect further on the current divide that exists between obesity and eating disorders and the prevalent public health discourses that still casts a negative light on obesity by reinforcing narratives of shame, blame and individual responsibility for one's health as well as taking into account the wider

role of socio-environmental factors (Lawrence, 2004; Hill, 2015). This could explain why there remains a lack of psychological input within this client group that ought to be treated, in my opinion, under the same umbrella services as eating disorder clients as there are more crossovers and similarities than disparities in terms of their clinical presentations.

4.7 Contribution to counselling psychology

Weight management and bariatric psychology services are largely run by clinical as well as health psychologists across the NHS as counselling psychology is still a newcomer on the scene, having been established as an independent division of the BPS in 1994 (Woolfe, Strawbridge, Douglas & Dryden, 2010). The strength of counselling psychology reside in its impetus on the relational aspect of the helping relationship, focusing on well-being instead of pathology, on the client's internal subjective experience and not their diagnostic labels, and the importance of being a reflective practitioner while staying grounded in the latest evidence-based practice (Woolfe et al., 2010). Counselling psychologists foreground the '*use of the self*' in the therapeutic process, which is at the core of being a reflective practitioner (Lewis, 2008; Schön, 1983).

Counselling psychology is primarily rooted in humanistic and existential values, which adopt a phenomenological lens of enquiry that places emphasis on the importance of the intersubjective world of the client and the therapist in co-constructing meaning (Douglas, Woolfe, Strawbridge, Kasket & Galbdraith, 2016). However, counselling psychologists are currently located between two conflicting epistemological positions: the phenomenological versus the dominant empiricist positivist stance that is situated within the medical model of psychology and accentuates the use of diagnosis and classification systems to understand and steer appropriate treatment for human distress (Larsson, Brooks & Lowenthal, 2012; William & Irving, 1996).

Nevertheless, the current *Zeitgeist* within the NHS and other statutory agencies stipulate the need to use a medical model of mental distress such as the DSM-V that acts as a *lingua franca* among the wider mental health community and to be driven by performance indicators and measurable outcomes that demonstrate alleviation of psychological suffering (Larsson et al., 2012; American Psychiatric Association, 2013). This is where the epistemological clash resides as counselling psychologists working in a weight management and bariatric setting within the NHS will be expected to work following the prevailing medical model and to adapt to the current political, economical, socio-cultural and environmental agenda and suspend at times their humanistic ethos (Douglas et al., 2016). The forte of counselling psychologists, as Ponterotto (2005) describes, is that we are '*bricoleurs'*. In other words, we are integrative practitioners that draw on multiple research paradigms as well as therapeutic modalities when working with our clients

While there is a lack of evidence-based guidelines regarding bariatric psychological assessment in terms of the process, content and outcomes of the assessment, there is a general consensus about the domains that should be covered as stipulated by the Boston Interview for Bariatric Surgery (BIBS) and the Cleveland Clinic Behavioural Rating System (CCBRS) (Heinberg, Ashton & Windover, 2010; Sogg & Mori, 2009) (refer to the literature chapter). These are primarily rooted in people's psychological and behavioural readiness for change in order to ameliorate postoperative bariatric outcomes (see Ratcliffe, 2016). The present study has complemented and enriched the above domains by exploring men's idiosyncratic understanding of their relationship with food by taking into account their wider socio-cultural and economic contexts. By adopting both a hermeneutic and phenomenological lens to the research inquiry, which is aligned with counselling psychology's therapeutic stance, themes of identity and meaning-making ascribed to the relationship with food were unravelled. The critical stance taken in this project towards diagnostic labels such as 'obesity' is also congruent with counselling psychology's philosophy. As Martin Milton (2012) said: "Diagnosis is subjective, flexible, imperfect, subject to change and just one way of viewing of human distress" (p.9).

4.8 Limitations of the current study and ideas for further research

The men who participated in this study had either heard of the research through an online advert that I had placed with WLSinfo and BOSPA or had heard me speak about the project at one of their local weight loss support groups. This, in turn, could have resulted in a self-selection bias and possibly demand characteristics and response biases as participants might have sought to respond in a more favourable manner during our interviews. Although the inclusion criteria was open to any male who is at least 18 years of age and fluent in English, all the men who contributed in this study were White British and in heterosexual relationships; therefore, it did not encompass men from different ethnic background, nationalities and sexual orientations. This means that it rendered to quite a purposive homogeneous sample which allowed a detailed examination of the psychological variability and patterns of convergence as well as divergence that arose in the analysis leading to theoretical transferability rather than generalisability of the findings (Smith, Flowers & Larkin, 2009).

In terms of ideas for further research, it would be noteworthy to triangulate the findings of the present study with a larger scale quantitative methodology in order to be able to draw generalisations to a broader sample, guide and inform government policy, further clinical practice and psychological service implementation directed specifically at men's psychological well-being within bariatric psychological services. Furthermore, it would be valuable to conduct further qualitative longitudinal studies following men classified as 'obese' prior to as well as post-surgery to see how their relationship with food evolves in order to steer appropriate psychological treatment. Being able to follow men after they have been discharged from their bariatric psychology services would be vital as problematic relationships with food might resurface as well as their weight stagnate and/or increase, which may provoke difficult feelings of disappointment, failure and hopelessness and lead some to turn to food for emotional nourishment which would act as a vicious circle. Lastly, it would also be important to conduct similar qualitative studies with men prior to undergoing

weight loss surgery who opted to have their surgery carried out in the private sector and to compare and contrast their lived experiences as well as hopes and aspirations post-operatively and where psychological provisions sit in their care.

4.9 Implications for clinical practice

4.9.1 Bringing men's voices to the forefront of the obesity discourse

As stated previously, there is paucity of research representing men's relationship with food who are waiting for bariatric surgery and are being classified as 'obese'. One explanation resides in the way that men are socialised to embrace *masculine hegemonic ideals* from infancy onwards. This view stipulates that '*real men*' should be physically strong, uninterested in their physical and emotional health and exert control, power and self-reliance (Connell, 1995; Farrimond, 2012). It is concomitant with a social constructionist portrayal of masculinity that leans on a social learning paradigm whereby gender is contextually situated and learned through the interaction between an individual's thoughts and behaviours with their environment (Rowbottom, Brown & Cacchia, 2012).

This could explain why there is resistance by men to seek help for their psychological well-being as well as their physical health as evidenced by the empirical research carried out in the United Kingdom which found that men were less likely to engage in help-seeking behaviour and consult with health professionals compared to their female counterparts (Galdas, Cheater & Marshall, 2005). However, Addis and Mahalik (2003) forewarn of the flaws of doing gender comparative studies as sex-differences studies do not account for intra and inter-individual variability among men that ought to be the methodological focus in order to devise effective therapeutic interventions. That is why the above study used IPA, which is grounded in social constructionism,

and employed a small homogeneous sample of men in order to delve in further depth into understanding their subjective experiences and perceptions about their relationship with food prior to undergoing weight loss surgery. The aim of the study is to inform the clinical practice of applied psychologists as to how to engage men in psychological services earlier on in their weight management care pathway before they are referred to bariatric psychology services (Tier 4).

In terms of terminology employed for physical descriptors, being a 'big' man versus an 'obese', 'overweight' or 'fat' man is more appropriate in a fatphobic society where biomedical labels conjure pathology, disease and illness (Monaghan, 2008). Interestingly, none of the men who partook in this study referred to themselves as 'obese' or 'overweight'. This reinforces the importance of health care professionals to be more sensitively attuned to the language used in the clinical settings of their clients and to distance themselves from the prevailing biomedical narratives that surround us.

4.9.2 Engaging men in bariatric psychological provision

Men's lack of help-seeking behaviour for their psychological well-being could stem from an underlying thought that it is an attack on their masculinity and a sign of weakness and vulnerability (Addis & Mahalik, 2003; Mansfield, Addis & Mahalik, 2003; Galdas, Cheater & Marshall, 2005; Rowbottom, Brown & Cachia, 2012). However, Haggett (2014) intriguingly recounts that men's reluctance to speak about their emotional world was not always seen as effeminate or calling into question their masculine traits of toughness, bravery and stoicism.

Men of Georgian Britain (1714-1830), for example, openly displayed their emotions, which was then socially constructed as virtuous and a sign of wisdom, and men were also encouraged to be self-reflective of their inner psyche (Haggett, 2014). Unfortunately, since the Victorian period (1837-1901) a

socio-cultural shift unfolded that led to the present day stigmatisation of male emotionality where men are taught to embody an image of power, courage and control which ties in with the construct of '*manliness*' (Haggett, 2014). This, in turn, acts as a therapeutic interfering barrier as men are less likely to engage in mental health services as their psychological ailments are more likely to be expressed and treated as somatic symptoms (i.e.: being referred for a BMI ≥ 30 while negating the psychological implications). Seager and Wilkins (2014) raise very pertinent points regarding the need for mental health services within the UK to be more tailored to men who conform to a traditional masculine norm in order to engage them in psychological treatments and not put their lives at risk (i.e.: men represent the majority of suicides).

Morison, Trigeorgis and John (2014) argued that the provision and management of psychological services within the NHS as well as the psychotherapeutic approaches (psychodynamic, cognitive-behavioural, humanistic and systemic therapy) offered are inherently *feminised,* which might be off putting for men, especially if they subscribe to a traditional masculine norm of self-reliance and emotional control. In fact, the National Mental Health Developmental Unit (NMHDU), in partnership with the Men's Health Forum (centre of excellence for men's health policy and practice) and Mind (leading mental health charity in the UK), commissioned a report entitled "*Delivering Male*" to address issues of good practice around male mental health as it's an area that has been recognised to be under-researched. Indeed, men have been known to lead unhealthier lifestyles than their female counterparts, which intrinsically ties in with a graver impact on their mental as well as their physical health (Wilkins & Kemple, 2011).

So what can be done to change and tailor psychological services for men so that they are more accommodating to men's mental health needs? Kingerlee, Precious, Sullivan and Barry (2014) discuss the design and implementation of male-specific psychological services and local schemes that have been delivered throughout the UK to deliberately try to break away from the dominant social discourse depicting men as overtly avoiding any form of help-seeking

behaviour as it's seen as a social threat that places their masculinity in peril. Addis and Mahalik (2003) propose the introduction of contextual factors in the help-seeking environment, such as increasing opportunities for reciprocity in group settings, ameliorating the perception of normativeness of psychological distress in men as well as understanding ego-central themes related to masculine socialisation.

Whether or not male outreach services and mentorship programmes, such as local mental health '*ambassadors*', are the way forward, there is an increasing recognition that gender awareness and sensitivity training in the NHS and in psychology training courses are greatly needed (Wilkins & Kemple, 2011; Morison, Trigeorgis & John, 2014). More recently, there has been a proposal to devise a Male Psychology Section within the BPS to address this gender gap in terms of researching and gaining a better understanding into the mental health needs of men, even though historically psychology was initially male dominated and women were seen as the disenfranchised gender (Mallows, 2013). Mahalik, Good and Englar-Carlson (2003) have devised an array of '*masculine scripts'* (e.g.: '*winner*', '*independent*', '*tough-guy'*, '*strong and silent'* scripts, etc.) that clinicians can recognise and use in their therapeutic practice when engaging with men's '*masculine-selves*' in order to create more flexibility in enacting them. Understanding masculine socialisation, which is influenced by cultural, racial, political, economic and historical drivers, is imperative in order to foster an appropriate milieu to facilitate help-seeking behaviour in men (Englar-Carlson, 2006).

In terms of bariatric psychology provisions, the same phenomenon is apparent whereby men are under-represented in clinical settings and almost invisible in the research arena. Newhook, Gregory and Twells (2015) conducted a qualitative study in Newfoundland and Labrador in Canada critically examining the gender meanings in weight loss surgery (WLS). They queried the gender imbalance present in weight loss interventions whereby as many as 80% of individuals who undergo bariatric surgery are women, yet gender remains unspoken of in the WLS literature (Newhook et al., 2015). Newhoook et al. (2015) found that the men who partook in their study (6 out of 27 participants),

did not refer to their physical selves as ‘fat’, but described themselves as ‘big guys’ which felt much more socially acceptable and in line with the masculine discourse of big men portrayed as tough, robust and strong (Monaghan, 2008). Men are taught to distance themselves from emotional aspects of self-care such as talking therapy which is categorised as a feminine behaviour and explains why the majority of WLS support groups are dominated by women which was experienced as off-putting for male patients wishing to engage in them to discuss their weight-loss issues (Courtenay, 2000; Newhook et al., 2015). Farinholt, Carr, Chang and Ali (2013) devised a quantitative population-based study to shed light on why bariatric operations are disproportionately female and found that although men comprised less than 20% of patients, they tended to be older, with more complicated comorbidities, which reinforces the need to conduct further research to investigate the barriers of treatment in this specific client-group.

4.9.3 Psychological conceptualisation of the findings

Based on the superordinate and cluster themes that transpired from the analysis, one way we can conceptualise the lived experiences of the men who partook in this research study is by employing a compassionate-focused as well as self-compassion therapeutic stance, as the clinical themes of *shame* and *high self-criticism* were very apparent in their narratives. A compassion-focused case formulation would comprise of looking at the client’s presenting problem, current context, background and historical influences, key threats and resulting fears (e.g.: abandonment, shame, rejection, etc.), safety strategies and unintended consequences (see Tirch, Schoendorff & Silverstein, 2014).

Compassion-focused therapy (CFT) is a “third wave” contextual cognitive-behavioural therapy (CBT) approach that was developed by Professor Paul Gilbert, of the University of Derby. and has been flourishing in its application in the past 15 years (Gilbert & Procter, 2006). CFT is an integrated multimodal approach originating from evolutionary, social, developmental psychology, neuroscience models of affect regulation and Buddhist psychology (Gilbert,

2009). In CFT, the therapist works with the client on developing a compassionate mind training and applying the skills and attributes of compassion as well as transforming the self-attacking feelings of shame into feelings of self-compassion and self-soothing (Gilbert, 2009). For example, all the men in this study described varying degrees of internal and external evaluations of body shame which can be broken down into three key components: (1) "self as seen and judged by others, (2) self as object and (3) self as judged by others" (Gilbert & Miles, 2002, p.17).

Compassion means to be able to be touched by the suffering of others, offering a non-judgemental understanding, and being open and aware of other's pain and not disconnecting from it (Neff, 2003). Neurophysiological research of emotion stipulates that there exist three types of affect regulation systems: (1) the threat and self-protection system, (2) the incentive and resource seeking system and (3) the soothing and contentment system (Gilbert, 2010). We are primed evolutionarily as human beings for the activation of threat, which can either be triggered internally by cognitive and affective content, or externally by something that happens to us, which makes us respond either by withdrawing or by reverting to our safety seeking behaviour (Goss, 2011). Among some of the themes that arose from the men in this study, activation of the threat system could be in response to a trauma experience, loss, adverse home environment, body shame, internal embodied experiences, social stigma and death anxiety.

The function of the threat and self-protection system is to give us cues of potential threats which will lead us to experience feelings of anxiety, anger and disgust, and activate our sympathetic nervous system into the fight, flight, freeze or submission response (Gilbert, 2010). As therapists, we explore the client's early life and gain a deeper understanding of the safety strategy responses put in place and seek to explain from an evolutionary perspective the function and origins of safety behaviours in order to de-shame and validate their experiences (Gilbert, 2009). Clients are told that "*it is not their fault*" that they have developed their safety strategies (e.g.: as the men in this study turned to food in order to appease difficult feelings) and are taught to move away from

their critical and condemning thoughts and feelings, and to take responsibility for learning how to deal with them and be more acceptant (Gilbert, 2009). CFT is about de-pathologising and de-labelling the client and seeking to gain an idiosyncratic understanding of their lived experiences and current coping strategies.

This brings us to the construct of self-compassion, which has been defined and broken down by Kristin Neff (2011) into three main components which are mutually interactive: "(1) self-kindness versus self-judgement, (2) feelings of common humanity versus isolation and (3) mindfulness versus over-identification" (p.4). Self-kindness means being caring, and understanding rather than being harshly critical and judgemental of ourselves (Neff, 2011). Common humanity involves recognising that we all are human and make mistakes, and that this connects us to the shared human condition (Neff, 2009). Mindfulness involves being aware in the present moment in a non-judgemental way so that one neither ignores nor ruminates about an aspect of themselves that they dislike (Neff, 2011). Mindfulness embraces a meta-perspective on our experience so that it can be evaluated with greater clarity and objectivity and we can take the time to process our pain instead of gearing into a solution-focused mode (Neff, 2009). This can be greatly beneficial to introduce to the men in this study who display a deep sense of shame and criticism towards their relationship with food and physical embodiment.

We need to accept that as human beings we are imperfect and that when we ruminate about our flaws and inadequacies, we are shutting ourselves from the world and instilling feelings of disconnection (Neff, 2011). Individuals who have higher levels of self-compassion have been associated with emotional intelligence and wisdom, social connectedness, curiosity, positive affect are mastery goal driven, and are less fearful of failure, have less anxiety and depressive symptoms, (Neff, 2009). Lastly, people with higher self-compassion have been shown to have greater self-regulatory skills and have better mental and physical health (Terry & Leary, 2011).

4.10 Concluding thoughts

The preponderance of the literature regarding obesity and fat embodiment has been put forth by feminist scholars who adapted a stance that body shame, stigmatisation, discrimination, pressure to strive towards an unattainable beauty ideal is primarily rooted in the realm of the feminine (Chernin, 1985; Lawrence, 1987; Wolf, 1990; Orbach, 2006). However, the pendulum has shifted since the post-World-War-II era where patriarchal societal norms put graver criticism and pressure on women's bodies that were deemed 'too fat' to lose weight (Gilman, 2010).

On the contrary, this research has demonstrated that men, just like women, are not immune to the biomedical rhetoric of what constitutes a 'sick' or 'at risk' body in a contemporary Western culture where *fatness* is frequently equated with laziness, immorality, disgust and gluttony (Monaghan, 2008). As Lupton (2013) states: "fat men are seen as effeminate rather than masculine in their soft roundness and lack of apparent virility" (p.63). However, due to men's early onwards gender role socialisation that has moulded their '*traditional masculine-selves'*, men have been taught to hide their vulnerabilities and emotional lives, which is why there is an urgent need to devise gender-specific psychological treatment to enable men to access mental health services and not remain the silent and forgotten gender.

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Contents of Appendices

A. Invitation to take part
B. Information sheet
C. Consent form
D. Demographic sheet
E. Interview schedule
F. Debrief sheet
G. Participant information and reflective notes
H. Copy of the ethics form
I. Exemplar: stage two and three of the analysis process
J. Exemplar: stage four of the analysis process
K. Exemplar: stage six of the analysis process
L. Appearance of themes for each participants

Appendix A: Invitation to take part

Your chance to help!

CITY UNIVERSITY LONDON

OBESE MEN'S RELATIONSHIP WITH FOOD PRIOR TO WEIGHT LOSS SURGERY

What is this study about?

There is very little research done on obese men's experience with food who are placed on a waiting list for weight loss surgery. This would be a chance for you to have your voice heard in a safe, confidential environment and will help us gain further knowledge and understanding on how best to support men psychologically prior to undergoing bariatric surgery. This would also enable you to empower others who share a similar story.

I would like to hear from you if:

- You are male
- You are on a waiting list for bariatric surgery
- You are 18 years or older
- You are fluent in English
- You have a Body Mass Index (BMI) of 35 or above and have a another serious health condition that could improve if you lost weight and/or
- You have a Body Mass Index (BMI) of 40 or above

What would participation entail?

- A face- to- face semi-structured interview with the Researcher of 60 minutes that will be audio recorded. It will take place at a location of your convenience (a community or university setting close to you).
- You will be compensated £15 for your participation.

About this research

This research is being conducted by Anna Abramowski, Trainee Counselling Psychologist at City University. This project is conducted as part of the Professional Doctorate in Counselling Psychology qualification and is supervised by Dr Fran Smith, C.Psychol, Registered Psychologist and has received ethical clearance.

Contact me



If you are interested in participating please contact Anna Abramowski.
Email: Anna.Abramowski.1@city.ac.uk
Mobile: 07515 026 177

I look forward to hearing from you!

Appendix B: Participant Information Sheet

Title of research study:

Obese men's relationship with food prior to weight loss surgery

You are being invited to take part in a research study. Before you decide to take part it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. If there is anything that is not clear or if you have any further questions, please contact the Researcher, Anna Abramowski at XXX. If you decide to take part in the study you will be given a copy of this information sheet to keep and will be asked to sign a consent form.

What is the purpose of the study?

This study is conducted by Anna Abramowski, Trainee Counselling Psychologist at City University. This research study is conducted as part of the Professional Doctorate in Counselling Psychology qualification. The study is being conducted as there is little research done exploring obese men's experience with food prior to having weight loss surgery. This would be a chance for you to have your voice heard in a safe, confidential environment and will help us gain further knowledge and understanding on how best to support men psychologically prior to undergoing bariatric surgery. This would also enable you to empower others who share a similar story.

Why have I been invited?

We are inviting all male participants who are over 18 years old, are fluent in English, have a BMI of 35 or more and are on a waiting list for weight loss surgery.

Do I have to take part?

Your participation is voluntary and it is up to you to decide whether or not to join the study. If you agree to take part, we will then ask you to sign a consent form. You are free to withdraw at any time without reason or penalty.

What will happen to me if I take part?

If you decide to take part, you will have a telephone conversation with the researcher to discuss the research and have the opportunity to clarify any questions you might have. Consequently, we will arrange a convenient time and place for the interview to take place and you will meet the researcher for a face-to-face interview of 60-90 minutes about your experience with food prior to having weight loss surgery. The interviews will be audio-recorded and take place in a private and quiet room at City University. If you are unable to travel to City University, alternative arrangements can be made with the researcher. Remember there are no right or wrong answers and the researcher is interested in your experience from your point of view. After the interview, you will have an opportunity to ask any questions about the research.

What are the possible benefits of taking part?

There is a scarcity of studies that have focused on obese men's relationship with food prior to undergoing weight loss surgery. This would be a chance to enable us to gain further understanding and knowledge on how best to support men psychologically prior to undergoing bariatric surgery. Additionally, you will receive £15 for your participation.

What are the possible disadvantages and risks of taking part?

The disadvantages and risks of taking part in this research study are considered to be minimal. In the unlikely case that you feel distressed (e.g. feeling tearful, uneasy, etc) talking about your experience, you will not be required to answer any questions that you feel uncomfortable with. Additionally, you can contact the researcher, Anna Abramowski, during or following your participation in the study with any of your concerns (contact details are provided at the end of this

information sheet). If you are unable to contact the researcher, please contact your GP.

Confidentiality

In line with normal procedure, the researcher will keep all of the information related to this research project for a maximum of five years and then it will be destroyed. All information collected about you during the course of the research study will be kept confidential and will be anonymised in accordance with the 1998 Data Protection Act and the researcher will abide by the code of ethics outlined by the British Psychological Society. All the material will be stored on an encrypted, password protected computer. Consent forms and demographic information, will be kept in a locked cabinet in the researcher's office. Only the researcher will have access to personal data and information relating to this study.

Will my GP be informed?

Details from your GP will be taken prior to the interview. However, we will not inform your GP of your participation in the research study unless the researcher deems that you are at risk of harming yourself or others.

What if there is a problem?

Any complaint or question about any aspects of the research study can be addressed to the researcher, Anna Abramowski or research supervisor, Dr Fran Smith. Furthermore, City University provides insurance and indemnity to meet the potential legal liability for harm to participants arising from the running and design of this research project. If there is an aspect of the study, which concerns you, you can make a complaint. City University has established a complaints procedure through the Secretary of the Research Ethics need Committee. To complain about the study, you can phone XXX

Alternatively, you could write to the Secretary at:

Anna Ramberg
Secretary to Senate Ethical Committee
Research and International Development Office
City University
Northampton Square
London, EC1V 0HB

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

You are free to withdraw from this research study and at any time without reason or penalty.

What will happen to the results of the research study?

Results from the interviews will be analysed, written up as part of the thesis portfolio and are intended to be published. You will not be identified in any report or publication and all the quotes taken from the interviews will be anonymised.

Who has reviewed the study?

The study has been reviewed by the Research Supervisor, Dr Fran Smith, and has been approved by the City University Ethics Board.

Further information and contact details:

Researcher:
Anna Abramowski
Trainee Counselling Psychologist
City University
Social Sciences Building
Northampton Square
London
EC1V 0HB
Email: XXX
Tel: XXX

Research supervisor:
Dr Fran Smith

Counselling Psychologist
City University
Social Sciences Building
Northampton Square
London
EC1V 0HB
Email: XXX

Thank you for taking the time to read this information sheet and for your consideration in taking part in this study

1 copy for the Participant

Appendix C: Consent form

Obese men's relationship with food prior to weight loss surgery

surgery"

1. I confirm that I have read and understand the participant information sheet for the above research. I have had the opportunity to consider the information and ask any questions for clarification. □

2. I understand that my participation is voluntary, that I can choose not to participate in part or all of the project and that I can withdraw at any stage of the project without being penalised or disadvantaged in any way. □

3. I understand that this interview will be audio-recorded and, following the interview, it will be written up. □

4. I understand that this interview is part of a doctorate research project and that anonymous quotes from my interview may be published in a thesis or article. □

5. I understand that any information provided will be confidential and that all material relating to the research will be stored securely, anonymously on a computer and will be destroyed after 5 years. □

6. I have provided the researcher with the details of my GP. □

7. I confirm that I have received £15 for my participation □

8. I agree to participate in this research. □

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Name of participant Date Signature

---------- ---------- ----------

Name of Researcher Date Signature

1 copy for the Participant and 1 copy for the Researcher

Appendix D: Demographic sheet

Name: …….

Address: …….....

Date of birth: ……

Occupation: ……

Family status: (please circle):

Married / living with partner/living alone/ living with relatives / friends

Ethnic background (please circle):

White
British
Irish
Any other white background

Mixed
White & Black Caribbean
White & Black African
White & Asian
Any other mixed background

Black or Black British
Caribbean
African
Any other Black background

Asian or British Asian
Indian
Pakistani
Bangladeshi
Any other Asian background

Any other ethnic group (please state):
……

I do not wish to answer this question

GP Details:

Name of GP: …….. **GP Phone number:** ……

Appendix E: Debrief sheet

Thank you for taking part in this study. Your contribution has been valuable and appreciated. The purpose of this study is to investigate obese men's relationship with food prior to weight loss surgery. This would enable us to gain further understanding and knowledge on how best to support men psychologically prior to undergoing bariatric surgery.

If you have any questions regarding the study, please feel free to contact the Researcher, Anna Abramowski, at XXX or you can leave a message on XXX and she will call you back. You can also contact the Researcher Supervisor of this study, Dr Fran Smith at XXX.

If you would like additional support following the study, please contact the following:

1. BOSPA (British Obesity Surgery Patient Association)
   http://www.bospa.org/
2. OWLSS (Obesity Weight Loss Surgery Support)
   Tel: 0794801744 http://www.owlss.org.uk/
3. WLSinfo (Weight Loss Surgery Info)
   http://www.wlsinfo.org.uk/
4. Big Matters
   http://www.bigmatters.co.uk/
5. Weight Concern
   Tel: 0207 679 6639 http://www.bigmatters.co.uk/
6. BEAT (Beating Eating Disorders)
   Tel: 0845 634 1414 http://www.b-eat.co.uk/
7. MGEDT (Men get eating disorders too)
   http://mengetedstoo.co.uk/
8. The Samaritans (they are available 24 hours a day and provide confidential emotional support for people experiencing feelings of distress, despair or suicidal thoughts).

Tel: 08457 90 90 90 www.samaritans.org.uk

9. If you feel so distressed and are experiencing suicidal ideation and are considering harming yourself or others following the study, please go call your GP surgery and ask for an emergency appointment. Alternatively call 999 or go to the Accident and Emergency service of your nearest hospital.

Appendix F: Interview schedule

10. Can you describe the role that food had for you growing up?

Prompts
-Did you eat as a family?
-Who prepared the meals?

11. Can you tell me about your relationship with food?

Prompts
- When you think of food, what does it make you think of?
-When you are eating food, what feelings does it evoke?
-When you are preparing food, what thoughts, memories cross your mind?

12. When do you eat?

Prompts
-Any particular times, moments?
-When you experience different emotions? (E.g.: sadness, anger, loneliness, joy, happiness, boredom, frustration, excitement, rejection, shame, etc.)

13. Can you please describe what food means to you?

Prompts
-To your self-identity?
-To your social interaction?
-To your cultural identity?

14. Have you changed the way you eat over time?

Prompts
-When you left home?
-Did you ever go on diets? If so, could you tell me more?

15. What made you consider having bariatric surgery?

Prompts

-Who advised you?
-What is your understanding?

16. What changes do you hope the surgery will have?

Prompts
-What are your expectations?

Finally, one last question:

17. **If food could speak back to you what would it say?**

18. **Is there anything you would like to add?**

Appendix G: Participant information and reflective notes

William

William was very warm, hospitable and transparent about his current, past and aspired relationship with food following bariatric surgery. William described a happy family time around food during his childhood. However, he experienced his father as the aggressor, as the man who had betrayed his mother, and felt frightened of him until he was physically tough enough to defend himself. William spoke very candidly about food as being "*his lover, his friend, his companion*" and I was struck when he used the analogy of divorce to describe his hopes for a "*breakup*" from his full relationship and aspired future-self post-operatively. William discussed wanting to provide the best for his children and a wish to repair for what he did not have in his own childhood, most noticeably, a male role model figure. He spoke about feeling deprived of certain foods as a child and making sure that his children never experience the same thing. William sought meaning in terms of his weight difficulties and blamed his parents and familial conflicts for being one of the precipitating factors that lead him to turn to food for affective comfort.

Throughout the interview, William was very gregarious, used humour to deflect from more painful feelings of shame and blame. I remember leaving the interview feeling uncertain about having oscillated at times from the researcher's stance to a more therapeutic/practitioner's role with some of my follow-up prompts and whether I had stayed true to the phenomenological interview and method of inquiry.

Adam

Adam was chirpy, bubbly, agreeable and laughing a lot through the interview, perhaps as a means of defense.

Adam professed that after having spoken to a Psychologist prior to our interview as part of the pre-operative surgical psychological assessment, he realised that he used food as a means of rebellion and depicts his ex-wife as a "*feeder*". He spoke about his struggle of losing weight ever since and that he has tried and failed "*every diet under the sun".* Adam inquired about bariatric surgery four years ago and conceptualised having the gastric band as: "*have this fitted and you will be slim for life",* but later on was advised by his surgeon to elect to have a gastric bypass instead. What struck me in the interview was when Adam told me: "*I have got you to loose, I am carrying you in my stomach*". I only reflected upon the meaning of his words as we parted ways, but it felt like a merged sense of embodiment or that I was engulfed in his corporeality. It also made me much more aware of my own physicality as playing a crucial role in our encounter as he must have taken notice of my body and given me an approximate weight which symbolised his target and aspired weight loss.

Peter

Peter spoke about being very close to his grandfather whom he considered like a father figure. He discussed a childhood traumatic event that made him tearful during the interview. He also spoke about being bullied as a child in school due to his physicality, and he laughed when he reminisced about those memories. Peter suffered from a heart attack, which triggered him to change his diet regimen, and he lost a lot of weight. However, later on he lost his mother and experienced a lot of environmental stress (financial, professional and social), which lead him to turn to food to self-soothe. Peter is on the waiting list to have a gastric band and wishes to look like a 'normal' person, gain more confidence and regulate his hunger pangs through the bariatric procedure. What struck me during the interview was when Peter described himself as a happy person from the outside, but inside there is a lot of sadness. He compared himself to a comedian wearing a mask. This made me reflect further on how I had experienced him as he was very talkative, sociable, agreeable, cheerful during the interview, although at times, tears rolled down his cheeks and a bit of his mask would come down. Peter was socialised to put on a '*hard man'* image and be strong for his girls and also taught that men should not cry. I was honoured

by Peter's interview as I felt that he was capable of being very transparent, open and willing to be vulnerable and share a morsel of his private self.

Jack

Jack spoke about being the youngest of four boys and that food would always get stolen off his plate by his siblings if he did not eat fast enough. Food symbolised love as his mother made it from scratch. Jack said there was a lot of conflict at home and he started working from a very young age to gain financial independence. Jack described himself as a "*big fat slob*" in terms of his self-identity, which saddened me because I could feel how deeply shamed he was behind his tough persona. He said that food meant happiness, euphoria, reward and was associated with his greatest memories. Jack spoke rapidly during the interview, was buoyant, chirpy and later on, when asked about what made him consider weight loss surgery, he got tearful and openly said that suicide and feeling embarrassed about his weight led him to consider it. I was relieved that he was no longer experiencing suicidal feelings, but also felt that my role in that instant vacillated back towards the therapeutic stance, and I made sure to go over the debriefing form and highlighted the fact that he should call the Samaritans, 999 or go to A&E should his suicidal feelings escalate. Jack discussed how WLS has become part of our social culture. However, he is fearful of the procedure, refuses any help from anyone and said that he does not want people seeing lying like a "*coward*" or falling over him when he ill. I felt a deep sense of compassion for him as I felt that underneath his strong veneer lay a great sense of trepidation and uncertainty about his future and anticipated changed relationship with food, and I felt like reassuring him and letting him know that he was going to be alright.

Ross

Ross spoke a lot about his feeling of body shame, of feeling noticeable and like a social outcast due to his larger size and needing to buy clothes in specialists' shops. Ross explained that his physical difficulties (i.e.: not being to keep the same pace as his friends while walking), prompted him to take effective action and change his physical stamina. Thus, he started to research WLS options.

Ross consciously avoids mirrors and does not have any in his home and said that his dating profile is on old picture of himself because that is how he sees himself in his mind's eyes. Ross has a low body image, but also a split sense between his physical and intellectual selves. He spoke about wanting to be accepted, noticed and seen for himself and not his physicality. He also spoke about external factors that might have contributed to his weight pain throughout the years such as unknown medical ailments, genetic and socio-cultural facets (such as the cost-effectiveness of foods in poorer nutritional content) that might have exacerbated his long-standing struggle with his weight. Ross felt saddened because he always took personal responsibility for his weight and has always been very critical of himself. Interestingly, Ross also spoke about feeling self-conscious as a man if he eats healthily and that he was socialised to think of men being able to eat anything and still function and be virile, and that food is seen as fuel. Ross engaged in a food competition of who can eat the largest piece of meat which would symbolise who is the alpha male in the social group. Ross said that he felt the change in recent years in terms of greater emphasis being placed on male body image. However, the fact that most men don't care as much about their weight and health, he believed, was attributed to the "*macho bit of society*". Throughout our interview, Ross was well-spoken and humorous, and I could tell that he had done a lot of research into exploring all the various bariatric procedures and keeping himself informed by attending conferences and seeking as much information as he could.

Alfred

Alfred used to work as an accountant and described experiencing long-standing weight difficulty, which he viewed as a physical disability for which he was bullied at school because of his visible difference. Alfred spoke about being brought up in a patriarchal family where he was told that he needed to finish his plate because of his parents' war experience, he believes. He mentioned that growing up he experienced less emphasis socio-culturally on weight and shape than he does now because it is constantly in the spotlight and in every media outlet. Alfred has been in limbo for numerous years as he is waiting for both knee surgery and bariatric surgery and the constant physical pain greatly affects his mobility which acts as a vicious circle, as the lack of mobility prevents him

from exercising, which would help him reduce his weight. Furthermore, his present feelings of *stuckness* accentuate his feelings of anxiety, frustration and living with uncertainty, which affect his mood. Alfred recounted that he felt lonely, however, he was very active within his local support group and was extremely helpful, putting me in touch with his dietician who co-facilitates the support groups. He also sent me his past food diaries that he had completed in excel sheets after the interview. I told him this was not necessary and would not be included in the research study, but his enthusiasm, energy and kindness really moved me. Alfred is a firm believer in the importance of attending monthly pre and post-bariatric support groups and acting as a leader and exemplary member in his local group.

John

John used to work with disabled children, but he had an accident that rendered him disabled. He spoke about being bullied as a child and that he would turn to food for comfort as a result of the bullying. Currently, he fears that the patterns are repeating themselves as his son is being bullied as well, and John wants to protect him from the same damaging repercussions. He described his eating as akin to an addiction, and he is trying to challenge himself emotionally. He said that he starting eating mindfully in order to recognise his satiety levels and when he feels full. John spoke about his physical pain that is excruciating and makes him feel dependent, withdrawn, isolated and low in affect. Overall, I experienced John as gentle, sensitive and unguarded, with a calm mannerism during the interview.

Mark

Mark said that he has been on a waiting list for bariatric surgery for numerous years and unfortunately had been removed from the list on two occasions as he had missed several appointments within the bariatric team due to personal circumstances. Mark described being a difficult, fussy eater as a child and that feeding him was akin to World War III for his mother who was anxious and enjoyed a regimented eating pattern at home. Later, when he travelled to the United States, he developed a love of food and a different rapport and

relationship with it as he experienced food as the land of opportunity and choice and described feeling amazed by the portion size and like a "*kid in a candy land*". From then onwards, he said that food was embedded in his professional, social and self-identity and he started becoming a "*foodie*". When I met Mark his mobility was severely reduced, and he explained that he has a carer who comes daily to help him shower and with his daily chores. He said that he feels at times almost as a prisoner of his home and socially isolated. He showed me pictures of his old self and was mourning his old life as he no longer leaves the house much, and his family are concerned about his physical well-being. During the interview, I experienced Mark as a very passionate, proud and lonely man. At times throughout our meeting, he struggled with his breathing and got very sleepy (he told me that he suffered from long-standing sleep apnoea).

Appendix H: Copy of ethics form

Ethics Release Form for Student Research Projects

All students planning to undertake any research activity in the School of Arts and Social Sciences are required to complete this Ethics Release Form and to submit it to their Research Supervisor, **together with their research proposal clearly stating aims and methodology,** prior to commencing their research work. If you are proposing multiple studies within your research project, you are required to submit a separate ethical release form for each study.

This form should be completed in the context of the following information:

- An understanding of ethical considerations is central to planning and conducting research.
- Approval to carry out research by the Department or the Schools does not exempt you from Ethics Committee approval from institutions within which you may be planning to conduct the research, e.g.: Hospitals, NHS Trusts, HM Prisons Service, etc.
- The published ethical guidelines of the British Psychological Society (2009) Guidelines for minimum standards of ethical approval in psychological research (BPS: Leicester) should be referred to when planning your research.
- **Students are not permitted to begin their research work until approval has been received and this form has been signed by Research Supervisor and the Department's Ethics Representative.**

Section A: To be completed by the student

Please indicate the degree that the proposed research project pertains to:

BSc M.Phil M.Sc **D.Psych** n/a

Please answer all of the following questions, circling yes or no where appropriate:

1. Title of project

" Obese men's relationship with food prior to weight loss surgery"

2. Name of student researcher (please include contact address and telephone number)

Anna Abramowski

[redacted]

3. Name of research supervisor

Dr Fran Smith

4. Is a research proposal appended to this ethics release form? **Yes** No

5. Does the research involve the use of human subjects/participants? **Yes** No

If yes,

a. Approximately how many are planned to be involved? 10 participants

b. How will you recruit them?

I will recruit my participants by placing a web advertisement on the BEAT (Beating Eating Disorders) website and will send the flyer and participant information sheet to BOSPA (British Obesity Surgery Patient Association) that will be disseminated to their team leaders around the country. If by May 2013 I have recruited five or less participants then I will send my NHS Ethics form (proportionate review) to an NHS Trust.

c. What are your recruitment criteria?
(Please append your recruitment material/advertisement/flyer)

Please refer to Appendix A for my recruitments flyer/web advertisement.

d. Will the research involve the participation of minors (under 18 years of age) or vulnerable adults or those unable to give informed consent? **Yes** No

d1. If yes, will signed parental/carer consent be obtained? Yes **No**

d2. If yes, has a CRB check been obtained? **Yes** No
(Please append a copy of your CRB check)

6. What will be required of each subject/participant (e.g. time commitment, task/activity)? (If *psychometric instruments are to be employed, please state who will be supervising their use and their relevant qualification).*

Research participants will meet the researcher for a 60-90 minutes face-to-face semi-structured interview that will take place at a location of their convenience. The interviews will take place either in a Community Centre or a University setting. There will not be any psychometric measurements used for this project. They will be asked questions about their experience with food.

7. Is there any risk of physical or psychological harm to the subjects/participants? **Yes** No

yes,

a. Please detail the possible harm?

There is a minimal possibility of harm to the participants in taking part in this research study. However, the possible benefits to the targeted population outweigh the risks and the probability of harm is relatively low.

b. How can this be justified?
Although the risks are deemed to be low, it is possible that during or following the interview, participants might feel distressed and/or vulnerable as some questions might have elicited stronger emotions than others.

c. What precautions are you taking to address the risks posed?

If at any time of the interview the participants feels distressed they have the right to withdraw without given any explanation. Furthermore, I will give them a debrief sheet indicating support groups, organisations and services that they can access.

8. Will all subjects/participants and/or their parents/carers receive an information sheet describing the aims, procedure and possible risks of the research, as well as providing researcher and supervisor contact details?

Yes No

(Please append the information sheet which should be written in terms which are accessible to your subjects/participants and/or their parents/carers)

9. Will any person's treatment/care be in any way be compromised if they choose not to participate in the research?

Yes **No**

10. Will all subjects/participants be required to sign a consent form, stating that they fully understand the purpose, procedure and possible risks of the research?

Yes No

If no, please justify

If yes please append the informed consent form which should be written in terms which are accessible to your subjects/participants and/or their parents/carers)

11. What records will you be keeping of your subjects/participants? (e.g. research notes, computer records, tape/video recordings)?

I will be keeping the audio-recording of the interviews, the transcripts, the GP details and some basic demographic information from my research participants. I will also be keeping my reflexive journal notes. Please refer to Appendix D for the Demographic Sheet.

12. What provision will there be for the safe-keeping of these records?

All the material will be stored on an encrypted, password protected computer. Consents will be kept in a locked cabinet in the researcher's office. Only the personal researcher will have access to personal data and information relating to this study.

13. What will happen to the records at the end of the project?

In line with normal procedure, the data (audio-recording, transcripts, consent forms, demographic information and reflexive diary) will only be used for this study and will be destroyed after five years after its completion

14. How will you protect the anonymity of the subjects/participants?

Anonymity will be ensured by using a pseudonym for each participant and changing any identifiable information. Transcripts will not be appended to the thesis if they are highly sensitive. Extracts that could possibly identity participants, as well as particularly sensitive extracts, will not be appended. A full set would be available upon the examiner's request.

15. What provision for post research de-brief or psychological support will be available should subjects/participants require?

Please refer to Appendix D for the debrief material.

(Please append any de-brief information sheets or resource lists detailing possible support options)

If you have circled an item in **underlined bold** print or wish to provide additional details of the research please provide further explanation here:

Signature of student researcher: Anna Abramowski Date: 3rd of March 2013

CHECKLIST: the following forms should be appended unless justified otherwise

Research Proposal
Recruitment Material
Information Sheet
Consent Form
De-brief Information

Section B: Risks to the Researcher

1. Is there any risk of physical or psychological harm to yourself? **Yes** **No**

If yes,

a. Please detail possible harm?

The risks are deemed to be low, but it is possible that during the course of the research project I might find some of the material collected more emotionally challenging at times and hence it could affect me psychologically. I don't anticipate any physical risk in this research project.

b. How can this be justified?

I might feel upset by some of the narratives that I collect and/or emotionally drawn to others. This would unable me to bracket my own internal processes while conducting the research. I don't anticipate any physical harm.

c. What precautions are to be taken to address the risks posed?

As a safety precaution, if I feel at any stage of the process of my research that I am experiencing psychological distress than I will discuss these matters with my supervisor and personal therapist and reflect on these feelings. As a physical safety precaution, I will use a sealed envelope technique and my supervisor will know where I will be meeting my research participant.

Section C: To be completed by the research supervisor

(Please pay particular attention to any suggested research activity involving minors or vulnerable adults. Approval requires a currently valid CRB check to be appended to this form. If in any doubt, please refer to the Research Committee.)

Please mark the appropriate box below:

Ethical approval granted

Refer to the Department's Research and Ethics Committee

Refer to the School's Research and Ethics Committee

Signature ---------- ---------- Date 11.03.13

Section D: To be completed by the 2nd Departmental staff member (Please read this ethics release form fully and pay particular attention to any answers on the form where ***underlined bold*** *items have been circled and any relevant appendices.)*

I agree with the decision of the research supervisor as indicated above

Signature ---------- Date 8/3/13

15

Appendix I: from stage two and three of the analysis process

Emergent themes	**Original Transcript #1**	**Exploratory comments** Normal text – descriptive comments *Italic text – linguistic comments* Underlined text – conceptual comments
Desire for rupture in his relationship Analogy to food as marriage and yearn for a separation	P: Yeah obviously my love of food I had for 25 years. You know I have loved food so much. But like any relationship after 25 years you get sick of it. Whether you are married for 25 years and you wake up every morning and you look at the same person, it's the same thing. I don't want that.	Love of food for 25 years. *"Loved food so much"- intensity and duration of the relationship.* Comparison to marriage and that with time you get "sick of it". Want a break-up/a divorce/separation of the relationship. Food as a lover.
	R: You can still love food.	Did I pick up on this finality? Wanting to salvage a relationship and not perceive it as all black or white? (slipping into practitioner role and fleeting from researcher's role)
Desire for breakup and	P: Exactly, but I got to break away from my full relationship I have with	Break away from "full relationship", wanting a

rupture Wanting to be accepted in society Incongruence between social-self and internal/true self. Wishing to end stigma Discrimination/racism Different construction of meaning depending on	food and now I have to have the mindset to say there is us now and we are going to separate. "You are here, that's fine. I know you are there. But I am going to go this way. I am going to go to the gym. I want to go to swimming. I want to look at nice clothes and also be accepted. It's a big thing. You know being accepted within the society. I am a very bubbly character. I am very chirpy, I talk away to everybody, anybody. That is my business taxi driving and obviously you have to talk. But it's the thought that everybody knows me as "big Tom" you know, the cab driver, the "large man". I don't want that stigma no more. I want to able to say I am a healthy man, you know? R: Do people ever say so…? R: Yeah, you know I take it as a joke. If you are a friend of mine and you call me "fat", I know that's a joke. If I don't know you and you call me "fat" then we have a problem. Simple as that!	separation. Acknowledgement that food is present and recognition. Dichotomy, split personalities, dual identities (the athletic self who is accepted by society and can buy nice clothes and the "big" self who everyone knows as the "large bubbly, chirpy character). Wanting to be accepted and seen as a "health man" and no longer experience stigma. <u>Anthropomorphism of the relationship with food</u>. Implication that the nature of his work necessitates that he is talkative and has these characteristics. Depending on if the critic is known versus unknown, he will construe the meaning differently. Calling him "fat" would equate with racism/religious discrimination and he

the critic	I don't go out taking the mick out of you, so don't feel you have the right to take the mick out of me. Because as I see that, as it is as good as racism, it is as good as religious discrimination, and to me that is the same as to say "I am big", "I made myself big". But then I could go up to someone and say: "you're ugly".	also indicates that the implied name-calling has an undertone of responsibility ("I made myself big"). *Getting angry with his tone of voice* Mirroring to others what he deems as equivalent hurtful comments. His defence mechanism
	I: Did you ever have any experiences with people you don't know?	
Care-free to responsibility. Different mode of defence-from physical to verbal Stating his physical prowess.	R: Yeah absolutely! I have had lots of experiences, but then like obviously when I was younger I had a care-free attitude. I didn't have any children, no family, nothing. If somebody came up to me and said the words and bad language against me and insult me, then before you know it was I was fighting. And then that was it. That was it they would think twice before calling someone fat. Because obviously this fat man could move. I can box, I can play rugby, I can go to the grounds, you know I can	Lots of experiences of being bullied over his weight. Used to have a "care-free attitude" and when he didn't have any family, he would fight back (reference to him being athletically fit). *"….this fat man could move. I can box, I can play rugby, I can go to the grounds, you know I can do that"-talking from the 3rd person and*

	do that. And when they do that they think twice about it. And that is just how it was.	*removing himself. Defensive and underlining aggressivity in his tone.* Don't mess with him?
	I: Can you describe, you mentioned you want to be accepted?	Desire for normality
Desire to be perceived as normal Buy clothes in shops instead of online Wanting to be fit for his children	R: I want to be normal, someone who can go into the shop and buy clothes off the row, that's normal. All my clothes come off the computer. I have to buy off the internet and that's not normal you know. Not when you are buying for an extra-large man like 3XL, 4XL, that's not good but at least when I do it and the picture is I weigh 28 stones now and by Christmas I could be 22-20 stones. You know I could lose all that weight by then. And for my Christmas present instead of me going on a computer and looking at something nice, my family can go to the shop and buy me something off the peg and if it doesn't fit, I know that in a few	Buying clothes online. Normality means buying clothes in a shop. Family can buy him clothes from a shop and not from a computer. Positive change/direction. Anticipation of Christmas. *"I know that in a few months' time it will fit because I am going in the right direction and its down. That's the way it is so that is what I am*

	months' time it will fit because I am going in the right direction and it's down. That's the way it is so that is what I am looking forward to. That is the positive side of it. And also the fact that I can run around and my kids will grow up and we will take the bikes out and I can cycle around the park with them and do the things that I can't do now. You know that's the pleasure.	*looking forward to"- certainty in his language.* Pleasure in being physically active for his children.

Appendix J: Exemplar from stage four of the analysis process

Emergent themes ordered chronologically for William

Emergent themes:

Happy family time around food during childhood
Finding meaning behind current body size/mum as the reason for his current size?
Patriarchal family values
Privacy of the relationship with food burgeoning
Food as comfort
Self-identified as clever child/financial independence
Stealing from mother/shamed-self?
Difficult family life
Food as his friend/Food as his validating self.
Responsibility inflicted upon him/victimized-self?
Rebellious self? /self-soothing with food
Disempowered and lonely-self
Father's betrayal

Father as the aggressor/Search for meaning for father's anger
Food and self as deeply and intimately connected/merged identity?
Incessant presence of food
Reward with food/annoyed at himself
Irritated and annoyed self/self-destructive relationship with food?
Overpowering, disempowered self/lack of agency/food taking over
Starting the mourning process/Grieving over anticipated change in eating pattern
Living for fast-food/Endings
Cooks but at times convenience of take-away
Food as social self-concept/his only guilty pleasure?
Food demonstrating his loving kindness to others
Eagerness of change, new life post-op/fatalistic beliefs?
Hidden nervousness?
Community support
History of dieting
Healthy despite his weight/feeling lucky/comparison to others
Feeling unique/special
Feeding others as part of his cultural heritage
Food essential component in terms of his cultural identity
Transformation, happy with his decision making
Irreversible pathway/fear of death?
Worry and fear about longstanding side effects.
Needing to be contained and looked after.
Enable to trust and feel safe/knowledgeable professionals
Feeling well-contained/attuned to his needs
Irregular pattern of eating due to his work
Convenience and availably of food.
Night eating
Predicting future eating patterns/change in anatomy post-op
Food as fuel necessary to survive/Change in mental signalling process from brain to gut
Self-critical, shamed-self
Desire for rupture in his relationship/Analogy to food as marriage and yearn for a separation
Desire for breakup and rupture of relationship with food
Wanting to be accepted in society
Incongruence between social self and internal/true self/Wishing to end stigma
Discrimination/racism/Different construction of meaning depending on the critic
Transition from carefree self to assuming responsibility.
Different mode of defence-from physical to verbal
Stating his physical prowess.
Desire to be perceived as normal
Buy clothes in shops instead of online
Wanting to be fit for his children
Want to provide a better life for his family
Feeling deprived of certain foods

Financial difficulty
Taste of take-away as amazing/special occasion
"Feeling like scavengers"
Anger at his father
Blaming his parents for his weight difficulties
Wanting to provide for his children a good life.
Good provider, hard-worker
Terrible relationship with his father
Food as a reward
No male role model
“Own man”/financially independent
Rebellious-self/ascertaining his independence
Operation will act as gatekeeper
Bariatric surgery will remove pressure/act as an aid and facilitator
Reconfiguration of his gastric anatomy
Re-learning boundaries and limits with food
Been on every diet
Success of diets attributes to social components of groups
Perception of self as funny and easy-going
Used to work with his father/Used to be physically active both in and out of work
Started to feel body conscious
Ascertained his physical strength in front of his father.
Transition from boyhood to manhood
Protective value of physical toughness/No more physical abuse from father
Exercise to feel and look good
Men versus women in terms of diet and exercise
Male body image as muscular with high definition
Creating greater divide between ideal body and real body
Smallness to largeness
No male model/mentor to look after him
Training his son to be physically fit/Wanting the best for his son
Did not have girlfriends until late
Comparison to today’s generation.
Partner loves him for his size/grew up in a family of “big” men
Increased his food intake as he got more comfortable with his partner
Ate what he wanted/partner as a feeder?
Association of volume of food with torture
Parents making comments on his weight
Blaming the wife for his weight
Takes full responsibility for his weight/rebellious-self?
Low body image/Sees himself as big and depresses him
Low mood leading to continuous emotional eating to self-soothe
Does not like his current body/used to like his old physicality
Food would say to eat me
Assuming expert knowledge/Health comparison to his ideal male figure
Knowledge of perfect diet/rebellious-self?
Surgery as the solution

Surgery will act as regulator/Energy promoter
Smaller portion control will lead to improved lifestyle
Increased knowledge in the field
Groups and support groups which are innovative
Man who changed following surgery-transformative change
Look straight ahead/Bright future after bariatric surgery/Need knowledge, preparation for success

Further exemplar of stage four of the analysis

Emergent themes for William	**Line and page number**	**Key words**
Happy family time around food during childhood	(Line 6-8, P.1)	"Happy times, family time"
Finding meaning behind current body size/mum as the reason for his current size?	(Line 8-9, p.1)	"Hence the affect I am a big boy"
Patriarchal family values	(Line 8-12, p.1)	"She was a house mum and she cooked"
Privacy of the relationship with food burgeoning	(Line 12-21, p.1)	"I used to pass a shop and pick a mars bar"
Food as comfort	(Line 21-22, p.1)	"Ffood is a very big part...a comfort in my life"
Self-identified as clever child/financial independence	(Line 29-33, p.1)	" I was very clever very quickly from a young age"
Stealing from mother/shamed-self?	(Line 33-38, p.1)	"I would dip into my mother's purse.. I was naughty"
Difficult family life	(Line 46-48, p.1)	" Times at home were hard…any problem in the family it would be put on my shoulders"
Food as his friend/Food as his validating self.	(Line 49-51, p.2)	"Food was my friend...the love from food was from an early age"

Responsibility inflicted upon him/victimized-self?	(Line 53-58, p.2)	"I was kind of the responsible one in the family"
Rebellious self?/self-soothing with food	(Line 58-61, p.2)	"I would find an excuse to say…be down the parking with a portion of chips"
Disempowered and lonely self/Difficult home life	(Line 62-69, p.2)	"trouble at home it would be me against the height of things...though life"
Father's betrayal	(Line 75-77, p.2)	" my dad was having an affair...leading a double life"
Father as the aggressor/Search for meaning for father's anger	(Line 77-82, p.2)	"It was always me who would get the beating or such.."
Food and self as deeply and intimately connected/merged identity?	(Line 83-88, p.2)	"It's my friend, it's my lover, it's my soul mate.."
Incessant presence of food	(Line 86-88, p.2)	"Food has always been there so for me it's a very big companion in my life"
Reward with food/annoyed at himself	(Line 93-97, p.3)	"I will treat myself and it's terrible…every treat I had was food related"
Irritated and annoyed self/self-destructive relationship with food?	(Line 98-108, p.3)	"I picked up some food. It was ridiculous, I shouldn't have...annoying me"
Overpowering , disempowered self/lack of agency/food taking over	(Line 103-108, p.3)	"I couldn't stop it…Why do I do this to myself?"
Starting the mourning process/Grieving over anticipated change in eating pattern	(Line 116-119, p.3)	"I am thinking that now I should be getting in…will not be able to because it is going to be a different world for me"
Living for fast-food/Endings	(Line 123-124,p.3)	"Fast-food is what I live for"
Cooks but at times convenience of take-away	(Line 126-139, p.3)	"I cook good food...sometimes it's hard and it's just

		easier to call up...and the Chinese shop"
Food as social self-concept/his only guilty pleasure?	(Line 142-146,p.4)	"My only suffice is that I love my food...it's my social thing as well"
Food demonstrating his loving kindness to others	(Line 145-155, p.4)	"I cooked…three times and last week I cooked.."
Eagerness of change, new life post-op/fatalistic beliefs?	(Line 158-16, p.4)	"I can't wait…you move on to the next chapter…This is my new page"
Hidden nervousness about WLS?	(Line 167-170, p.4)	"I am not nervous at all.."
Community support	(Line 170-178, p.4)	"The good news is that it is all support because everybody puts comments"
History of dieting	(Line 184-185, p.4)	"I have lost weight, I have gained it and lost it again.."
Healthy despite his weight/feeling lucky/comparison to others	(Line 187-200, p.5)	"I have no diabetes, no high blood pressure…I don't smoke, I still play sports.."
Feeling unique/special	(Line 195-200, p.5)	"Iit makes me separate from the others"
Feeding others as part of his cultural heritage	(Line 204-213, p.5)	"That's what my family does, my ancestors did…"
Food essential component in terms of his cultural identity	(Line 204-213, p.5)	"cook for people that is how us, that is our culture"
Transformation, happy with his decision making	(Line 216-220, p.5)	" I am happy with this you know. This is right for me"
Irreversible pathway/fear of death?	(Line 221-225, p.5)	"There is a big point of no return…I need the help and I am getting it so I am very fortunate"
Worry and fear about longstanding side effects.	(Line 227-236, p.5)	"I was really worried because I spoke to two people…that scared me right

		away"
Needing to be contained and looked after.	(Line 241-246,p.6)	"So for me it was very much that they needed to look after me in order for me to look after myself better"
Enable to trust and feel safe/knowledgeable professionals	(Line 249-253, p.6)	"I got all the advice I need...it puts my mind right into the right place"
Feeling well-contained/attuned to his needs	(Line 254-257, p.6)	"They want you to do the right thing that is better for you, better for them.."
Irregular pattern of eating due to his work	(Line 262-283, p.6)	"I will not eat until 1-2 pm or even go through to dinner time"
Convenience and availably of food.	(Line 269-276, p.6)	"Where do you go? You have to go to McDonalds because it's the only place that is open"
Night eating	(Line 282-283, p.6)	"Before I go to bed I might have...something silly or pitta cake..."
Predicting future eating patterns/change in anatomy post-op	(Line 285-293, p.7)	"I know that I will not need it because I am full because of the balloon"
Food as fuel necessary to survive/Change in mental signalling process from brain to gut	(Line 294-298, p.7)	"You know the food is there for a fuel, not for a treat, not for a snack not for this"
Self-critical, shamed-self/low body image	(Line 297-298, p.7)	"There is enough of me here to last one year. You know that is the reason why"
Desire for rupture in his relationship/Analogy to food as marriage and yearn for a separation	(Line 304-308, p.7)	" like any relationship after 25 years you get sick of it. Whether you are married for 25 years and.."
Desire for breakup and rupture of relationship with food	(Line 310-314, p.7)	" I got to break away from my full relationship I have with food"

Wanting to be accepted in society	(Line 314-315, p.7)	"You know being accepted within society"
Incongruence between social self and internal/true self/Wishing to end stigma	(Line 315-320, p.7)	"It's the thought that everybody knows me as...the "large man". I don't want that stigma no more.."
Discrimination/racism/Different construction of meaning depending on the critic	(Line 322-329, p.7)	"I see that as it is as good as racism…the same as to say "I am big".."
Transition from carefree self to assuming responsibility.	(Line 331-335, p.7)	"I was younger I had carefree attitudes. I didn't have any children, no family, nothing..."
Different mode of defence-from physical to verbal	(Line 333-339, p.8)	"If somebody came up to me and said the words and bad language against me and insult me, the before you know it I was fighting"
Stating his physical prowess.	(Line 333-339, p.8)	"Because obviously this fat man could move. I can box, I can play rugby, I can go to the grounds.."
Desire to be perceived as normal/Buy clothes in shops instead of online	(Line 341-350, p.8)	"Someone who can go into the shop and buy clothes off the rail, that's normal"
Wanting to be fit for his children	(Line 350-356, p.8)	"The fact that I can run around and my kids will grow up and we will take the bikes out and I can cycle.."
Want to provide a better life for his family	(Line 354-362, p.8)	"I am looking forward to giving my family a better life as well"
Feeling deprived of certain foods	(Line 365-376, p.8)	"It was like living in Africa you know in a poor country. Give us a small taste like this"
Financial difficulty	(Line 367-370, p.8)	" You know it's all they could afford"

Taste of take-away as amazing/special occasion	(Line 376-377, p.8)	" the taste was amazing"
"Feeling like scavengers"	(Line 377-381, p.8)	"We were like scavengers, we would pick up the chicken and we would take everything of"

List of superordinate themes and emergent themes from William

Themes

Family milieu: past and present

Happy family time around food during childhood
Patriarchal family values
Self-identified as clever child/financial independence
Finding meaning behind current size/mum as the reason for his current size?
Stealing from mother/shamed-self?
Difficult family life
Responsibility inflicted upon him/victimised-self?
Disempowered-self and lonely-self/difficult home life
Father's betrayal
Father as the aggressor/search for meaning for father's anger
Wanting to be fit for his children
Want to provide a better life for his children
Feeling deprived of certain foods as a child
Financial difficulty
Anger at his father
Blaming his parents for his weight difficulties
Wanting to provide for his children a good life
Good provider/hard-worker
Terrible relationship with his father
Used to work with his father/used to be physically active both in and out of work
Ascertained his physical strength in front of his father
Protective value of physical toughness/no more physical abuse from father
Training his son to be physically fit/wanting the best for his son
Did not have girlfriends until late/comparison to today's generation
Partner loves him for his size/grew up in a family of ”big” men
Increased his food intake as he got more comfortable with his partner
Ate what he wanted/partner as a feeder?
Parents making comments on his weight
Blaming his wife for his weight

Food and the self-soother

Privacy of the relationship burgeoning
Food was comfort
Food as his friend/food as his validating-self
Rebellious-self?/self-soothing with food
Food and self as deeply and intimately connected/merged identity?
Incessant presence of food
Reward with food/annoyed at himself
Irritated and annoyed self/self-destructive relationship with food?
Overpowering, disempowering self/lack of agency/food taking over
Starting the mourning process/grieving over anticipated change in eating pattern
Living for fast-food/anticipated endings
Cooks but at times convenience of take-away
Food as social self-concept/his only guilty pleasure?
History of dieting
Irregular pattern of eating due to his work
Convenience and availability of food
Night eating
Desire for rupture in his relationship/analogy to food as marriage and yearn for a separation
Desire for breakup and rupture of his relationship with food
Taste of take-away as amazing/special occasion/"feeling like scavengers"
Food as reward
Been on every diet/success of diets attributes to social components of groups
Association of volume of food with torture
Low mood leading to continuous emotional eating to self-soothe
Food would say eat me
Knowledge of perfect diet/rebellious-self?

Food and WLS expectations

Eagerness of change, new life post-op/fatalistic beliefs?
Hidden nervousness about WLS
Community support
Healthy despite his weight/feeling lucky/comparison to others
Feeling unique/special
Transformation, happy with his decision making
Irreversible pathway/fear of death?
Worry and fear about longstanding side-effects
Needing to be contained and looked after
Enable to trust and feel safe/knowledgeable professionals
Feeling well-contained/attuned to his needs
Predicting future eating patterns/change in anatomy post-op

Food as fuel necessary to survive/change in mental signalling process from brain to gut
Operation will act as a gatekeeper

Bariatric surgery will remove pressure, act as an aid and facilitator
Reconfiguration of his gastric anatomy

Re-learning boundaries and limits with food
Surgery as the solution

Surgery will act as a regulator/energy promoter
Smaller portion control will lead to improved lifestyle

Increased knowledge in the field
Groups and support groups which are innovative
Man who changed following surgery-transformative change
Look straight ahead/bright future after bariatric surgery/need knowledge/preparation for success

Food and self-identity

Transition from care-free self to assuming responsibility
Different mode of defence-from physical to verbal
Stating his physical prowess

No male role model

Own man/financially independent
Transition from boyhood to manhood
Men versus women in terms of diet and exercise

No male model/mentor to look after him

Body shame (Ideal and stigmatised bodies)

Wanting to be accepted in society
Incongruence between social self and internal true self/wishing to end stigma
Discrimination/racism/different construction of meaning depending on the critic
Desire to be perceived as normal/buy clothes in shops instead of online

Started to feel body conscious
Exercise to feel and look good
Male body image as muscular with high definition
Creating greater divide between ideal body and real body
Smallness to largness

Low body image/sees himself as big and depresses him

Socio-cultural ramifications

Food demonstrating his loving kindness to others

Feeding others as part of his cultural heritage
Food essential component in terms of his cultural identity

Appendix K: Exemplar from stage 6 of analysis process

Table illustrating superordinate themes, cluster themes with accompanying quotes with the line and page references for each participant

Superordinate themes	**Cluster themes**	**Participant**	**Participant quote (line/page number)**
Family milieu: Past and present	Patriarchal family values	**William**	"She was always cooking good food and it was too tasty and I liked lots of it (…) She was a house mum and she cooked" (8-12,1)
		Ross	"Mum prepared the meals a lot, and Dad was at work, and then would come" (25,1)
		Alfred	"My father always worked, my mother, she was a...a good housewife, they never argued and that" (500-502,15)
		John	"My wife used to put me a packed lunch every day" (729-730,21)
		Adam	"I, out of a sense of duty... I got my girlfriend pregnant, and the only way we could be together was to marry" (49-50,2)
		Peter	"My mum did mainly all the

			food" (46,1)
		Jack	“Food, kind of, I suppose meant love because Mum would spend the time cooking, making food. Mum would make food from scratch” (9-11,1)
		Mark	“His dad was a bit of a hard nut, bit of a hard case. If ever there was a problem, he could always come to dad. Dad would work it out.”(958-960,22)
	Adverse home life	**William**	“ The times at home were hard you know. My parents were very strict and they come from an Irish background so if there was any problem in the family it would be put on my shoulders and obviously I found comfort in the food because it was my friend” (46-49, 1-2)
		Alfred	“My mother died in xxx and as it happened it was around teatime, my dad got… He came in from work looking for her and she

			was...”(508-510,16)
		John	“I’ve never dad a dad, there was just me and my mum, and I was quite close to my grandma and granddad, and he passed away when I was five” (39-41,2)
		Adam	“Food was scarce when I was growing up, my dad left home when I was three or four” (5-6,1)
		Peter	“My parents split up so my grandfather was a bit like my dad. It was obviously hard for my mother at the time because I had a sister as well, so she didn’t get time…”(19-26,1)
		Jack	“Although I’m the youngest of four boys we didn’t have a brilliant family life. My mum and dad kind of split up a few times in the time that they were together. There were problems” (52-55, 1-2)
	Family rules around eating	**William**	“When my parents on a Friday night or Saturday night they would have take-away. My mum would put beans and toast

			for us and you would get sick of that. You know it's all they could afford." (366-370,8)
		Ross	"Everyone likes to be a member of the clean plate club, you try to get through as much of it as you can." (287-288,9)
		Alfred	"When people were brought up during the war time and that, food was obviously As I was being brought up, if you don't have that you're not having, you know... You finish that or you finish it... you finish it off later for your tea or you have tomorrow morning for your breakfast." (266-232,7)
		Adam	"As I got older, my mum you know, you must eat up your dinner, all that sort of thing, so that's as a child, it was scarce so you ate what was put in front of you no matter what it was" (9-12, 1)
		Peter	"I used to eat what my grandparents used to give me,

			because I think the way they used to eat then was different to what it is now. For instance, like it was a load of fried…everything was fried then" (7-10,1)
		Jack	"I was the youngest of four boys. Food would get nicked off your plate by your older brothers. You had to finish your meal."(7-9,1)
		Mark	" My mother was a typical Jewish mother, who thought that her child should eat. I didn't eat." (8-10,1)
Food as the self-soother	Trauma	**William**	"From that point onwards it was always me who would get the beating or such. It was his way of venting a little bit of anger I suppose and frustration" (77-80, 2)
		Alfred	"Other kids would take the Mickey out of me but that's just the way it goes" (25-26,1)
		John	" I used to get bullied a lot. After I got to a certain age I started putting weight on so I used to get bullied a lot." (5-7,1)

		Adam	"Going back to when I was a child, there was quite a disruptive upbringing when my stepdad arrived on the scene" (49-50,2)
		Peter	"I was sexually abused and didn't think there was anything wrong with it at the time" (71-72,2)
	Disordered eating	**William**	"The only way I had comfort was to eat" (391,9)
		Ross	"We'd immediately spend all on sweets and chocolates and that kind of thing, and then we'd just immediately gorge ourselves on that kind of thing" (10-13,1)
		Alfred	"If you excuse the expression, sod it, I'll eat that too because it's not too much, I'll have one and a bit portions" (82-84,3)
		John	"When I'm mad if I turn to food, before I know it I'm not mad you know. It's sort of calmed me down, and it has the same effect when I'm upset, you know, it's strange" (79-82,3)
		Adam	"The only way I could rebel was by eating" (77-78,2)

		Peter	"Food is very important to me, I feel it gives me satisfaction, it cheers me up" (756-757,14)
		Jack	"Happiness, euphoria, contentment. If you're eating there is different things you get. It's a treat. It's a reward" (240-244,5)
		Mark	"I don't eat breakfast. I invariably skip lunch and it gets to the stage that at nine or ten o'clock at night, I might make myself something to eat" (573-575,13)
	Mourning the losses	**William**	"I got to break away from my full relationship I have with food and now I have the mindset to say there is us and we are going to separate" (310-312,7)
		Alfred	"A company that's now sold out and is.. but I've been with that company for over 30 years. So that was my life really, you know, I mean that was it" (410-414,13)
		John	"Since I fell that day, I lost my job, a job I loved. " (636-637,18)
		Peter	"I was 14, so obviously, he

			died over a heart attack. My cousin was a little bit jealous sometimes because we had that special bond" (987-992,19)
		Mark	"I was very, very low, really, really low. We'd put the stone on my mother's grave, next to my father, who was my best, best friend and I think everything just welled up." (946-953,22)

Appendix L: Appearance of superordinate and cluster themes for each participant

Superordinate themes and cluster themes	**Participants who display this theme**
Family milieu: Past and present	All participants
➢ *Patriarchal family values*	All participants
➢ *Adverse home life*	6/8 (all but Ross and Mark)
➢ *Family rules around eating*	7/8 (all but John)
Food as the self-soother	All participants
➢ *Trauma*	5/8 (all but Ross, Jack and Mark)
➢ *Disordered eating*	All participants
➢ *Mourning the losses*	5/8 (all but Ross, Adam and Jack)
Socio-cultural ramifications	All participants
➢ *Cultural identification with food*	7/8 (all but Adam)
➢ *Social versus private eating*	All participants
Food and self-identity	All participants
➢ Competitive-self/alpha male	6/8 (all but Alfred and John)
➢ Body shame	All participants
➢ Self-identity/merged identity	6/8 (all but Ross and John)
Food and WLS expectations	All participants
➢ *Future aspired-self*	All participants