An Exploration into the Decision-Making Process of Female Patients Going Abroad for Bariatric Surgery.

An Interpretative Phenomenological Analysis.

A thesis submitted in partial fulfilment of the requirements of the Professional Doctorate in Counselling Psychology of London Metropolitan University

by

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November 2025

Declaration

I hereby declare that the work submitted in this thesis is the result of my own investigation, except otherwise stated.

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Acknowledgements

My gratitude goes to my supervisors, Amanda and Keren, who have patiently helped me navigate this process. As a mature student, there were times when the journey felt particularly challenging and your encouragement and belief in my ability have been so valued.

To my family and friends, I often said this phrase was overrated, but in truth I could not have done it without your support. You have championed me all the way and believed in me even when I doubted myself. Pop, I hope I have made you proud. Maurice, Mollie and Eva you have been there for me and allowed me to sacrifice family time to meet deadlines and reach the finish line. I love you more than you know. Thank you for helping me get to the top of the hill!

To my cohort, what an amazing and supportive group of people I have had the privilege of sharing this journey with. We kept each other going when times were tough and your patience, humour and never-ending WhatsApp messages have been incredible.

Finally to the women who bravely stepped forward to take part in this research this study would not have existed without you. Your openness and generosity made this work possible. It was a privilege to hear your experiences and to represent your voices within this thesis. Thank you for sharing your story so honestly.

Glossary

Abbreviation

BMI	Body Mass Index
BPS	British Psychological Society
ESs	Experiential Statements
GETs	Group Experiential Themes
IPA	Interpretative Phenomenological Analysis
NHS	National Health Service
PETs	Personal Experiential Themes
LMU	London Metropolitan University
UK	United Kingdom

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Abstract

Bariatric surgery is for many a life-saving intervention for people with severe obesity and serious health complications such as type 2 diabetes (Courcoulas et al., 2024; Ebadinejad et al., 2022). Decision making forms an important part of the pre-surgery process to have bariatric surgery, including deciding whether to have surgery abroad, which the rise in medical tourism has shown (Border, 2020). However, concerns have been raised that bariatric tourism poses significant health risks, with post-operative complications frequently managed by healthcare services once patients return home (Carey et al., 2025). To date, the lived experience of deciding to have bariatric surgery abroad has not been explored in depth. This study therefore aims to address this gap by examining how patients make sense of that decision, with the goal of informing Counselling Psychologists in supporting patients through the decision-making process and in their psychologically preparation for their life after surgery abroad.

Design and Method: Participants were six women who had travelled abroad for bariatric surgery over 24 months ago. Semi-structured interviews were conducted, and the data was analysed using Interpretative Phenomenological Analysis.

Findings: From the analysis, three Group Experiential Themes (GET) emerged: 1 - Jumping through a “trillion hoops”, referring to feeling dismissed and overlooked by the NHS versus feeling reassured and cared for abroad both pre and post surgery; GET 2 - Reaching a breaking point, referring to personal agency in weight management, taking control and who holds control; GET 3 “No regrets” and “worth it in the end”, referring to reconciling physical suffering with a strong sense that surgery abroad was worth it in the end.

Conclusion: The findings of this study highlight that the decision to choose to go abroad for bariatric surgery is driven by women’s experiences of feeling dismissed and overlooked by the NHS, culminating in a psychological breaking point in which control and agency became central. Despite some negative health consequences, all women reported being satisfied with their decision, though they also described a difficult post-surgery adjustment. These findings emphasise the importance of accessible psychological support before surgery, to help individuals navigate the decision to go abroad, and afterwards to process their decision-making and adjust to lifestyle changes, regardless of whether the procedure takes place abroad or in the UK.

Reflexivity Part 1

Reflexivity allows the researcher to think about the role they play within the research (Woods & Sikes, 2022). This was an important factor to consider, as I have previously worked with the patient demographic referred to in this literature review. I offered short-term (6-12 sessions) psychological interventions to pre and post bariatric surgery patients, during my 12-month placement, on my

Professional Doctorate in Counselling Psychology. Most of the patients I supported were post bariatric surgery and had been referred by their dietician for psychological support, due to weight regain. By hearing their experiences, this enabled me to have a deeper understanding of the dynamics experienced by this client group. Many patients reported the distressing impact that weight regain had on them. One patient reported feeling that she had not only let herself down, but also the surgeons and her family by putting the weight back on.

I was aware that due to my placement experience, I had only seen the negative side of bariatric surgery and patients who had regained weight post-surgery. I was not seeing patients who had lost weight and maintained that weight loss. I realised I had certain assumptions, which included they had not been fully informed of what the surgery involved and if they were fully informed, they might not have regained the weight.

During my placement, I also heard anecdotal evidence of surgeons who were often reluctant to take heed of pre-surgery psychological reports. The surgical procedure was seen as a solution to fix the physical problem of obesity, with little consideration for the psychological. Therefore, whilst the physical was being dealt with, the psychological often was not. I also had personal experience from family members and close friends who have struggled to lose weight over the years, with one friend having bariatric surgery as a solution. Unfortunately, this friend has since regained all her weight and is very negative about the experience.

When I examined my own feelings around these experiences, through journaling and supervision, I noticed I had a sense of anger on behalf of the patients. A sense of injustice at them going through the long process to have surgery and to be back where they started. Talking about this in supervision and reflecting in my journal, I became aware that although I had labelled it anger, it was more a sadness that these patients had tried everything else and then this last resort had not worked either.

Being mindful of my own assumptions, I had to ensure that I explored the topic as broadly as possible and when exploring the research, I purposefully looked for studies showing both the positive impacts of bariatric surgery, along with the negative. I therefore started my literature review by gathering evidence to show that bariatric surgery is successful for some people, which helped me step back from my previous stance and be more open.

Another feeling I noticed on reflection, was my nervousness when approaching the literature review. This was due to my limited knowledge of research in the field of bariatric surgery and a fear there might be nothing left to research. I was often triggered when it was stressed to us by lecturers that we had to find something new, to be the expert in this field. How could I be an expert after one year’s placement and a few months reading? I felt out of my depth and with a personality of someone who had been brought up to be modest, this felt incredibly uncomfortable. I reflected on this at length and took this to therapy, which I found helpful, in exploring elements of imposter syndrome, perfectionism and a fear of getting it wrong. I did look to reframe this and successfully

got to a place of excitement, possibility, and optimism, that this research might uncover something of use to this population. Reading around the purpose of research, also motivated me to view this as a chance to raise understanding and in doing so, help ease human suffering (Douglas, 2016). Epistemologically I wanted to advance knowledge of what exists (Martin, 2010) and to gain a greater understanding of the experiences of bariatric patients, in relation to the phenomenon of deciding to have surgery. I felt this linked well to my objective as a Counselling Psychologist, which is to "help people lead lives that are more fulfilled" (Murphy, 2017, p42). This allowed me to approach the literature review with a more open and enquiring mind.

As the literature review progressed, I encountered another time when my imposter syndrome arose. I noticed in the literature that there was little research around the increase in people going abroad for bariatric surgery. I heard first hand from someone who had gone aboard for bariatric surgery, as they had not met the criteria for surgery in this country. Their BMI was not high enough for acceptance of surgery in the UK. They shared the ease of being accepted for surgery abroad, with a brief screening process that was initially carried out via WhatsApp messages. They then had an online interview with the surgeon with what appears to have been no pre or post psychological assessment. In addition, there was a recent BBC documentary and newspaper headlines, calling for a review into bariatric surgery abroad, due to several deaths and complications (UK Insight Team, 2023). They reported numerous patients who on return from surgery abroad, had to then be treated in the UK NHS system because of these complications, thus adding extra strain on an already stretched service. I initially thought this could be an up-to-date area of interest to explore, however my insecurities resurfaced that it would not be possible for me to find something new. I again journaled this and using the Cognitive Behavioural Therapy I had learnt, noticed it was unhelpful negative thought patterns. I took this to therapy and successfully got to a space where I was able to notice the patterns yet move forward to explore the possibilities my research might take. I learnt this is a recurring theme for me and I could stay with old unhelpful patterns of thinking, or I could be bold and expand my research. I am consciously boldly committing to quieten my inner critic and take the path less travelled, in the hope of helping my future patients enter (if they decide) into a life of bariatric surgery in a more robust psychological state.

Chapter 1. Introduction

This chapter sets the context for the study by examining the key issues surrounding the decision to undergo bariatric surgery abroad. It begins with outlining the global prevalence and psychological impact of obesity, before introducing bariatric surgery as a treatment approach. A critical appraisal of bariatric surgery follows, highlighting its benefits and drawbacks. The chapter then examines medical tourism, considering its growth, associated risks and impact on the NHS.

1.1 Obesity

Obesity is an eating disorder and classified in the DSM-5 as overeating when not feeling physically hungry and can include binge eating (Da Luz et al., 2018). Overweight is a condition of excessive fat deposits and obesity is a chronic complex disease defined by excessive fat deposits that can impair health (World Health Organisation [WHO], 2025). They define overweight as a body mass index (BMI) greater than or equal to 25 and obesity as a BMI greater than or equal to 30.

Obesity is prevalent and rising. According to WHO (2025) the global prevalence of obesity has more than doubled since 1990, with recent data from 2022 indicating that one in eight individuals worldwide is currently living with obesity. If current trends persist, projections suggest that by 2035, nearly one in four people, equating to approximately 2.5 billion adults (43%) aged 18 years and older will be considered overweight, of whom 890 million (16%) will be living with obesity (43% men and 44% women) globally (WHO, 2025). Alarmingly, obesity and overweight are now among the leading contributors to global mortality, with an estimated 2.8 million adults' deaths annually attributed to these conditions, making them the fifth most significant risk factor for death worldwide (Easo, 2023; World Obesity, 2023).

Obesity has biopsychological consequences contributing to emotional distress, such as mood, self-esteem, quality of life and body image, with between 20% and 60% of people living with obesity suffering from psychiatric illness (Rajan & Menon, 2017; Sarwer & Polonsky, 2016.) Research also highlights a strong association between obesity and adverse childhood experiences (Grilo et al., 2005). The Adverse Childhood Experiences (ACE) study found that a history of child maltreatment was strongly linked to having a BMI of over 40 (Felitti et al., 1998, as cited in Grilo et al., 2005). Furthermore, bariatric surgery candidates scored two to three times higher on the Childhood Trauma Questionnaire (CQC) than the general population (Grilo et al., 2005), suggesting that early trauma may play a significant role in the development of maintenance of obesity. These psychosocial complexities not only compound the emotional burden of obesity but may also influence individual's motivations to seek weight loss interventions, with improved health and longevity often cited as key drivers (Sarwer & Polonsky, 2016).

1.2 Bariatric surgery

Bariatric surgery is an established treatment for obesity and has been shown to achieve significantly greater short and long-term weight loss then medical treatment (Tolvanen et al., 2022; Kim et al.,2023). Patients can typically expect to lose between 20-35% initial body weight, within 12-18 months of bariatric surgery (Mechanick, 2019). BMI loss was most significant up to eighteen months post surgery compared to 12 months (Magro et al., 2008). Additional benefits are a

reduction in cardiovascular disease (Wang et al., 2024; Wolfe, et al 2016) and the prevention of other comorbidities, like type 2 diabetes (Ebadinejad et al., 2022; Courcoulas et al., 2024).

Currently, two of the most performed bariatric surgeries are Laparoscopic Sleeve Gastrectomy and Laparoscopic Roux-en-Y Gastric Bypass, which together account for most surgical interventions in many settings (Lei, 2024; Ordemann, 2022). The gastric bypass involves joining the top part of the patient's stomach to their small intestine, so they feel fuller sooner and fewer calories are absorbed. The Laparoscopic Sleeve Gastrectomy involves removing a portion of the stomach, which reduces capacity and promotes earlier satiety (NHS, 2023). Research shows that Laparoscopic Sleeve Gastrectomy resulted in significantly greater short and long-term weight loss compared with medical treatment, with this procedure demonstrating the most substantial reduction (Kim et al., 2023).

Although bariatric surgery initially results in substantial weight loss, research shows these effects often dimmish over time. BMI loss is no longer significant 24 months after surgery ($p < 0.01$) and approximately 50% of patients regain weight (Magro et al., 2008). By 48 months, weight regain becomes significant ($p < 0.01$), with 20% regaining most of what they had lost (Heinberg et al., 2020). Despite the physical and anatomical changes, the bariatric surgery brings, there is still significant weight regain (Heinberg et al., 2020).

1.3 Health and Medical Tourism

Health tourism refers to travelling abroad for medical, preventative, or wellness services and has grown significantly in recent years, particularly in response to rising global health concerns (Figueiredo et al., 2024). Within this broader category, medical tourism, which is travel specifically undertaken to receive medical or surgical treatment, has expanded rapidly, with increasing numbers of individuals seeking procedures such as bariatric surgery to improve or restore their health (Roman, et al., 2022). In the UK context, with rising obesity rates, long NHS waiting lists, and the high cost of private treatment, an increasing number of UK patients are opting to undergo bariatric surgery abroad (Kowalewski, 2019; McGirr et al., 2025). Beyond financial and access barriers, the limited availability of bariatric services within the UK has also been identified as a key driver for this trend (Carey et al., 2025). This practise, commonly referred to as medical or health tourism, involves individuals travelling internationally for non-emergency procedures (Border, 2020).

Although estimates vary, recent analyses suggest that approximately 5,000 UK residents undergo bariatric surgery abroad each year, a figure that now exceeds 4,500 procedures conducted annually within the NHS (Aggarwal & Ahmed, 2024). This shift is largely driven by the lower cost of procedures abroad, averaging £2,500 - £4,500 compared to £10,000 - £15,000 for private surgery in the UK, alongside NHS waitlists that often exceed two years (McGirr et al., 2025). Globally,

bariatric surgery accounts for an estimated 2% of the broader medical tourism market (Kowalewski et al, 2019), which continues to grow rapidly. Accurate data remain difficult to obtain due to the absence of international regulation and centralised reporting (Lunt, 2014). Nonetheless, concerns have been raised that bariatric tourism poses significant health risks, often leaving complications to be managed once patients return home (Carey et al., 2025). One NHS hospital reported 15 bariatric tourism patients presenting as emergencies in a single year, costing the Trust over £100,000 (Beynon et al., 2023). Between 2019 and early 2024, at least 28 UK nationals died following bariatric surgery abroad, most commonly Turkey, raising concerns about safety, aftercare and governance (McGirr et al., 2025). Moreover, analyses in 2025 indicate that medical tourism for weight-loss surgery continues to grow, even in the context of novel pharmacological interventions such as GLP-1 receptor agonists (McGirr et al., 2025). These developments stress the importance of enhancing understanding of the rise on choosing to go abroad for bariatric surgery.

1.4 Theoretical Framework

This section will explore the theoretical frameworks that help illuminate different aspects of complex decision-making processes described by participants. As the analysis developed, it became clear that decisions about undergoing bariatric surgery abroad were shaped by how individuals assessed health risks and benefits in relation to their own needs. The Health Belief Model (HBM) (Rosenstock, 1966), Protection Motivation Theory (PMT) (Rogers, 1983), Prospect Theory (Kahneman & Tversky, 1979) and Maslow's humanistic framework were therefore identified as particularly helpful in understanding these motivations.

The Health Belief Model (HBM) originally conceptualised by Rosenstock (1966), is one of the earliest models used to understand health-related behaviours and examines how individuals evaluate risks and benefits associated with health decisions. It theorises that individual's engagement in protective health actions is determined by their perceptions of susceptibility to a health threat, the perceived severity of that threat, the anticipated benefits of the protective behaviour and the perceived barriers to action. In addition, cues to action (such as medical advice or a health scare) and self-efficacy (confidence in one's ability to act) influence the likelihood of behaviour change (Champion & Skinner, 2008). In the context of obesity, individuals may be prompted to consider weight-loss interventions, including bariatric surgery, following significant cues such as the onset of obesity-related health conditions like diabetes, or persistent difficulties losing weight through conventional means (Balkhi et al., 2021). The HBM has however been criticised for underestimating the role of emotional distress, fear or stigma in health decision-making (Conner & Norman, 2015). These are important factors, as for many women living with obesity, the emotional impact of feeling judged or dismissed by healthcare professionals can be just as significant as the physical health concerns they face (Puhl & Heuer, 2009).

Protection Motivation Theory (PMT) (Rogers, 1983) was developed in part to address these limitations by incorporating both threat and coping appraisals. It offers a psychological perspective on how individuals decide to take protective action in response to perceived health threats. According to the theory, this decision-making process involves two key components; threat appraisal, which includes assessing the seriousness of the threat and one's perceived vulnerability to it; and coping appraisal, which involves evaluating the perceived effectiveness of the protective behaviour (response efficacy), one's confidence in their ability to perform it (self-efficacy), and the perceived costs or barriers associated with the action. Together, these appraisals determine whether an individual is motivated to engage in protective behaviour (Rogers & Prentice-Dunn, 1997). Unlike the HBM, the PMT includes affective motivators such as fear or urgency, offering a more comprehensive account of how individuals evaluate and respond to health threats. This theoretical framework is applicable to the context of obesity and the decision to pursue bariatric surgery, particularly abroad. Many individuals may perceive their weight as a significant and escalating health threat, experience fear about future comorbidities and feel frustrated by delays or restrictions in local healthcare access. Bariatric surgery abroad may be perceived as a more immediate and effective solution, particularly when response efficacy and self-efficacy is judged to be high, and perceived barriers such as cost and travel or stigma are outweighed by the urgency of the threat. For Counselling Psychologists, PMT offers a valuable framework to understand the emotional and cognitive processes underpinning such high-stake health decisions and to better support patients navigating this complex journey.

While HBM and PMT focus on cognitive beliefs and motivations, Scarcity Mindset Theory (Mullainathan & Shafir, 2013) introduces a socio-psychological perspective, highlighting how perceived scarcity of time, money, healthcare access or emotional support can narrow cognition. This creates a tunnelling effect, where attention becomes focused on immediate demands or urgent problems, often at the expense of long-term planning or broader perspective (Mullainathan & Shafir, 2013). Individuals dealing with ongoing health challenges like obesity, may prioritise immediate solutions over carefully evaluating future risks. The decision to seek BS abroad may thus emerge from this tunnelling effect, where overseas options are seen as quicker, more responsive and more emotionally validating than NHS-based alternatives.

Prospect Theory (Kahneman & Tversky, 1979) adds further depth by explaining how people make decisions based on potential losses and gains (Lim, 2015). It theorises that individuals are more motivated by avoidance of losses then the pursuit of equivalent gains. From this perspective, despite the potential risks, choosing to undergo bariatric surgery can be viewed as a rational decision, particularly when weighed against the ongoing psychological, physical and social losses associated with obesity. Research has shown that individuals who perceive themselves to be at greater risk of health issues are more likely to engage in preventive or corrective behaviours including those related to weight management (Brewer et al., 2007). The cost of inaction may feel more prominent and intolerable than the risks of surgery abroad. This was supported by a

retrospective survey study which found that patients opting for bariatric surgery perceived obesity as a greater personal health threat than the surgical risks themselves (Prasad, et al., 2014). For instance Lim & Bruce (2015) identified “weight-gain aversion”, where higher BMI individuals exhibited increased risk-seeking for weight-loss decisions and heightened aversion to weight gain. This is highly relevant for Counselling Psychologists, as it enables them to help patients understand the psychological processes influencing their health-related decision-making.

Humanistic psychology looks at the uniqueness of the individual in helping us understand the motivations behind human behaviour (Maslow, 1943). Motivations for people seeking bariatric surgery are varied. Many are motivated by wanting to improve their health and life span, whilst others want improvements to body image (Sarwer & Polonsky, 2016). Humanistic psychology helps us explore whether people are driven by intrinsic or extrinsic motivation. A person seeking bariatric surgery may be intrinsically motivated to improve their self-esteem and extrinsically motivated by other expectations or social pressure (Lanoye et al., 2018). Humanistic psychology can help gain an understanding of the experiences of bariatric parents in relation to the phenomenon of deciding to have surgery and to epistemologically advance knowledge of what exists (Martin, 2010).

Maslow’s (1943) Hierarchy of Needs and Theory of Motivation theorises that human behaviour is driven by the fundamental needs, progressing from basic physiological requirements to safety, love and belonging, esteem and ultimately self-actualisation. Within this framework, the need for care and support is central to the third tier, love and belonging, which encompasses the human desire to feel cared for, supported and accepted and emotionally connected. For individuals living with obesity, these needs are often unmet due to the experiences of stigma, judgement and marginalisation in both the personal and healthcare context (Puhl & Heuer, 2009; Lewis et al., 2011). Stigma appeared to have the biggest impact on health and social wellbeing and created a barrier to participation in health-promoting activities (Lewis et al., 2015).

When individuals feel emotionally attuned to others, whether through compassionate care, empathetic understanding or validation, they are more inclined to engage in behaviours that promote physical and psychological health (Baumeister & Leary,1995; Cohen & Wills, 1985). Cohen & Wills, (1985) highlight the significant role that emotional support, namely understanding and attentiveness can play in helping individuals navigate health challenges and make more informed health-promoting decisions. For individuals who do not feel heard or cared for by the NHS practitioners, it might help explain why they then seek surgical solutions abroad, where they perceive a higher degree of personalised care and support.

The pre-surgery information given about bariatric surgery is varied, with vast amounts of information to absorb (Zevin, 2022). Broadbent’s (1958, as cited in Sullivan, 1976) Model of Attention suggests that because we cannot attend to all the sensory information we are presented with, we selectively choose which to attend to. So due to a bombardment of sensory information,

we tune out certain information and focus on what is important. This is called Selective Attention, which is a process of ignoring irrelevant stimuli to allow us to focus our awareness on relevant stimuli (Sullivan, 1976). For bariatric patients, it is possible that information may have been tuned out, like possible weight gain. Also, they may have selectively focused on what was important to them, such as weight loss.

Chapter 2. Critical Review of Extant Literature

This chapter critically examines the existing literature on bariatric surgery, with the aims of identifying both established findings and gaps in current knowledge to inform the development of a focused research question and proposal. It outlines the literature search strategy, then examines empirical evidence on the outcomes of bariatric surgery, particularly in relation to weight reduction and the psychological impact of weight regain. It will then explore patients' motivations for pursuing surgery, including the growing phenomenon of medical tourism, as well as the informational and psychological factors shaping their decision-making processes. In addition, the review will engage with relevant theoretical frameworks to contextualise these experiences and will consider the implications for Counselling Psychology practice. Through this synthesis, the review seeks to highlight areas requiring further investigation and establish a rationale for the proposed research.

2.1 Literature searches

To ensure a comprehensive and transparent understanding of existing evidence base, a structured literature search was conducted using PsycINFO, Cochrane and Google Scholar between 2003 to 2025. Boolean operators and the following combinations of key search terms were applied; ("bariatric surgery" OR "weight loss surgery" OR "gastric bypass surgery" OR "gastric sleeve surgery") AND ("weight gain" OR "post operative") AND ("decision-making" OR "decision-making process") AND ("medical tourism" OR "surgery abroad") AND ("Interpretative Phenomenological Analysis"). Titles and abstracts were screened for relevance, and full-text papers were reviewed to access eligibility. Studies were included if they focused on adult patient's experiences of decision-making around bariatric surgery abroad or explored the psychosocial and experiential aspects of this process. Studies focused on adolescent samples or non-peer reviewed material were excluded.

2.2 Success of Weight Loss Surgery

Several studies have focused on the success of bariatric surgery in reducing weight, with the maximum weight loss happening in the first and third years after surgery (Baheeg et al., 2021; Courcoulas et al., 2013; Courcoulas et al., 2024; Kim et al., 2023;). Even quantitative and qualitative research, thirteen and fifteen years post bariatric surgery, concluded that bariatric surgery is effective at producing long term weight loss (Herb Neff et al., 2021; Mitchell et al., 2001), with most patients (74%), reporting they felt the surgery had benefited them (Mitchell et al., 2001). Although this research looked at the benefits of bariatric surgery, it did not explain the experience of 26% who did not report a benefit. It is also not clear from the research if they had gained weight after bariatric surgery.

Whilst the longitudinal span of the research reviewed above offers a broad temporal perspective, its relevance is limited due to the evolution of bariatric surgery techniques over the past decade. Much of this earlier research focused on the Roux-en-Y gastric bypass (RYGB), whereas the current leading intervention is the sleeve gastrectomy, now the most performed surgical procedure for obesity worldwide (Ordemann, 2022; Wilson & Aminia, 2021). These studies often address bariatric surgery in general terms, rather than exploring patient experiences associated with specific procedures such as sleeve gastrectomy.

In addition to weight loss successes, quantitative research using quality of life survey measures, has demonstrated significant improvements across multiple domains of wellbeing following bariatric surgery (Alrshid, et al., 2025). Large-scale analyses and meta-analytic reviews further support reductions in symptoms of anxiety and depression (Al-Kadi & Al-Sulaim 2024; Alrshid, et al., 2025; Law et al., 2023), alongside enhancements in body image and self-confidence, often leading to more active social lives and improved romantic relationships (Al-Kadi & Al-Sulaim, 2024; Bramming, et al., 2021). However a limitation of these studies is that its' quantitative nature does not give insight into the meaning individuals attribute to these improvements.

Existing qualitative research exploring the social and emotional experiences of patients following bariatric surgery, also reported positive psychosocial outcomes, including increased self-confidence, enhanced self-esteem and broader positive lifestyle changes such as social participation (Coulman, K. et al., 2020; Griauzde et al., 2018; Gullaam Rasul et al., 2022; Jiertorn et al., 2024*)*. Whilst these studies offer valuable insight into patient's post-surgical changes, they provide limited exploration of the pre-surgical experiences that shaped their decision to pursue surgery.

2.3 Weight Regain Post Bariatric Surgery

Interpretative Phenomenological Analysis (IPA) research makes it clear that there are negative psychological impacts on patients who regain weight after bariatric surgery. Patients reported experiencing shame (Tolvanen et al., 2022) and regret (Lloyd et al., 2018). Others also described a

sense of self-blame, perceiving the negative consequences of surgery as self-inflicted due to their decision to undergo the procedure (Berg, 2020). Some patients appeared to believe that the surgery would physically stop them from putting on weight "I did not believe I could regain the weight. I actually did not believe that." (Tolvanen et al., 2022, p5). Research also examined behavioural aspects such as physical activity (Heinberg et al., 2020), eating in the absence of hunger and stress-induced eating (Kofman et al., 2010) to help explain weight regain post bariatric surgery. However, comparatively little is known about the preoperative decision-making process that may shape these later outcomes. Despite these findings, limited research has explored patients' pre-surgical experiences or why some individuals believed weight regain was unlikely. It also remains unclear what information, or psychological preparation might have better supported their decision making. This is of relevance to Counselling Psychologists, who seek to understand and address patients' pre-surgical needs to improve post-surgical outcomes.

Subsequent research has examined factors such as self-concept, self-efficacy and depression (Geraci et al., 2015), which may offer insight into mechanisms underlying weight regain. For example, weight regain has been associated with low self-esteem (Dionisi et al., 2025), which in turn may lead to social isolation and reduced engagement in post-surgical aftercare, a known contributor to further weight regain (Carvalho et al., 2014). Yet it remains unclear whether these psychosocial factors influenced patients' initial decision making to pursue bariatric surgery. Exploring patients' psychological state pre-surgery could provide important context for understanding their decision-making process. Additionally, while studies have highlighted a need for greater encouragement from bariatric teams and peers' post-surgery (Liu & Irwin, 2017), less is known about the psychological support needs that may have been beneficial prior to surgery to better inform such decisions.

Another apparent gap in the literature appears to be regarding the lived experience of weight regain following bariatric surgery. While some quantitative studies have explored the use of decision aids to support patient choice between RYGB and sleeve gastrectomy (Nijland, 2023), such research continues to overlook the subjective experience of choosing and living with sleeve gastrectomy. These personal perspectives are central to Counselling Psychology, which values an in-depth understanding of individual's lived experiences as the basis for meaningful therapeutic support (Van Scoyoc, 2009). Previous research has also highlighted that patients often feel unsupported after surgery, expressing a need for greater encouragement from both bariatric team members and peers (Liu & Irwin, 2017; Lloyd et al., 2018). It is therefore important to consider how patients perceive the removal of part of the stomach, not only as a means of weight loss, but also as a safeguard against future weight regain, an area that remains underexplored in current literature.

2.4 Reasons for Seeking Surgery

Reasons for seeking bariatric surgery vary across qualitative studies but consistently reflect a desire to transform aspects of physical, psychological and social lives that have been constrained by obesity. For some, the primary motivation is to improve obesity-related medical conditions (Jaensson et al., 2022), while for others it is to achieve a more aesthetic appearance or take control to help alleviate health-related worries (Eker & Yildiz, 2025; Ogden et al., 2006). Quantitative evidence also shows that women represent around 80% of the bariatric surgery population and tend to pursue surgery earlier than men (Kochkodan et al, 2018). Studies also suggest that women's motivations are often linked to improving appearance, body image and self-esteem (Hult et al., 2019; Kolotkin., et al, 2008; Pearl et al 2019). However, a limitation of this body of research is that most studies are cross-sectional or rely on self-report data collected post-surgery, offering limited insight into the pre-surgical decision-making process.

Another key reason for seeking surgery is that many patients view surgery as a definitive solution to their struggles with weight and eating behaviours. IPA research shows that patients often believe surgery will prevent them from engaging in unhelpful behaviours such as excessive eating or alcohol use (Wood & Ogden 2016). This perception reflects a deeper hope that surgery will bring an end to their ongoing battle with food (Karlsson et al., 2003), even though it may involve overlooking the possibility of future weight regain. Such pre-surgery psychological orientations can narrow patients' focus on the immediate change, potentially obscuring the need for ongoing behavioural adaptation and missing consideration of the long-term risks. A limitation of this research, therefore, is that it provides little insight into how patients anticipate managing their risk post-surgery or how they plan to cope with the unhelpful behaviours they struggled with before.

Cultural and contextual factors influence both the decision to undergo bariatric surgery and post-surgical outcomes, with culture-specific approaches shown to improve recovery and adherence (Inocian et al., 2021). Beliefs about excess body weight differ internationally. In some societies, larger body size may be associated with prosperity or social status, whereas in others it is more heavily stigmatised, potentially heightening motivation to seek surgery abroad where treatment is more accessible or less socially visible. In addition, cultural stigma surrounding mental health and psychological support may discourage some patients from engaging with pre-or post-surgical psychological support, despite evidence of its benefits (Alobaidly et al., 2018). These cultural dynamics may therefore shape not only the decision to undergo surgery abroad, but also the ways in which patients prepare for and manage the psychological and physical consequences of bariatric surgery. Broader contextual issues, including cuts to public services, NHS staff strikes and rising waiting times, may further drive patients to seek faster or more affordable options abroad, factors that are often underrepresented in existing research.

2.5 Decision Making and Informed Consent

Research stresses the importance of patients being fully informed about the consequences of bariatric surgery, including both the physical and psychological risks and benefits (Breuing, 2022; Liao et al., 2018; Lloyd et al, 2018). Qualitative findings have identified three major themes relating to the consequences of bariatric surgery, living with the side effects, regret and lack of support following surgery and have called for improved informed consent prior to surgery (Lloyd et al., 2018). Studies also highlight unmet information needs both pre- and post-bariatric surgery, with patients feeling well informed about general aspects of the procedure but lacking crucial information around postoperative issues such as nutrition (Breuing, 2022). Both studies emphasise the importance of post-operative support, noting that many patients turn to online groups. This did vary however in how helpful patients experienced them, with some finding it frightening in terms of knowing about the risks (Breuing, 2022). However, this research does not address the preoperative thought processes underpinning patient's decisions to undergo bariatric surgery and what information they felt they needed at that stage. It also only reports on patient's experience of laparoscopic adjustable gastric band and not sleeve gastrectomy.

Some research has examined the pre-surgery evaluation process, including expectations and understanding of the pre-surgery process and how methods of informed consent have evolved (Sahar & Riazi, 2021; Zevin, 2022). Findings suggest that patients often saw the pre-surgery evaluation process as something out of their control and a "wall" to surgery (Sahar & Riazi, 2021, p7) with the surgeons, dieticians and psychologists having the power to decide. It also highlighted how patients found the pre-surgery evaluation process challenging yet essential in allowing them time to self-reflect and gather more information. These studies, however, do not offer insight into what occurs during the self-reflection phase or the decision-making process the patients went through. It remains unclear what information participants drew upon to inform their decision, including whether they considered details about physical and psychological risks, potential benefits, or the possibility of weight gain. The research does not consider the patients' thought process pre-surgery and if they were making an informed decision. What is clear however, is that being better informed does not always guarantee a better outcome, such as sustained weight loss. Research shows that patients often forget potential complications associated with bariatric surgery (Madan, 2007) and there is still a need to see informed consent as a psychological process rather than the procedure of an exchange of information between two parties (Liao et al., 2018).

2.6 Bariatric Surgery Abroad

Bariatric surgery is on the rise due to limited access of services in patients' home countries and long wait times (Aggarwal & Ahmed., 2024; Carey et al., 2025; Foley et al., 2019; Gagner, 2017;

Kowalewski, 2019). In their systematic review of patient and clinician experiences of bariatric tourism, Carey et al. (2025) highlight that restricted service availability within home healthcare systems frequently motivates individuals to seek surgery elsewhere. Similarly Gagner (2017) found that limited domestic access to bariatric surgery within the Canadian healthcare system drove patients abroad in search of more timely and affordable treatment. Xu et al. (2020) and Aggarwal & Ahmed (2024) also identify unmet healthcare needs as a broader push factor in medical tourism, intensified by long waiting lists (Aggarwal & Ahmed, 2024; Carey et al., 2025; Foley et al., 2019; Gagner, 2017; Kowalewski, 2019; Xu et al., 2020). Although these studies clearly show that accessibility plays a key role in motivating bariatric tourism, the quantitative evidence predominantly comes from systemic reviews and review articles. While these provide useful policy insights, they provide limited understanding of patient's lived experiences or the psychological meanings attached to their decision to travel abroad.

Lack of affordable local care and lower cost of procedures abroad, have also been shown to contribute significantly to the decision to seek surgery abroad (Aggarwal & Ahmed, 2024; Foley et al., 2019; McGirr et al., 2025; Xu et al., 2020). Kaur's (2024) review states that the rise in medical tourism is being driven not only by lengthy waiting lists but also by high private healthcare costs, calling for better regulation to support informed decision-making by ensuring patients are aware of the risks and benefits of surgery abroad (McGirr et al., 2025; Foley et al., 2019). Collectively, these studies suggest that bariatric surgery abroad is not solely a financial decision but also an emotional and practical response to perceived delays and barriers within domestic healthcare systems. Again these quantitative reviews largely focus on why people go abroad in terms of health system limitations such as cost and wait times, but do not inform of how patients make sense of these barriers or the psychological processes that shape their choices.

Patients' perceptions of care quality and satisfaction with healthcare facilities have also been shown to influence their choice of destination (Azlan et al., 2023; Zarei & Maleki, 2019, as cited in Roman et al., 2022). Azlan et al. (2023) conducted a cross-sectional study of international bariatric centres gathering information such as clinic accreditation, cost, preoperative care, clinical outcomes and patients' follow-up care. While identifying deficits in preoperative care, the study did not explore patients lived experiences or the psychological factors influencing their decisions, nor did it clarify whether choices were based on fully informed consent. Azlan ultimately called for stronger systems to support informed decision-making among those seeking bariatric surgery abroad. The COVID-19 pandemic further accelerated this trend, with research indicating that people began to place greater value on their health and wellbeing in its aftermath (Williams & Ólafsdóttir, 2023), contributing to the continued rise in demand for bariatric surgery.

The growing phenomenon of individuals seeking bariatric surgery abroad has also raised increasing clinical concern. A BBC *UK Insight investigation* (2023) and accompanying documentary highlighted that British healthcare professionals are frequently required to provide follow-up care for patients returning from Turkey with post-operative complications, with seven

patient deaths reported. Earlier analyses of media coverage identified 26 fatalities of those who travelled overseas for bariatric surgery between 1993 and 2011 (Turner, 2012). The *UK Insight* report (2023) further found that many individuals opt for treatment abroad primarily to circumvent lengthy waiting times and are influenced by social media advertising offering surgery at a fraction of UK costs, approximately £2,000 abroad compared to around £10,000 privately in the UK. Concerningly, the report documented cases of individuals being accepted for surgery who would not meet the NHS medical criteria, including patients with a BMI as low 24.5, well below the threshold of 40 typically required for NHS-funded bariatric surgery. This is supported by more recent research (Mahase, 2024), which highlights, many overseas surgical providers promote highly appealing, expediated packages that include travel and accommodation, potentially obscuring the seriousness of the procedure and reinforcing the perception of bariatric surgery as an easy, immediate solution rather than a complex, lifelong commitment. Such findings reveal both the accessibility and potential "reckless" (UK Insight Team, 2023, p1) side of the current trend of weight loss surgery abroad, highlighting serious issues around patient safety, eligibility and informed consent.

Qualitative research identified motivators for seeking bariatric surgery abroad were not only a lack of NHS provision, but also the restrictive eligibility criteria imposed by domestic healthcare systems (Hanefeld et al., 2015; Jackson et al., 2019). Jackson et al. (2019) explain how patients are "bypassing barriers within the Canadian health care system that appear to be preventing access to this type of care domestically". (Jackson et al., 2019 p2). Using a qualitative case study design, they explored patients' motivations and found that participants perceived domestic evaluation process as lengthy and strict in terms of meeting criteria, versus surgery abroad as empowering by giving them more control. They found that many patients also faced stigma and isolation from friends, family and medical professionals, which further influenced their decision to seek surgery overseas. While these qualitative research findings add depth by providing valuable understanding of the motivations for seeking bariatric surgery abroad, they do not explore how patients experience the psychological process of decision-making. Also they are not specifically on women's experience and include other forms of medical tourism not just bariatric surgery.

Taken together, this literature shows that bariatric surgery abroad is a complex, multidimensional phenomenon driven by systemic, financial and psychological factors. While policy and review papers provide valuable context about healthcare limitations and costs, they offer limited insight into how patients experience and make sense of their decisions. There is therefore a gap in the literature, with limited IPA or other qualitative research exploring the patients' lived experiences of deciding to undergo bariatric surgery abroad. This study seeks to address this gap by exploring *how female patients who have had bariatric surgery abroad made sense of their decision,* including their pre-surgical understanding of the physical and psychological risks and benefits, and their awareness of the possibility of weight regain following surgery overseas. By illuminating these experiences, this research aims to deepen understanding of the decision-making process

and to support more informed and ethically sound choices for individuals considering bariatric surgery abroad.

This study will use Interpretative Phenomenological Analysis (IPA) to explore how adults experience and make sense of their decisions to seek bariatric surgery abroad. IPA is appropriate because it is explicitly designed to examine the lived experience of significant life events and to attend to the meanings participants attach to bodily, social, and psychological changes. Through individual and group reflection on the best methodology for researching this topic, it was decided that carrying out IPA research method was the most appropriate. It would enable the use of open questions, which would allow the patient to tell their whole story, which fits with the ethos of Counselling Psychology, to believe that each case can bring something new that can be merged with theory (Murphy, 2017). In addition, as the proposed research is interested in understanding the experiences of bariatric patients in relation to the phenomenon of deciding to have surgery abroad, an IPA approach is consistent with the type of knowledge that the research aims to gain. Critical Realism (Bhaskar, 1975) is an appropriate epistemological pairing with IPA because it is concerned specifically with the phenomenology of experience (Willig, 2008). Therefore, whilst the experience of deciding to have bariatric surgery is always open to interpretation and therefore constructed, it is still 'real' to the person who is having the experience (Willig, 2008, pg. 13).

2.7 Counselling Psychology Relevance

Obesity, bariatric surgery and weight gain represent multi-layered and complex issues. In clinical practice, difficulties such as depression, anxiety, trauma and eating disorders often coexist within the same individual. Counselling Psychology training equips practitioners to manage this complexity while maintaining a patient-centred focus and developing an integrative framework for practice (Rogers, 1951, as cited in Murphy, 2017).

Counselling Psychologists are trained to take a holistic approach to therapy and draw flexibly on a range of modalities, which is of particular benefit to this client group. For example, some patients may benefit from a Cognitive Behaviour Therapy approach to address unhelpful thought patterns driving maladaptive eating behaviours (Moraes et al., 2021), while others may respond more effectively to Compassionate Focused Therapy to reduce body shame and foster self-compassion (Carter et al., 2021). Counselling Psychologists are also well placed to facilitate bariatric surgery support groups, both pre- and post-surgery, where patients can share experiences, receive psychoeducation around emotional eating and develop greater self-awareness.

Counselling Psychologists are often involved in supporting patients both before and after surgery, with many NHS trust requiring a psychological assessment as part of the pre-surgical process. These assessments are often conducted by a Counselling Psychologist, to explore patients' motivations for surgery, their relationship with food and their overall psychological wellbeing,

including any emotional distress that may contribute to disordered eating. This is crucial, as unresolved psychological difficulties can resurface post-operatively, increasing the risk of maladaptive coping strategies and weight regain (Sarwer & Polonsky, 2016).

Counselling Psychologists are also well positioned to help patients identify the emotional drivers of binge eating, which is often a necessary step toward lasting behavioural change (Leach, K. 2006). Gaining insight into whether individuals use food as a means of emotional regulation or avoidance can be instrumental in understanding and treating obesity. As Leach (2006) observed, many individuals living with obesity may eat to suppress difficult emotions rather than confront them directly. This form of psychological inquiry is an essential component of the pre-surgical decision-making process, supporting patients in making informed and psychologically attuned choices about undergoing bariatric surgery.

The psychological impact of bariatric surgery does not end with the procedure itself. Many patients report complex emotional responses post-operatively, including shame (Tolvanen et al., 2022) and regret (Lloyd et al., 2018). Weight regain can be both unexpected and distressing, leaving individuals unprepared for its emotional consequences (Tolvanen et al., 2022). This highlights the vital role Counselling Psychologists can play in both the preparatory and follow-up phases of bariatric surgery. By facilitating exploration of the psychological risks and benefits, practitioners can help patients make more informed decisions, develop realistic expectations and create personalised coping strategies for post-surgical adjustment. This may include reflecting on behavioural patterns, identifying pre and post surgical eating habits and developing healthier responses to emotional distress. Exploring how patients make sense of and respond to change following surgery can foster greater resilience and long-term psychological wellbeing.

Chapter 3: Methodology

3.1 Overview

This chapter outlines the rationale for adopting a qualitative research design, specifically Interpretative Phenomenological Analysis (IPA), to explore the research topic. It will include a critical justification for selecting IPA over alternative qualitative and quantitative methodologies. The chapter also outlines the epistemological stance and the theoretical framework that informs the research, highlighting its relevance and alignment with the principles of Counselling Psychology. Subsequently the section details the processes of participant recruitment, research procedures, ethical considerations, and data analysis.

3.2 Rationale for Qualitative Methodology

The critique of the existing literature around the research question exploring the decision-making process to go abroad for bariatric surgery, led to a rationale for using qualitative methods. It is essential to explore and grasp the complexities and emotions underlying individuals lived experiences of this topic, as these aspects are not accessible through quantitative methods.

Quantitative methods of analysis emphasise testing pre-established hypotheses and obtaining a measurable understanding of reality (McLeod, 2001). In contrast, the qualitative approaches facilitate an in-depth exploration of the participants lived experiences, allowing the researcher to engage with the internal, subjective world of the meaning-making, an approach that closely parallels the role of the Counselling Psychologist in therapeutic practice (McLeod, 2001). This study was particularly interested with such subjective lived experience, aiming to develop a deeper understanding of personal and complex decision-making process to go abroad for bariatric surgery.

3.3 Interpretative Phenomenological Analysis as a Methodology

IPA sits within a broader tradition of phenomenological methodologies that centre on lived experience, prioritising first-person perspectives and recognising subjective knowledge as essential for advancing psychological understanding (Eatough & Smith, 2017). It focuses on the individual's subjective experience and personal meaning-making (Smith & Eatough, 2007). Smith et al. (2022) outlines core principles that make IPA a flexible yet rigorous approach for exploring complex human experience. The method is grounded in three key philosophical principles, phenomenology, ideography, and hermeneutics (Smith, 2011).

3.3.1 Phenomenology

Phenomenology, as developed by philosophers like Husserl, Heidegger, Merleau-Ponty and Sartre underpins IPA's focus on the lived experience. Phenomenologists are interested in understanding an individual's experience of what the world is like and what the experience of being human is like (Smith et al., 2022). Phenomenological inquiry seeks to understand lived experience from the individual's subjective perspective, describing how it is perceived and made sense of rather than explaining it through theory or objective causes (Smith & Nizza, 2021).

For Husserl (1982), the study of subjective experience must precede any objective scientific account, as it is the lived, experiential world that underpins and gives meaning to the scientific or objective realm (Smith & Nizza, 2021). Husserl emphasised the importance of stepping outside

everyday experience to explore phenomena as they are lived, advocating for the suspension of preconceptions to attend more fully to experience itself (Smith et al., 2022). Husserl described this process as ‘bracketing’ which sets aside prior assumptions to allow the world as it is perceived to become the central focus (Husserl, 1982; Finlay, 2014). This connects with IPA, as recognising the distinction between how the world is experienced and how it is interpreted is fundamental.

Heideggerian phenomenology built on this by considering the contextual and relational nature of being, emphasising that we make sense of and interpret the world from our position within in (Smith et al., 2022). It shifted the focus toward human experience of being in the world and the worldly nature of subjective experience (Smith & Nizza, 2022). Heidegger’s notion of the *lifeworld* emphasises that individuals’ realities are inseparable from the environments in which they exist (Cena et al., 2024). Along with Merleau-Pointy and Satre, there is an emphasis on viewing the individual as embedded and immersed with a world of objects, relationships, language and culture, projects and concerns (Smith, 2022). Our perception of the world is always being mediated through our embodied experience, a perspective that aligns with IPA’s emphasis on how individuals interpret and make sense of their lived realities (Eatough & Smith, 2017). As part of the interpretative process, the initial description is explored and understood within the broader social and cultural context (Cena et al., 2024).

IPA draws on these philosophical foundations to emphasise the importance of exploring participants’ subjective experiences and the meaning they assign to them, while acknowledging the complexity and depth of human experience. This philosophical grounding is particularly pertinent to the present study, which seeks to understand the multifaceted decision to undergo bariatric surgery abroad. A decision that is also situated within a broader network of relationships with medical professionals and family members, that sit alongside both personal and sociocultural narratives surrounding obesity.

3.3.2 Hermeneutics

The hermeneutic principle within IPA recognises that understanding participants’ experiences is always an interpretative process. Influenced by hermeneutic philosophy, Heidegger proposed that phenomena posses both visible and concealed dimensions of meaning, and that genuine understanding requires moving beyond the surface of an account to engage with the deeper significance embedded within it (Smith et al., 2022). From this perspective, the meaning of the experience is not always immediately accessible or explicitly articulated by individuals. Heidegger’s phenomenology was therefore concerned with attending closely to how an experience reveals itself, whilst staying close to what is being described and also seeking subtle clues that point to deeper meaning and significance (Smith & Nizza, 2022).

IPA's hermeneutic dimension focuses on the interpretative nature of understanding human experience, focusing on how individual's make sense of their lived worlds and how in turn researchers make sense of those interpretations (Smith et al., 2022). Central to this is the concept of double hermeneutic, whereby the individual is engaged in interpreting and articulating the meaning of their own experiences, while the researcher seeks to interpret that meaning at a deeper level. The researcher making sense of the participant making sense of their experience (Smith et al., 2022). Gadamer (1975) however, argues that understanding is always shaped by the interpreter's historical, cultural and personal standpoints, which interact with the individual's account. IPA therefore does not strive for complex objectively and instead takes a reflexive stance in which researchers critically examine the influence of their own preconceptions and positionality on the interpretations they generate (Finlay, 2014).

3.3.3 Ideography

IPA values the unique context of each participant's experience and is grounded in an idiographic commitment that prioritises depth, specificity and the detailed exploration of individual meaning making (Smith, 2009). Rather than seeking to generate broadly generalised findings, IPA focuses on developing a rich and nuanced understanding of individual cases in their own unique terms before cautiously drawing connections across cases (Smith & Nizza, 2022). This emphasis on the individual, reflects IPA's broader epistemological stance, which recognises that psychological phenomena are best understood when explored within the lived, subjective and contextual grounded realities of those experiencing them. By privileging depth over breadth, the idiographic approach, enables the researcher to move beyond surface level description and engage with ways in which people interpret and make sense of their worlds. This approach is particularly well suited to studies with small, homogenous samples, such as the present research, whose aim is not to claim representativeness but to generate detailed, context-rich insights into a specific phenomenon, such as deciding to have bariatric surgery abroad (Smith & Nizza, 2022).

3.4 Rationale for Interpretative Phenomenological Analysis

Interpretative Phenomenological Analysis (IPA) was selected as the most appropriate qualitative methodology for this research, as it facilitates a detailed examination of how individuals make sense of their life experiences (Smith et al., 2009). IPA's focus on subjective experience and personal meaning-making (Smith & Eatough, 2007) aligns with the aims of this study, which seeks to explore the experiences of female bariatric patients in relation to their decision to undergo surgery abroad.

The IPA qualitative method looks at the quality and texture of the lived experience (Willig, 2001). This methodological approach is particularly suited to this research, which seeks to explore the rich, personal meanings and subjective experiences of individuals undergoing bariatric surgery abroad, which is harder to capture in quantitative research (Smith, et al., 2021). Quantitative research operates on positivist principles assuming that knowledge is objective and governed by natural laws, whereas qualitative research focuses on the lived experiences. It recognises that non-observable aspects, such as emotions and thoughts, can be examined with observations shaped by the subjective perspectives of both the researcher and the participant (Kasket, 2013). By focusing on the individual's interpretative engagement with their experience, this study aims to undercover an understanding that contributes to a more detailed comprehension of the decision-making process involved in seeking bariatric surgery outside one's home country.

IPA facilitates the use of semi-structured interviews to gather in-depth data using open-ended questions that enable participants to share their experiences in their own words, without being directed by the researcher. The approach aligns with the ethos of Counselling Psychology, which emphasises the importance of not allowing theoretical frameworks to dictate the exploration of individual experiences. Instead, it values the uniqueness of each case and the belief that each case can bring something new (Murphy, 2017).

While IPA offers a powerful framework for exploring the richness and complexity of lived experience, it is not without its limitations. Its idiographic commitment and reliance on small, purposive samples mean the findings are not intended to be statistically generalisable beyond the specific context of the study (Brocki & Wearden, 2006; Smith et al., 2009;). While such depth allows for nuanced understanding of this current research's topic of the decision-making processes of choosing to go abroad for surgery, it also limits the extent to which conclusions can be applied to broader populations of bariatric patients. Moreover, the interpretative nature of IPA, particularly the double hermeneutic, introduces the possibility of researcher bias, as the researchers' own assumptions and positioning inevitably shape the analysis (Smith & Osborn, 2015; Willig, 2013).

The method of IPA is also time-intensive and analytically demanding, requiring detailed engagement with each participant's narrative before cautiously identifying patterns across cases (Eatough & Smith, 2017). As a result, the sample size remains necessarily limited, which can restrict the range of experiences captured. In addition, IPA's focus on individual meaning-making has been critiqued for potentially underemphasising broader social, political and systemic influences that shape experience (Larkin et al., 2066; Willig, 2013). In the context of this research, IPA may not fully capture broader systemic influences such as current economical pressures on the NHS that shape the decision to pursue surgery abroad. Future research could also benefit from examining factors influencing patient choice, such as the increasing availability of weight-loss mediations, such as GLP-1 receptor agonists, introduced since the inception of this study.

3.5 Consideration of Alternative Qualitative Methods

Grounded Theory was considered as an alternative qualitive method to IPA, given its focus on investigating individuals' experiences within their broader social context (Willig, 2013). Grounded Theory aims to create a conceptual framework and develop theories that explain social processes around a specific phenomenon. However, the aim of this research is not to develop a theory of social processes, but rather to gain a rich understanding of the lived experience of bariatric patients in relation to the phenomena of deciding to have surgery abroad. As the primary focus of this study is on the subjective meaning making of individual participants, rather than the social dynamics involved, IPA was deemed more suitable for capturing the depth and complexity of these personal lived experiences.

Discourse Analysis was also considered, as it focuses on the relationship between language and social life, employing various qualitative methods to explore how language is used to convey meaning within specific social contexts (Willig, 2008). This approach also accounts for the influence of historical, cultural, and social interactions in shaping discourse (Willig, 2008). Whilst the examination of language is of interest to this research, particularly in examining the participant's specific use of language to explain their experience during the interviews within their scripts, the primary focus of this research is on the individual's sense making processes regarding their decision to undergo bariatric surgery abroad. Therefore, IPA was believed to be more appropriate, as it emphasises the personal, subjective interpretation of experiences over the social context of language used.

3.6 Ontological and Epistemological Position

Research is primarily built upon a set of philosophical assumptions regarding the nature of reality and the subjects being studied (Willig, 2008). These assumptions guide researchers in adopting a specific ontological and epistemological perspective (Willig, 2008). This research takes a relativist ontological approach.

Ontology is the branch of philosophy that deals with the nature of reality, existence or being (Willig, 2008). This perspective sees reality as a subjective experience. Various realities exist as each individual constructs their own reality subjectively, influenced by their unique context (Khalil, 2014). This is of relevance to this research which is looking at women's personal, subjective and unique experiences of deciding to have bariatric surgery abroad.

This research aims to expand epistemological knowledge of existing realities (Robert, 2010) by gaining a deeper understanding of the experiences of bariatric patients regarding their decision to undergo surgery abroad. Epistemology is a branch of philosophy that studies the nature and origin

of knowledge and how we acquire knowledge (Robert, 2010). It is philosophically connected to ontology and concerned with how we know what they know (Finlay, 2006). It helps us understand how knowledge is constructed and validated, which is important in helping us make informed decisions (Crotty, 1998). Realism asserts that knowledge is acquired by observing the external world and discovering an objective reality, independent of human perception of interpretation (Bhaskar, 1978). Relativism on the other hand, says we acquire knowledge by understanding how human experiences, contexts and interpretations shape what we know and believe to be true (Bhaskar, 1978). Knowledge is socially constructed, and we are shaped by our individual perspectives, cultural contexts and historical circumstances.

Critical Realism bridges the gap between realism and relativism (Willig, 2008). It accepts that an objective reality exists but acknowledges that our understanding of it is always facilitated by subjective and cultural interpretations. It offers a balanced perspective. It is invaluable in research, as it allows for a nuanced exploration of complex phenomena, such as deciding to have bariatric surgery abroad, while encouraging the exploration of deeper causes and mechanisms beyond the observable. Critical Realism aligns well with IPA and this study, as they both look at the interplay between objective reality and subjective interpretation. This study will use IPA to explore how the women make sense of their experiences of having bariatric surgery abroad within their personal and social contexts. It will take a Critical Realism's position that the external reality exists, that of the experience of undergoing bariatric surgery abroad, and the participant's interpretation and construct meaning around it, will be based on their unique perspectives.

The researcher therefore aims to expand epistemological knowledge of existing realities (Robert, 2010) by gaining a deeper understanding of the experiences of female bariatric patients regarding their decision to undergo surgery abroad.

3.7 Method

3.7.1 Participants

A purposive, self-selected sample of six female UK residents who had travelled abroad for surgery were recruited using snowball sampling to gain an in depth understanding of medical tourism experiences (see Table 1.0 for participant demographic information). Smith et al. (2022) recommend a sample of between four and ten participants for IPA research. The idiographic nature of IPA supports small sample sizes, allowing for detailed, in-depth exploration of the phenomenon under study (Willig, 2022). Due to the sensitive nature of the research question around weight loss, gain and body image, it was decided that six interviews would provide an adequate opportunity to explore both similarities and differences within the sample. This is of value when using qualitative

methods in health research, as small in-depth samples enable rich exploration of personal experience (Brocki et al., 2006).

Purposive sampling in IPA is guided by inclusion and exclusion criteria to ensure a relatively homogenous participant group for whom the phenomenon is directly relevant. In this study, all participants had made the decision to undergo bariatric surgery abroad, making their experiences central to the research aims. While not statistically generalisable, the findings contribute to the theoretical generalisability by offering insights that may resonate with and inform understanding of others considering bariatric surgery abroad. This allows connections to be made between the study's results, personal experiences and the existing literature on this phenomenon.

3.7.2 Inclusion and Exclusion criteria

To ensure homogeneity of the sample and address the purpose of the study, the following inclusion and exclusion criteria were adhered to. Participants were required to be female, as research shows that women are five times more likely to pursue bariatric surgery compared to men (Kolotkin et al., 2008; Sarwer et al., 2016). Additionally, it was anticipated that females might feel more at ease and open when discussing sensitive topics, such as body image, with a female researcher. Another inclusion criterion was that the participant had been abroad to have their surgery, so in another country other than the one they reside. Specifically people from the UK travelling to external countries. The rationale for this, was that the research was looking at the experience of UK citizens going abroad for bariatric surgery as part of medical tourism. All participants were required to have undergone bariatric surgery abroad within a period ranging from twenty-four months to ten years prior to the interview. This specific time frame was chosen to ensure the research captured experiences relevant to more recent surgical procedures, such as the Sleeve Gastrectomy.

Exclusion criteria included individuals in the pre-operative phase, as well as those who had undergone surgery within less than 24 months prior to the interview. This decision was informed by existing research, which found that body mass index (BMI) loss becomes statistically insignificant twenty-four months after surgery ($p < 0.01$), and that approximately 50% of patients gain weight after this period (Magro et al., 2008). This was of interest to the research, to explore if people being interviewed included weight gain as part of their experience. The exclusion criteria also included those aged under 18, so full informed consent was given by them and not guardians (BPS, 2021) and to ensure the mental capacity and maturity of participants. A final exclusion was anyone who had undergo surgery in the UK, as this research's aim was to explore surgery abroad. The information sheet also detailed the exclusion and inclusion criteria (see appendix A).

Six female participants were recruited for this research. The participant demographics are presented in table 1.0 to provide context for the research findings. Care was taken to exclude any potentially identifiable information, ensuring confidentiality and anonymity.

Table 1.0 Demographic information for the six participants

Pseudonym	Gender	Age (Years)	Time since bariatric surgery	Country of Surgery	Hospital Name (Pseudonym)
Anna	Female	51	36 months	Turkey	J Mooress
Brianna	Female	62	36 Months	Poland	Stanhill
Billie	Female	58	36 months	Turkey	J Mooress
Maureen	Female	52	26 months	Turkey	Blue Line
Mary	Female	35	37 Months	Turkey	Blue Line
Joy	Female	56	48 Months	Lithuania	Braystain

3.7.3 Recruitment Procedures

Participants were recruited via a Recruitment Poster (see the appendix A) shared within online bariatric support groups on Facebook, specifically Obesity UK Bariatric and Metabolic Surgery Support Group and the Bariatric Services UK Group. Six responses were received through Facebook. Of these responses, three met the inclusion criteria and three did not, due to them having surgery within the last twelve months. Those who did not meet the criteria were contacted via a private chat on Facebook, thanking them for their interest and informing them that as per the information sheet, the research was seeking participants that had surgery more than twenty-four months ago and they were welcome to share the information with anyone they felt might be able to take part. For those that met the inclusion criteria, an initial contact with potential participants was made via email to verify they met the established inclusion criteria. Those who qualified were subsequently sent a Participant Information Sheet and Consent Form by email (appendix B and C). Upon receipt of their consent, a time and date were confirmed for the interviews, which were conducted virtually using Microsoft Teams.

Additionally, snowball sampling was employed, whereby participants were asked after each interview if they could refer others within their networks who might also meet the study's criteria. Three participants were recruited via this method.

3.7.4 Semi-Structured Interviews

Data collection was conducted through video calls on Microsoft Teams, with each interview lasting between 45 – 60 minutes.

The primary objective of IPA is to “enter the world of the research participant” (Willig, C. 2008, p46) and focus on the unique, experiencing individual, therefore a semi-structured interview appeared the most appropriate method for this study. This method provided the researcher with the flexibility to ask pre-determined questions related to participants’ decision-making processes regarding bariatric surgery abroad, while also allowing for follow-up questions based on participants’ responses (see the appendix for Interview Schedule D). This adaptive approach facilitated a deep exploration of the participants’ personal experiences. Open-ended questions were employed to encourage participants to share their full narratives, avoiding any potential researcher-led bias. This aligns with the ethos of Counselling Psychology, which is not to be led by the theory but to believe that each case can bring something new (Murphy, 2017). This non-directive and non-judgmental approach are a core value within Counselling Psychology, reflecting its emphasis on respect for the individual’s subjective experience and autonomy (Strawbridge & Woolfe, 2011).

This approach was considered more suitable than using focus groups, as this study aimed to capture the individual experiences of participants, uninfluenced by the perspectives of others. Although decision making is often socially influenced, the focus here was on the lived experience of the decision-making process, which is inherently personal. It was also recognised that discussing such sensitive topics in a group may evoke distress or feelings of vulnerability, whereas one to one interview allows for the development of trust and rapport, which are core values within Counselling Psychology (Cooper, 2008). Furthermore, maintaining confidentiality is more challenging in group settings, raising ethical concerns about potential breaches (British Psychological Society, 2021).

3.7.5 Interview Schedule

The interview schedule (see appendix D) was designed to align with the research aims and address the core research questions. It was developed in collaboration with a supervisor and underwent peer review with a Clinical Psychologist working in the field of bariatric surgery and three counselling psychology trainees. This process ensured that all questions were open-ended and non-directive, encouraging participants to reflect freely on their experiences. The schedule functioned as a flexible guide throughout the interviews, with prompts incorporated via the “Prompt sheet” (Nizza et al., 2021) as needed to help participants expand upon their experiences of having bariatric surgery abroad (Smith, 1996).

The interview questions were formulated after a comprehensive literature review of existing research on bariatric surgery and the phenomenon of undergoing surgery abroad. They encompassed a broad range of topics relevant to the study’s aim, such as participant’s awareness of the physical and psychological risks and benefits of bariatric surgery (appendix D).

3.7.6 Procedure

At the start of each interview, participants were welcomed and briefed on the purpose of the study, reassured about confidentiality and reminded of the right to withdraw at any time without consequence. To facilitate rapport and ease participants into the interview process, a series of warm-up questions were posed before moving on to the core interview schedule. A semi-structured form was employed, allowing participants the freedom to explore and articulate their experiences in as much depth as they felt comfortable. The interviewer adopted a flexible and responsive stance, using prompt questions where appropriate to encourage elaboration or clarify meaning, while ensuring that the participant's narrative remained central. Upon completion of the interview, participants were thanked for their contribution and provided with a debrief form outlining support resources and contact details for any follow-up queries.

3.7.7 Ethical Considerations

Ethical Approval

Prior to participant recruitment, this research gained ethical approval by the LMU Research Ethics Review Panel (see appendix G).

Informed Consent and Confidentiality

The research adhered strictly to the BPS Code of Ethics and Conduct (2021). Participants were provided with an Information Sheet (appendix B) and Consent Form (appendix C), ensuring they could give fully informed consent. These documents outlined the principles of anonymity, confidentiality and the participants' right to withdraw at any stage of the study. Furthermore, the recruitment poster (appendix A) clearly stated that all information would be treated as confidential and anonymous, consistent with the ethical standards set by the (British Psychological Society, 2021).

To ensure participants' well-being, post-interview debriefing and follow-up support were provided via the Debrief Form (see appendix E), which was emailed to the participant after the interview. This form included details of confidential support services that participants could contact if they experienced any concerns or issues because of their participation, as well as contact information for the researcher and supervisor.

In compliance the GDPR, participants were informed their data would be processed accordingly. They were also provided with a link to further information about GDPR policies through the university's website (http://www.londonmet.ac.uk/about/policies/data-protection/). They were also informed that they can access the results from the study when completed, by contacting the researcher.

All collected data was stored in encrypted files on a password-protected laptop, with access restricted solely to the researcher. In line with British Psychological Society (BPS) guidelines (2021), these files will be securely destroyed after a five-year period to ensure data protection and confidentiality.

Potential Distress and Vulnerability of the Participants

At the commencement of each Microsoft Teams call, participants were informed that they were under no obligation to answer any questions that caused discomfort and that all responses would be treated with the utmost confidentiality.

Given the potential vulnerability of this participant group, the researcher exercised heightened awareness of the emotional and psychological sensitivities involved. Acknowledging the possibility that some participants may have experienced weight regain following bariatric surgery, it was essential to consider the associated psychological impacts including feelings of shame (Tolvanen et al., 2022) and the perception that weight regain was self-inflicted due to their consent to undergo surgery (Heinberg et al., 2020). To mitigate potential distress, a comprehensive Distress Protocol (see appendix F) was implemented in line with best practices outlined by Whitney et al., (2022). This protocol provided guidance on identifying signs of participant distress and the appropriate actions to take should such signs emerge during the interview.

Although the researcher's primary role was that of researcher rather than a Counselling Psychologist, the researcher drew upon training and experience in managing emotional distress, acquired through their Counselling Psychology programme at London Metropolitan University. This expertise was crucial in ensuring that any emerging distress was handled with sensitivity and professionalism, whilst maintaining the researcher's boundaries within their designated role.

In addition, the Information Sheet and Consent Forms (appendix B and C) clearly outlined the participants' rights, including the ability to pause the interview or withdraw from interview at any point. Participants were also informed they retained the right to withdraw from the study within one month following their participation. These documents emphasised the voluntary nature of the study, affirming that participants were not obliged to answer any questions that provoked discomfort. This transparency was critical in addressing the potential psychological challenges,

such as shame or guilt, particularly for participants who may have regained weight post-surgery (Tolvanen et al., 2022).

Following each interview, participants were provided with a Debrief Form (see the appendix E) which included information about confidential support services available to them should any concerns or issues arise because of their participation. The form included the contact details of both the researcher and the research supervisor, offering participants further avenues to follow-up support if needed.

3.8 Process of Analysis

The analysis followed the rigorous, systematic guidelines outlined by Osborn & Smith (1998) and Smith et al., (2022) which are well-established within this field of IPA research. To ensure consistency and full engagement with the data, the principal researcher conducted and transcribed all interviews. They were transcribed verbatim including pauses and audible noises such as uhm or laughter. The process of immersion in the patients' narratives was a critical component of the IPA approach, allowing the researcher to remain close to the lived experiences being examined.

The data was analysed using the step-by-step approach to IPA as outlined by Smith et al, (2022).

Step 1: Reading and Re-reading

I began the analytic process by reading and re-reading each transcript in detail numerous times to familiarise myself with the data and allow me to fully immerse myself in the patients' narratives. This is a critical component of the IPA approach, to allow me to remain close to the lived experiences being examined (Smith et al, 2022). I found it helpful to listen to the audio recording whilst reading the transcripts, as this allowed for deeper connection to the data (Smith et al, 2022) and enabled me to often pick up on nuanced words I had missed before. The repeated reading also enabled full engagement with the nuances of the participants' language, tone, and overall narrative flow.

Step 2: Exploratory Noting

During this phase, detailed notes were made in the right-hand margin (appendix H) to capture my first impressions and reflections on the data. Data was extracted gradually and tentatively to ensure an exploratory attitude was maintained (Smith et al., 2022). Initial exploratory comments were descriptive, linguistic and more conceptual as I moved through the process (Smith et al., 2022). For descriptive comments I noted the content of what the participant was saying, such as key words, terminology and phrases. For linguistic comments I considered their use of metaphors, repetition, laughter and tone. Finally I made conceptual comments around the participant's understanding of their experience (Smith et al., 2022). This required me to shift my focus toward developing a more overarching understanding of the participant's experience, while ensuring that

all interpretations remained firmly grounded in the data. During this process it was essential I engaged in bracketing to ensure I set aside prior assumptions and expectations to allow the phenomenon to reveal itself as experienced by the participant (Finaly, 2014; Husserl, 1982). For example, I was aware that I initially anticipated participants might describe predominantly negative experiences of undergoing bariatric surgery abroad, such as regret, which was not the case. Through the process of bracketing, supported by reflexive journalling and speaking with my supervisor, I was able to acknowledge and suspend these preconceptions, allowing me to remain open to participants unexpectedly positive narratives.

Step 3: Constructing Experiential Statements

During the next stage of the analytic process, I identified Experiential Statements (ES) which were recorded in the left-hand margin (see appendix H). These statements reflected a shift from descriptive noting to more psychological interpretations, grounded in the participants' meaning-making. This process helped articulate how each individual understood and emotionally responded to their decision to have bariatric surgery abroad. I aimed to create concise summaries that captured what was significant at specific points in the text while remaining informed by the broader context of the entire transcript. This approach reflects the hermeneutic circle, in which the part is interpreted in relation to the whole, and the whole if understood through its parts (Smith et al., 2022).

Step 4: Searching for Connections Across Experiential Statements

Following the development of Experiential Statements, connections between them were examined within each case. This involved clustering related statements and identifying patterns, with the aim to move toward a more integrated and holistic account of each participant's experience.

Step 5: Naming the Personal Experiential Themes (PETS) and Consolidating and Organising Them in a Table

Experiential Statements were further refined and grouped into Personal Experiential Themes (PETs), which were organised into a coherent structure for each case. These PETs represented higher-order insights into the individuals lived experience and were documented in thematic tables for clarity and transparency. PETs were compared across cases to highlight the most prominent themes, reducing the data while retaining individual experiences (appendix I). Understanding how the participant made sense of the phenomenon was key, but this process inherently required an interpretative interaction with the text (Smith, 1996). To remain ontologically grounded, all themes reflected participant's lived experiences. Finally, PETs were clustered into a master table of three Group Experiential Themes (GETs) see table 2. Participant quotes are included to illustrate the themes and retain their perspectives. The results are presented in a sequence that reflects the women's experience of the decision to have bariatric surgery abroad.

Step 6: Continuing the Individual Analysis of Other Cases

The full analytic process was then repeated for each individual transcript, maintaining IPA's idiographic commitment to treating each case on its own terms before looking for patterns across cases. Once individual analyses were complete, cross-case analysis was conducted to identify shared themes and divergences, while still preserving the individuality of each participant's account.

Chapter 4. Analysis

4.1 Introduction

Three GETS were developed from the cross-case analysis. They were: (i) Jumping through a "trillion hoops" (ii) Reaching a breaking point to regain control (iii) "No regrets" and "worth it in the end".

Across participants, a common experience emerged of frustration and struggle when faced with systemic and personal challenges. Coupled with a personal determination to pursue and ultimately have bariatric surgery abroad. Their narratives conveyed how the decision to undergo bariatric surgery abroad was not taken lightly but developed over time, against a backdrop of frustration with the NHS, repeated efforts to manage weight, and the psychological toll of feeling unheard or dismissed. For many, reaching a breaking point created both urgency and clarity, prompting a decisive step towards reclaiming agency over their health. Although the journey involved considerable sacrifice and long-term lifestyle adjustments, participants consistently reframed these difficulties within a narrative of having no regret and it being worth it in the end.

Table 2: Group experiential themes, PETs, subthemes and relevant quotes/extracts

GET 1: Jumping through a "trillion hoops"

PETs	**subthemes**	**relevant quotes/extracts**
Feeling dismissed and overlooked by the NHS, shaped their journey abroad	Feeling frustration with the NHS systemic barriers	"*You seem to have to jump through a trillion hoops to just get one step forward (Joy)*
	Begging to be heard and experiencing the NHS as not accepting but rejecting	*"Sort of like begging the doctor" (Brianna).*
	Not feeling supported by NHS	*"But then when you phoned and had questions or looked for that support, it wasn't there" (Joy)*

	Impossible dilemma to get help and be eligible in the UK	"*If you can get to 40 BMI, then you'll get this. You will absolutely be a candidate for it. …..I'm not putting 3 stone on to go on a two-year waiting list*" (Billie).
Feeling reassured and cared for abroad both pre and post surgery	Feeling that they cared	*"I just felt that this care, the feedback, the information they needed to know about me. Before I even like flew out there, they just seemed more thorough than anyone else" (Anna).*
	Feeling guided, informed and reassured in the robust process abroad made them decide to have bariatric surgery abroad	*"They were very thorough. ….. You can still, you could still access the dietitian for so long after your surgery, …. They are very thorough" (Mary)*
	Feeling prepared for bariatric surgery abroad	*"The hospital was really, really good with giving me everything I needed to know… to reassure me…. that's what made me go abroad surgery instead of the UK" (Billie).*
They didn't disappear after surgery, there was ongoing support abroad anytime	Support any time post surgery	*"Yeah, I have a WhatsApp group with Turkey they're called the X in Turkey. So I'm with them. I can phone them, speak to them any anytime" (Maureen)*
	Feeling connected and supported by the company abroad at any time	*"So you could contact the surgeon directly through a WhatsApp messaging group. So it wasn't that you weren't able to contact him" (Joy).*
	Feels like a personalised experience due to post care support	*"I'm still in contact with my surgeon personally through Instagram he keeps in touch with me all the time asking me how I am so that is good" (Maureen)"*

GET 2 – Reaching a breaking point to regain control

PETs	**subthemes**	**relevant quotes/extracts**
Personal agency in weight management, taking control	Taking control now	"*I thought let me do something to help my health and general well-being" (Joy)*
	Reaching a breaking point with lifelong struggle with weight, control and lost time	*"I knew I needed to do something…… I just thought I'd need to sort this now…… they'd sort of said that obesity can be like a factor in these illnesses, and I just thought if I could do anything now to prevent it I*

		would……. I'd crack on and do it." (Anna).
	Challenges of weight management prior to surgery	*"…so from the age of 17 onwards it was just constant trying every diet under the sun giving up…. because it was hurting me joints and all that …. I've been doing this for 20 years, so we know it's not going to change" (Mary)*
	Taking ownership in researching the decision to have bariatric surgery abroad	*"I looked him up, checked his qualifications, all that sort of thing" (Anna)*
Secrecy and isolation - in order to maintain control over their decision they had to keep secrets	Wanting to keep bariatric surgery abroad a secret	"*No, I've told nobody about it apart from my husband and my mum. …… I said I need to do it for myself" (Joy).*
	Not feeling supported her decision to go abroad	*"I didn't tell many people initially, just some close friends and they were like, what the hell are you like? Why are you doing that? It's ridiculous". (Anna).*
	Shame and stigma of having bariatric surgery abroad to lose weight	*"I think I think there was a lot of embarrassment around the operation when it came to friends and family. I think my parents were definitely embarrassed that I was even thinking about having it done, let alone go into Turkey to have it done." (Billie).*

GET 3 - "No regrets" and "worth it in the end"

PETs	**subthemes**	**relevant quotes/extracts**
Physical and psychological adaptation	Physical adaptation post surgery abroad	*"I'm struggling with solid foods. I can't get any solid foods in me. As soon as I have solid food, I vomit them back up again (Maureen)*
	Psychological adaptation after bariatric surgery abroad	*"I think that your body doesn't catch up or your brain doesn't catch up to how quickly your body can actually change. And that for me was probably the hardest part" (Joy)*
Permanent lifestyle change	More than just losing weight it's a permanent lifestyle change	*"Your whole lifestyle has changed. In fact, my whole lifestyle has changed forever.*

		I've not had a solid meal in two years" (Maureen).
	Monotonous and relentless management of permanent lifestyle change	*"So you're literally having to take vitamins, every single, every single day" (Maureen).*
	Can't do what they used to do	"*So unfortunately for me, I've not been able to exercise or able to tone this up as what I'd have liked to have done. Because I had a personal trainer and I had to stop" (Maureen)*
Worth it in the end	Positive lifestyle outcomes	*"But you know, now I have more of a social life because when he says, come on, let's go out I go to the wardrobe and get out a pair of jeans and a top and that's it done" (Maureen).*
	Positive medical and psychological benefits	*"I do say that it definitely has helped my self confidence. I do feel much better in myself…. I don't need an inhaler now…. Everything else is completely cleared…. I don't need any medication.", (Mary)*
	Worth it in the end	*"Yeah, well, it was worth it in the end" (Billie)*

4.2 GET 1: Jumping through a "trillion hoops"

This theme captures participants' experiences of systemic barriers and a perceived sense of abandonment by the NHS, which ultimately compelled them to reclaim agency by seeking bariatric surgery abroad. Their decision to travel overseas emerged after encountering repeated obstacles and feeling a sense of despair and invisibility. This sense of not being heard, framed their choice to go abroad for bariatric surgery, as an act of reclaiming power. In stark contrast, participants described their interactions with bariatric teams abroad as validating and supportive. They felt seen, heard and reassured through attentive, consistent care that extended from initial contact to postoperative follow-up. This trust in the professionalism and thoroughness of overseas providers played a critical role in reinforcing their decision to pursue surgery abroad. While bariatric surgery was regarded as a necessary solution, participants perceived access within the UK as obstructed. Conversely, seeking surgery abroad offered a markedly different experience, one characterised by genuine care and a sense of being valued.

Participants described deep frustration with the systemic barriers they encountered when seeking bariatric surgery through the NHS. They had struggled for years to manage their weight and saw bariatric surgery as a solution. They repeatedly shared their struggles with weight management, seeking understanding and support to be accepted for bariatric surgery in the UK, yet instead

experienced persistent barriers. Whilst many shared they appreciated there had to be assessments and criteria for eligibility for surgery, they found these to be excessive and preventative from allowing them to move forward with their weight management. The process was described as lengthy, complex and emotionally draining. A strong sense of being caught in a cycle of delays, which participants experienced as moving a single step forward only to be pushed several steps back. As Joy reflected;

> "*You seem to have to jump through a trillion hoops to just get one step forward …and so you never seem to make any progress in terms of getting further on, you know, through the process or through their system of requirements" (Joy)*

Mary shared a similar experience, noting how even after completing initial steps, there was no certainty of approval for surgery in the UK. Her narrative gives a real sense of how long the process took, and even after years of waiting, there was no guarantee of being accepted for surgery;

> *"There's a lot of hoops to jump through for the NHS anyway but then at the end of the hoops it's whether or not you get accepted and it's a very long process and then it's if you do get accepted it's then again another two plus years before you get the surgery" (Mary).*

They viewed bariatric surgery as a critical intervention for managing their weight and health, yet the time taken was disempowering them from addressing both. They shared their experience of how long it was taking to go through the necessary process, which then created a sense of urgency to proceed with what they saw as a solution to help manage their weight and health. Joy emphasised (if);

> *"I had started the process of trying to go through the NHS…. I could probably be dead with the time that happened". (Joy).*

The word "*dead*" really emphasising how serious she viewed her decline in health and the awareness of the impact of lengthy delays. Urgency was also evident in Mary's account, as she realised being overweight was impacting other lifestyle elements like being able to conceive, so she needed to act now, as time was running out.

> *"I'm kind of on a time limit now. Because my main reason for losing weight was not only because I was, it wasn't ever to be thin. It was because my health was really suffering, and because I wanted another baby" (Mary).*

Participants described the experience of navigating the UK bariatric surgery system as emotionally draining, often using language such as "fighting" to convey the intensity and difficulty of the process. Their choice of words reflected a sense of struggle, exhaustion and "suffering" they had experienced in trying to access the care they needed. I had a sense that the participants were trying to convey their deep knowledge of their own bodies, developed through years of struggle with weight management. They understood their bodies and challenges the best, yet when trying to

explain what they needed, they felt they were not being fully listened to by healthcare professionals. Instead they experienced a continual battle to have their concerns acknowledged, often feeling they had to fight to be heard;

> *"Still fighting to try and prove to them the weight was causing an impact of movement mobility" (Joy) and "…but I've had 2 1/2 years of fighting with my doctor" (Billie).*

Participants narratives revealed the experience of NHS barriers felt less like receiving help and more like "begging the doctor" (Brianna). This invoked feelings of rejection rather than acceptance from the very healthcare system they were turning to for support. Such perceptions fed into a wider emotional narrative of silence and dismissal. Participants described themselves as actively seeking help, posing questions and demonstrating willingness to engage, yet encountering a system that offered little acknowledgement in return. This lack of reciprocity intensified their sense of abandonment.

> *"Yeah, yeah, that was just really hard to be heard." (Billie)*

also mirrored in Joy's experience when she said;

> "*They didn't really want to help me progress through their system" (Joy)*

I recall a sense of sadness and isolation in Joy's tone of voice when she shared, she felt the UK doctors did not want to help her get through the process to have bariatric surgery. Rejection also evident in Billie's narrative who experienced it on the grounds of financial restraints.

> "*I had previously applied on the NHS and got rejected due to lack of funding" (Billie)*

Participants also spoke about the exhausting effort involved in trying to be deemed eligible for bariatric surgery within the UK healthcare system. Many described already feeling emotionally "deflated" and physically depleted by challenges of living with their current weight and health issues, which made it even harder to summon the energy and motivation required to navigate what they experienced as a long, complex and often disheartening process. A particular source of frustration was the strict BMI requirements set by the NHS for accessing bariatric surgery. For some, their BMI fell just below the threshold, leaving them in a distressing situation, where they were considered not eligible. They felt an impossible dilemma, where they wanted to be healthier and thus improve their lives, yet were not overweight enough to get the help they wanted. They perceived the message as being that they needed to put more weight on before they could be helped. Even then it not being a guarantee they would get surgery.

> "*If you can get to 40 BMI, then you'll get this. You will absolutely be a candidate for it. …. I'm not putting 3 stone on to go on a two-year waiting list*" (Billie).

> "*It was quite hard work to keep it going and to have the effort to do it as well because you're so deflated with being overweight and feeling unhealthy and feeling like you're worthless because of your weight to then push yourself that much to try and get the*

resolution. It was months and months of back and forth and long phone calls and things. So it's a lot for the patient to have to do" (Billie).

Similarly, in Joy's account:

> ***"**So I was kind of torn because in one way they're saying that you're overweight and do something about it. And then when you try to do something about it, they want you to be worse. So it's kind of like it's a bit of a catch 22. If I stayed at home and put on an extra three or four stone and were worse, I felt then they would help me, which kind of would be defeating the whole point of trying to become healthier and better in the first place"*

The word "stayed" emphasises how stuck she felt in this dilemma. They wanted to be proactive in their health management, yet experienced being encouraged to be passive. Participants, spoke of wanting to have the procedure in the UK rather than abroad, however even when they proactively explored alternative options, such as private care, there were still long wait times;

> *"They can't get me in, in the UK, even privately was a ridiculous wait there" (Anna),*

The mix of a less rigid criteria abroad and no wait times, was therefore a key contributor in their decision to seek intervention abroad across all transcripts.

Participants also described a sense of depersonalisation in their interactions with the health care system in the UK. They repeated use of the word "*tick*" in participant's narratives, reflected a perception of being reduced to a checklist, rather than recognised as individuals with complex needs. For Joy, it felt as though the system required her condition to deteriorate before she would qualify for support:

> "*They didn't really want to help me progress through their system. I think they almost wanted me to be worse before I could then be in a situation that they would then tick the box to try and help me……they just really weren't interested" (Joy).*

The word "*support"* emerged repeatedly throughout interviews, both a perceived lack of and a need for, linking to a deeper emotional frustration of feeling unheard.

> *"But then when you phoned and had questions or looked for that support, it wasn't there" (Joy)*

This sense of abandonment was further compounded by participants' perceptions of the lack of continuity and aftercare within the UK system. Brianna's repeated emphasis on the word "care" underscores what she was ultimately seeking in her weight management journey. For Brianna, the absence of care was not only in relation to the surgical process itself, but also in the aftercare. This experience played a pivotal role in shaping her decision to pursue bariatric surgery abroad, as she felt the necessary support structures were fundamentally lacking at home. Brianna's narrative illustrating a striking reversal of expectations as she assumed that the UK system would provide comprehensive care compared to going abroad, yet she experienced the opposite;

*“But I don't think you have the care here” [in UK] ….and that's one of the reasons I really didn't want to go to the UK. There's no aftercare, actually, because you kind of think it might be like, say, the other way round” (*Brianna*)*

Collectively these accounts reveal how participants felt abandoned during a critical point in their healthcare journey. These reflections reinforced participants’ views that the NHS not only imposed barriers to access but also failed to offer adequate post-operative support, deepening their sense of being let down at every stage of their surgical journey.

As a result of this, participants began researching bariatric surgery abroad. In stark contrast to their experiences in the UK, participants consistently described feeling reassured and cared for throughout their journey of undergoing bariatric surgery abroad. The repeated use of the word “care” throughout all transcript narratives, reflects a personal experience of being valued and supported throughout their surgical journey abroad, both before and after. This perception of care appeared to extend across the entire process from their initial enquiries into having bariatric surgery abroad, before travelling, the surgery itself and through to aftercare. This created an experience of feeling cared for, guided, informed and reassured in the process of having surgery abroad. A personalised experience that many felt had been absent in their interactions with the NHS.

The attentiveness of the overseas team was especially evident in the preparation phase. Participants spoke of being given detailed information about their health and lifestyle both pre and post surgery. They experienced this as thorough and robust, which helped them feel trusting and confident in the process and their decision to seek bariatric surgery abroad. Anna’s narrative captures this well as she describes her experience of feeling cared for and seen;

“I just felt that this care, the feedback, the information they needed to know about me. Before I even like flew out there, they just seemed more thorough than anyone else” (Anna).

This “care” was not experienced by participants as purely transactional, but rather as genuinely personalised and individualised to their needs. Mary experienced that the level of care included her current needs and a consideration of the aftercare she might need post surgery;

“They actually care about the person and the life after they're going to have afterwards as well.” (Mary).

Similarly, Anna experienced pursing bariatric surgery abroad as more about her welfare before and after surgery, rather than a depersonalised monetary exchange. I recall the internation in her voice, as she seemed surprised, that almost as a bonus of them caring, it was not just before surgery but afterwards as well;

“But I just felt they weren't just out for grabbing my money. If you like. They cared and even the aftercare that they offered is good” (Anna)

Another striking feature of participant's experiences were their positive reflection on the depth of information provided by the team abroad. They consistently described the overseas process as highly structured and comprehensive, giving them a sense of reassurance and feeling prepared. This level of guidance appeared to be a stark contrast with the uncertainty they encountered in the UK system. Billie explained how the hospital's approach influenced her decision to go abroad.

> *"The hospital was really, really good with giving me everything I needed to know… to reassure me…. that's what made me go abroad for surgery instead of the UK" (*Billie*).*

This was echoed by Brianna, Anna and Mary who all used the word "thorough" to stress there was nothing that appeared lacking in their preparation for surgery abroad;

> *"They were very thorough. …… you can still, you could still access the dietitian for so long after your surgery, …. They are very thorough……I've had a whole barrage of tests …. Literally from top to tail. There was nothing they didn't do" (*Brianna*)*

The experience of undergoing bariatric surgery abroad stood in stark contrast to participants' interactions with the UK healthcare system. Whereas the NHS process was described as fragmented, dismissive and depersonalised, the process abroad felt collaborative and supportive. Participants expressed that, for the first time, they felt listened to and actively involved in their care;

> *"Before and prior to was fantastic and I could have asked anything and everything…..there was nothing that wasn't said, nothing that wasn't covered" (Joy)*

Anna echoed this sense of being guided through every step of the journey and the experience of someone being there to support her;

> *"She guides you through. Obviously, what you need to do to change, but also, why you have those bad habits and what could you do instead? What could you replace it with? Like I said, she's online, so there for you" (Anna).*

These experiences created a powerful emotional shift. Participants moved from "fighting to be heard" within the NHS to feeling cared for and fully supported abroad. Mary shared she felt *"in good hands there*", which ultimately reinforced for her and others that travelling abroad for surgery was the right decision.

Another key theme that emerged from the participants narratives about feeling supported abroad, was their shared experience of this support being ongoing. Many participants highlighted the positive experience of having direct and unlimited access to the medical team abroad before and after surgery, describing how they could contact them "anytime" of day. This constant availability, made them feel listened to, heard and supported, an experience that contrasted sharply with the lack of accessibility and responsiveness they felt within the UK system;

> *"Yeah, I have a WhatsApp group with Turkey they're called the X in Turkey. So I'm with them. I can phone them, speak to them anytime" (Maureen)*

*“I could ring up the hospital now and speak to them. We’ve got the coordinator there. His English is Immaculate…they’re always at the end of the phone if I need to speak to somebody” (*Brianna*).*

“… they were actually really helpful and I can't say anything negative about them because even if I had a problem now and I emailed them, they'd happily give me advice for free. …..They always got back to me and said no, it's absolutely fine. He even goes as far as giving you his WhatsApp number so you can contact him” (Mary)

“So you could contact the surgeon directly through a WhatsApp messaging group. So it wasn't that you weren't able to contact him” (Joy).

The participants really valued that this support extended beyond surgery itself, with Maureen repeatedly using the words *“I still have…..”* to convey a sense that the care was ongoing and consistently available to her. They seemed to value this twenty-four-hour access to care from surgeons, dieticians and people who had a similar experience. The idea of having questions that needed answering and them being able to have instant access to this was both reassuring and personal;

“I’m on their WhatsApp group. I still have the dietitian. I still have the lady who owns the company. I still have the girls from Scotland who were with me all the way and their coordinators who were with me all the way from there. So yeah, I can go on there anytime……” (Maureen)

“I'm still in contact with my surgeon personally through Instagram he keeps in touch with me all the time asking me how I am so that is good” (Maureen)

4.3 GET 2: Reaching a breaking point to regain control

This theme captures the participant’s experience of reaching a psychological and emotional threshold, a “breaking point” that propelled them towards making a decisive and self-directed choice to undergo bariatric surgery abroad. After years of feeling unsupported, powerless or trapped within a cycle of failed weight management attempts, participants described an urgent need to take control and reclaim agency over their health and wellbeing.

Participants recalled they had reached a point where they wanted to take control now of their weight management, as they had enough of trying it on their own. Anna and Joy’s shared experience was about acting immediately themselves to help deal with their health and well being. External factors contributed to the urgency, as they had first hand experience of the consequences of not dealing with obesity. They saw bariatric surgery as a preventative measure to manage their weight, and they wanted to act “now”. The repeat use of “*now*” in Joy and Anna’s accounts, emphasises the urgent, self-directed need to act. There was a strong sense of feeling that they

themselves could do something about managing their health and wellbeing and knowing for them it was the right thing to do.

> "*I thought let me do something to help my health and general well-being" (Joy)*

> *"I knew I need to do something…… I just thought I'd need to sort this now…… they'd sort of said that obesity can be like a factor in these illnesses [what her mum died of] and I just thought if I could do anything now to prevent it I would……. I'd crack on and do it."* (Anna).

The breaking point for many participants emerged after a lifelong struggle with weight control and a deep sense of time lost to repeated, unsuccessful attempts at change. Mary and Maureen reflected on how efforts to manage their weight began in childhood or adolescence and continued relentlessly into adulthood. They spoke of years of engaging with traditional weight-loss approaches, including dieting and exercise, yet none provided lasting results. This cycle of repeated effort and perceived failure was evident in their voices which I recall conveyed both exhaustion and resignation;

> *"…so from the age of 17 onwards it was just constant trying every diet under the sun giving up…. because it was hurting me joints and all that ….I've been doing this for 20 years, so we know it's not going to change" (Mary)*

> *"….no matter what I did, walking, going to the gym, nothing, nothing was working" (Maureen).*

This inevitability that if they continued doing what they had always done, nothing was going to change, was impacting them psychologically and physically. They had tried many options before, but nothing was working. Other weight loss attempts had ended in the same way and did not lead to the long-term weight loss they desired. The repeat process and outcome were not something they wanted to try again. It was enough is enough and a need to try something different, with bariatric surgery abroad perceived as the only remaining option.

> *…. I've tried slim fast numerous times. You're setting yourself up to fail before you start because no one's going to do that for the remainder of the life, are they? If I do that for six months, I'd be totally miserable. And then lose a load of weight. And then as soon as you start eating again. …. I'll just pile it all back on. So I'll just be doing that over and over again. And it's no life" (Mary).*

Both the desperation in Mary's words "no life" and the urgency participants felt, the decision to have surgery abroad was becoming less a choice and more a necessary lifeline, when other avenues of support or intervention had failed them.

Participants also reflected on the difficulties in managing their weight management prior to surgery, sharing personal accounts of the emotional, psychological and biological factors that contributed to their weight gain. Anna, Maureen and Billie all recalled how significant life experiences resulted in

emotional eating, a tool they often used in times of psychological distress. Anna remembered bereavement as a catalyst that saw her weight increase significantly and a realisation that if she did not take control of her weight, it could result in a similar outcome to her mother. For Maureen it triggered depression, which was compounded with her entering the menopause. Again a combination that led to them reaching a point where they wanted to reclaim control of their weight management.

> "*Because for me, a lot of the emotional side of it came in. I'd lost my mum to bowel cancer……when she [mum] died, I turned to food for comfort. And I was literally piling on weight in the same way as she'd gone" [quickly] (Anna).*

and

> "*I wasn't overly overweight. I went to 14 stone and then I lost some weight. And then when my dad died, I went back up again….. sort of went into a bit of a depression mode and it was menopause and everything as well (Maureen).*

For Billie, the challenge was less about weight itself and more about underlying factors. She had struggled for years with challenges around weight management and was diagnosed as a teenager with binge eating disorder. Similarly to Maureen and Anna it was not just one life element that made it hard, it was often several factors. I felt a real sense of how hard this process was for them and how much they had to endure and deal with.

> *"I had a really bad relationship with food for years from a teenager….. the weight isn't the problem, it's the hormones and the binge eating disorder" (Billie).*

Across transcripts, participants experienced their difficulties as overwhelming and beyond their control, fuelling a sense of urgency to seek bariatric surgery abroad as a decisive means of breaking free from this cycle and reclaiming control over their lives. A key aspect of reclaiming control was participants' determination to thoroughly research their options abroad. Rather than passively waiting on the NHS pathway, they became active agents. Anna, for example, sourced information on surgeon's qualifications and success rates;

> *"I looked him up, checked his qualifications, all that sort of thing….I literally looked into everything" (Anna).*

For Brianna comparing UK death rates was important;

> *"It sounds a bit morbid. I looked at sort of like death rates in England as opposed to abroad" (*Brianna*)*

Also following people's stories in social media for "real life" accounts for reassurance;

> *"So literally I followed her for nine months. We were speaking on WhatsApp and I was like, how do you feel and everything? And she was sending me videos of the hospital…. It's not been filtered, that's just her real life" (*Brianna*)*

Participants described being aware both before and after surgery that bariatric surgery was only a "tool" and not a magic solution to their weight management. Multiple participants shared they knew they still had to be active if they wanted the surgery to be successful. Whilst they were concerned about falling back into "old habits" they were clear that the control lay ultimately with them. The awareness that for bariatric surgery to work they needed to continue with a healthy diet as well.

> *"So obviously there is and I think as well psychologically as well, you're worried about that because you've had this surgery done. It's easy to fall back into your old habits" (Maureen)*

Another important element of the women's decision to have bariatric surgery abroad was for some the need to keep it secret from some friends and family. They saw having bariatric surgery abroad as a personal decision that they were doing for themselves. As a result they told as few people as possible. This sense of finally reclaiming control of their weight management and this secrecy allowed them to go ahead with their decision.

> "*No, I've told nobody about it apart from my husband and my mum…….I said I need to do it for myself" (Joy).*

Others experienced a lack of support from friends and family when they shared, they had decided to go abroad for bariatric surgery. To be eligible for bariatric surgery many were asked to follow a strict low-calorie diet beforehand. When friends and family found out they had done this, the participants experienced judgement about why they were not able to continue to do this to lose weight rather than have surgery. They perceived this as a judgment about why they could not lose weight the traditional way of eating less. Others experienced unhelpful comments about their size and it not being necessary to have surgery as they were not "big enough".

> *"So like people were saying well if you can lose that weight then why don't you just stick to it and lose more."*
>
> *"There's a lot of people that said I shouldn't have had it done that I wasn't big enough to have it done"* (Maureen).

This lack of understanding and support resulted in many participants choosing to keep their decision to undergo surgery a secret from friends and even close family members. Several described a sense of isolation in their weight loss journey, feeling they had to carry the emotional burden alone. The drive to have the surgery was so strong that they were prepared to go through with it independently if necessary, prioritising their need for change over the approval of others. For Billie, this was particularly evident when she reflected on the stigma she felt was associated with both bariatric surgery itself and the decision to travel abroad to have it done. When she told her

parents about her plans, they did not approve on two levels. First was their discomfort with surgery as a method of weight loss and second, their fears about the safety of having it performed overseas after hearing negative stories. Their response was so strong, Billie recalls they chose not to share the news with their own friends, which she experienced as deeply disappointing and isolating.

> *"I think I think there was a lot of embarrassment around the operation when it came to friends and family. I think my parents were definitely embarrassed that I was even thinking about having it done, let alone go into Turkey to have it done." (Billie).*

For some of the participants, the experience of keeping their surgery secret continued even after the procedure had been completed. They spoke of receiving comments about their weight loss from friends, family and people they met. Ranging from compliments about how they looked thinner and then enquiring how they had lost the weight. Their narrative indicating it was a secret they held on their own for some time, and a sense of not wanting to vocalise they were using in some people's opinion, nontraditional routes to loosing weight.

> *"I didn't vocalise the fact that I was having it done like publicly for a long time….. So I never said anything about how I was losing weight" (Mary).*

It appeared that to reclaim autonomy over their health decisions, they had to sacrifice potential social support from friends and family, again highlighting a sense of isolation in their decision making. Only one participant spoke about her mum supporting her, possibly because she had a deep understanding of the emotional turmoil that led to the decision from her own experience of trying to lose weight:

> *"So she said to me, if you're going to get it done, then I'm going to get it done with you. And I said, fair enough. So we went together" (Mary).*

The social stigma around weight was powerfully illustrated in Joy's account. As she reflected on her experiences after surgery, I recall feeling saddened by the way she described perceiving others' judgements of people living with obesity. After developing Wernicke's encephalopathy, which is a rare but serious neurological condition resulting from being unable to take post-operative vitamins, Joy was hospitalised for four months and left temporarily unable to walk. Here she spoke of being in a wheelchair because of bariatric surgery abroad and still being aware of the society's judgements and pressure. Her words convey not only the weight of external criticism but also the internalised pain of navigating a world where her body had so often been scrutinised and misunderstood.

> *"And a stone lighter, you know, and I think it's ironic. I sit in the wheelchair as a thin person, whereas if I'd thought about sitting in the wheelchair, people would see you as being overweight and just fat and lazy in a wheelchair. But now they know that you're in the wheelchair and you're a thinner person, so there must be something wrong with you. And that's OK that's acceptable in today's society, you know" (Joy).*

4.4 GET 3: “No regrets” and “worth it in the end”

Participants shared extreme physical and psychological adaptation, pain and long-term challenges of bariatric surgery abroad, yet appeared to reconcile these by sharing a narrative of positive transformation. They seemed to be able to reframe suffering as a price of regaining health and taking control of their weight management. They collectively shared a sense of profound gratitude for the transformation and weight loss, coexisting with ongoing struggles. Ultimately the desire to be thin is constructed as a benefit that justifies and outweighs the cost.

Joy’s experience powerfully illustrates the paradox at the heart of this theme of “no regret”. After developing Wernicke’s encephalopathy, she was hospitalised for four months and left temporarily unable to walk;

> “*When I came out of hospital, I couldn't walk and I'd lost the ability to walk……and so if I'm sitting here now, talking to you as I am, I can't feel my right leg at all from the knee down. And I have very limited feeling in the left leg” (Joy).*

Yet despite this life-altering complication, she reflected;

> *It's been a very positive thing, losing all that weight, but in conjunction with me losing the weight, I've obviously had to deal with this condition….nobody tells you how hard it is to get out your bloody front door when your legs don't work…. but I wouldn't change it for the world. I would still have the surgery a million times over.” (Joy)*

Although her experience is unique in severity, Joy’s account was reflected in other participant’s’ experiences, highlighting a complex process wherein participants reframed adverse outcomes as meaningful and acceptable trade-offs in the pursuit of weight loss and improved health. Across participant’s accounts, the physical aftermath of bariatric surgery abroad was frequently described as more severe than anticipated, requiring considerable physical adaptation. They shared their frustration of not being able to eat like they did before and the physical struggle that came with managing the basics of eating such as keeping solid food digested. It was as if they wanted to tell the positives of their surgery, however, could not “lie” about how challenging the aftermath was;

> *“I'm struggling with solid foods. I can't get any solid foods in me. As soon as I have solid foods, I vomit them back up again… So I'm basically on liquid foods at the moment. I'm not going to lie, because you know you if you are having a day where you are vomiting or you can't keep the food down, it is a frustrating day.” (Maureen).*

Other participants experienced tiredness and anaemia because of bariatric surgery. They spoke of not just physical impairments but cognitive too. There appeared to be a range of physical implications that participants experienced and almost listed from most severe to least.

> *“I became anaemic and felt tired all the time” (Anna)*

"My hands are just rubbish and my memory is probably the worst thing that I can't remember who people are" (Anna).

Along with physical adaptations, participants had to adapt psychologically after surgery too. Due to the rapid weight loss following their bariatric surgery, participants shared it took time for them to get used to their changed look. Some had looked a certain way for many years, so for their body to change in a space of a few months felt unfamiliar. They spoke of a brain body disconnect as they had to adapt to the rapid weight loss. The body appeared to be changing quicker than their brain could adapt. Joy's narrative captures this;

"*So when I saw myself, I was like, oh, bloody hell. Who's this woman?.....Whose body is this? …it takes your brain far longer to catch up to how you feel than what it does to what you're experiencing and how your body actually changes……I think that your body doesn't catch up or your brain doesn't catch up to how quickly your body can actually change. And that for me was probably the hardest part" (Joy).*

This narrative like others, depicts that postoperative was not a smooth recovery, but an ongoing negotiation with the body, often marked by pain, dysfunction and unpredictability. Yet, consistent with the theme of "no regrets", participants did not frame these difficulties as deterrents. Instead they appeared to take these physical consequences as part of the broader transformational process and reaffirming their decision to seek bariatric surgery abroad. Another possible consideration is that maybe they felt they could not have regrets, as they had chosen to have the surgery, so were not entitled to complain.

Participants described the post-surgical experience not merely as a period of recovery, but as triggering an enduring and often arduous lifestyle change. As a result of bariatric surgery, participants experienced not being able to engage in activities they used to enjoy. There was a real sense of the permanency of the surgery and the lifestyle changes that occurred as a result. From not being able to drive their car anymore, exercise with their personal trainer and having to take vitamins every day. In keeping with the overarching theme of "no regrets", participants did not express resentment for the new routine but rather acceptance, suggesting that the perceived benefits outweighed these limitations. There was never tones of anger or bitterness in any of the women's voices when being interviewed.

Maureen shared that she used to enjoy exercising and spending time with her personal trainer. Previously it was a method to lose weight and now she saw it as also a way to tone up lose skin, which is a common symptom of surgery. Her narrative however tells us that this is no longer possible.

"*So unfortunately for me, I've not been able to exercise or able to tone this up as what I'd have liked to have done. Because I had a personal trainer and I had to stop (Maureen)*

For Joy not being able to drive her car was the hardest part and the most emotive. A sense of having to lose something she loved, to gain what she wanted.

> *"I had to hand my car back and that was the saddest thing that I had to hand the car back because I couldn't drive it at that point. And that was a real moment for me that I actually was really upset and cried" (Joy)*

Maureen's account gives an insight to how monotonous and relentless the management of the new permanent lifestyle change can be. I recall the resignation in her voice as she described what she must now do post surgery. The repetition of "every single day" reinforces the sense of an unyielding regimen;

> *"Because I'm quite weak at the moment and I have to take vitamins constantly all the time now.…So you're literally having to take vitamins, every single, every single day" (Maureen).*

For Maureen her change extended far beyond weight loss and encompassed fundamental alterations to daily routines, social experiences and relationships with food;

> *"Your whole lifestyle has changed. In fact, my whole lifestyle has changed forever. I've not had a solid meal in two years" (Maureen).*

Here Maureen gives an insight to the physical limitations of bariatric surgery and a recalibration of what constitutes normality. The physical adaptation that needs to happen because of what they have undergone.

> *"You can't eat and drink at the same time. I have to sort of wait if I go out for a little meal …. most of the time when I do go out I just have soup because I know the soup is going to stay down" (Maureen).*

I found Joy's cognitive reframing of this challenging permanent lifestyle change both saddening and resourceful. These participants had been through a major life decision and were having to reconcile their losses for the gains they ultimately desired;

> *"So you have to kind of laugh at these things because I'd sit here and be in floods of tears if you didn't think positively and think of things like that. But to the flip side, I have no regret" (Joy)*

Participants were acutely aware of the potential physical dangers, describing risks of surgery such as paralysis stroke or even death. There appeared in their narratives a powerful internal negotiation between the fear of what might go wrong and a hope of might be possible in terms of managing their weight. This psychological weighing up of mortality and aspiration seemed a central feature of their decision-making process. Joy's account also gives insight into the possible suppression of emotions that needed to happen for her to come to terms with life post surgery, as she must "laugh" it off, rather than deal with the complexity of what she was feeling.

Despite recognising these dangers, participants described a determination to proceed, revealing how the anticipated benefits of surgery came to outweigh the risks. Even an awareness of the "horror stories" of people who had died following procedures overseas, did not deter them. As Brianna reflected

> "*We can die abroad. It's so dangerous" (*Brianna*)*

while Mary echoed this awareness.

> *"We just hear horror stories and people go abroad and they don't come back" (Mary).*

Despite the deep awareness of the potential life-altering consequences post-surgery Maureen also was determined to still proceed with surgery;

> *"And they said to me that I can, could have a form of a stroke and go paralysed. So I have to take things easy" (Maureen).*

Ultimately, however participants positioned these risks are a necessary price to pay for the life they hoped to reclaim. Many participants when reflecting on their decision to have bariatric surgery, expressed the gains in physical and emotional wellbeing, which appeared to justify the risk they had undertaken and ultimately validated their decision to travel abroad for surgery. Billie's narrative captures this when she said;

> *"Yeah, well, it was worth it in the end…. still very much a success….the benefits massively outweighed the cons" (Billie).*

When reflecting on their experience, all participants described undergoing bariatric surgery abroad in overwhelmingly positive terms. Looking back, they expressed certainty that they would make the same decision again, with some stating they would do it without hesitation. For many, the experience not only met but exceeded their expectations, reinforcing a strong belief they had made the right decision.

One of the most vivid and emotive recollections was the exceptional cleanliness of the hospitals. Maureen described being so moved by this aspect that she became emotional when leaving;

> *"Yeah, it was fantastic. It was. It was fantastic. In fact, I actually cried before when I left because I've never seen a hospital so spotless. I was just blown away" (Maureen).*

Similarly Brianna reflected simply but powerfully,

> *"It was the best thing ever. It was so clean"* (Brianna).

Participants repeatedly used words such as "fantastic" to a capture their positive experiences abroad. Joy shared that

> "*Before and prior to [the surgery] was fantastic and I could have asked anything and everything*" (Joy).

While Anna echoed

> *“And so yeah, I couldn't fault anything, really……I wouldn't hesitate anything like that. I would go back to them again” (Anna).*

These statements reveal a sense of trust and confidence in the care they received, contrasting sharply with their earlier struggles to access support within the UK. This overwhelmingly positive experience playing a pivotal role in how participants made sense of and emotionally justified the decision to travel abroad for bariatric surgery. The experience of having bariatric surgery abroad exceeding expectations and confirming they had made the right decision.

> *“I can't fault them. I've just been really fortunate and had a really good experience and as a result of it I’m having good results” (Anna)*

The use of the word “fortunate” suggests a deep sense of gratitude and relief, as if receiving the standard of care they had long been seeking felt almost like luck and they were “fortunate” to receive it.

Participants spoke with pride and joy about the physical transformations they experienced following bariatric surgery. These changes brought not only visible shifts in their bodies but also meaningful improvements in their everyday lives, such as being able to wear smaller clothes, to enjoying a new sense of social freedom. Maureen recalled the early stages of weight loss as both exciting and motivating, describing how it opened possibilities she had once found daunting. Before surgery she often felt anxious and resistant when her husband suggested going out for dinner as she worried about how she would look. After her weight loss, this anxiety lifted, and she described being able to respond with ease and confidence to her husband’s spontaneous request.

> *“In the beginning it was great. I was losing weight. It's great I was getting smaller clothes…now I have more of a social life because when he says, come on, let's go out I go to the wardrobe get out a pair of jeans and a top and that’s it done” (Maureen).*

Alongside these positive physical changes. Participants all described notable psychological benefits too. They experienced increased confidence, improved mood and a deeper sense of self-acceptance. These psychological shifts suggest that the surgery’s effects were not merely physical but also fundamentally shaped how they felt about themselves and how they engaged with the world. Mary reflected on how her self-esteem had been positively impacted stating;

> *“I do say that it definitely has helped my self confidence. I do feel much better in myself”, (Mary)*

Similarly Maureen shared;

> *“Yeah, it's worked for me because I'm happier in myself”. (Maureen).*

Importantly these emotional and psychological gains were complemented by significant improvements in physical health problems that had previously restricted their lives. Maureen recounted how previously she was reliant on antidepressants and other treatments, to then being completely medication-free;

> *"At the time I was on antidepressants. I'm not on antidepressants now I don't have any of them, I'm off everything". (Maureen)*

Similarly Mary celebrated her recovery from multiple chronic conditions;

> *"I don't need an inhaler now…. Everything else is completely cleared…. I don't need any medication. I'm not on any sleep machines. I'm not, yeah, so my pains have gone" (Mary)*

These accounts highlight how the surgery's impact went beyond weight loss and included a full transformation of mind, body and lifestyle. By participants reflecting on these wide-ranging improvements, they were able to construct for themselves a powerful narrative of success. One in which the physical and emotional gains ultimately outweighed the risks they had taken to proceed with bariatric surgery abroad. This narrative reinforced their sense of "no regrets", which allowed them to look back on their decision to chose to have bariatric surgery abroad rather than in the UK, with gratitude and confirmed they had made the right choice. For them it was ultimately "*worth it in the end*", they *"wouldn't change it for the world"* and would *"still have the surgery a million times over"*

Chapter 5: Discussion

This chapter presents a discussion of the research findings in relation to the study's aim and research question. The analysis will be considered alongside relevant existing literature and theory to provide context and depth. The chapter will also offer a critical evaluation of the study, outline recommendations for future research and explore the clinical implications and considerations for Counselling Psychology practitioners.

5.1 Overview of Research Findings

The study aimed to gain an in-depth understanding of the lived experience of female patients' decision to go abroad to have bariatric surgery.

This was achieved through the analysis of six, semi-structured interviews using IPA. From the analysis, three GETs emerged to capture the women's experience.

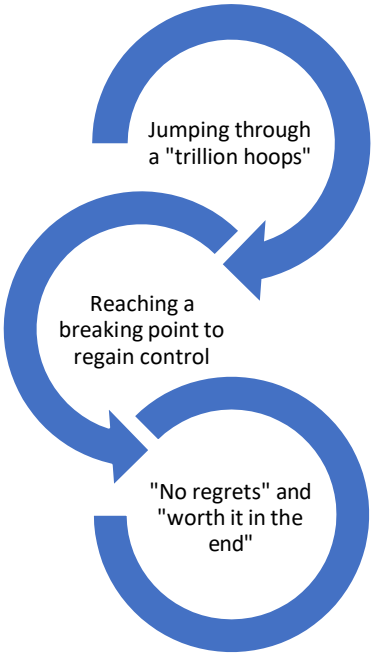
GET 1: Jumping through a "trillion hoops"

GET 2: Reaching a breaking point to regain control

GET 3: “No regrets” and “worth it in the end”

The GETs are both sequential in the women’s experience and interlinked. How the women experienced the systemic NHS barriers, appears to have led them reaching a breaking point and taking control of their health and well-being and pursuing bariatric surgery abroad. This seems to then in turn have allowed them to reflect on the experience and feel it was worth it in the end.

Figure 1: Depicts the sequential themes



5.2 GET 1: Jumping through a “trillion hoops”

In this study it was found that participants expressed considerable frustration with what they perceived as systemic barriers within the NHS when seeking bariatric surgery in the UK. They described the eligibility criteria as overly restrictive and waiting lists as excessively long. These findings are consistent with previous research that identified strict eligibility requirements and prolonged delays as key factors contributing to the rise of medical tourism (Carey et al., 2025; Jackson et al., 2019; Kowalewski, 2019; UK Insight Team, 2023). With Sahar and Riazi (2021) highlighting that patients often perceive the NHS pre-surgical process as a barrier, one that is predominantly controlled by healthcare professionals who ultimately determine their eligibility.

While existing literature has acknowledged that barriers and delays drive patients to seek surgery abroad, this study reveals the depth of the emotional and cognitive burden these processes impose. Rigid BMI criteria and long waiting times delayed their pursuit to deal with their health and

wellbeing, creating a sense of hopelessness in pursuing bariatric surgery in the UK. This hopelessness and lack of control were driving their motivation to seek bariatric surgery abroad. The findings revealed that the current NHS framework for bariatric surgery is not only a logistical barrier but also a psychological stressor which informs decision making and a creates a sense of agency.

Interesting, while previous research has emphasised the high cost of private treatment in the UK as a major driver for medical tourism (Carey et al., 2025; Kowalewski, 2019, Lunt et al., 2014), cost did not emerge as a prominent theme in the current study. Participants rarely framed their decision to go abroad in financial terms, instead focusing on emotional experiences of desperation, frustration and a need to gain control over their weight-loss journey. This studies' findings therefore highlight that the growth of bariatric tourism may not be fully explained by systemic or financial factors alone. They demonstrate that psychological drivers, such as feelings of urgency, helplessness and being out of control, may be more influential in the decision to pursue bariatric surgery abroad. This has important implications for service provision and health policy. Efforts to reduce costs or increase capacity may not fully address the underlying emotional needs of patients who feel abandoned by the system. Instead, there is a need to improve not just access, but the quality of the patient experience, in terms of feeling heard, cared for and supported. This may reduce the appeal of surgery abroad and support more informed decision making.

This prolonged frustration, ambiguity, and emotional fatigue in navigating the UK system led participants to actively seek care elsewhere. Many described their initial interactions and overall experience with providers of surgery abroad, as being listened to and cared for. Human beings have an inherent psychological need for connection, acceptance and emotional security, which is vital for wellbeing. As Baumeister and Leary (1995) and Cohen and Wills (1985) highlight, when individuals feel emotionally attuned to others through compassionate care or validation, they are more likely to engage in behaviours that support physical and psychological health. The decision to have surgery abroad might offer not only medical intervention but a more responsive and emotionally supportive system of care. This could be helpful for UK practitioners to be aware that patients are potentially looking for more than just the practical element of bariatric surgery, but to also feel seen and heard.

Like previous findings (Carey, 2005; Zarei & Maleki's, 2019), this study demonstrated that health tourists are strongly influenced by their perceptions of care quality and facilities. The current study extends this by highlighting the emotional impact of this. Witnessing high standards of cleanliness and responsive care abroad, were so positively recalled, they appeared to counteract previous experiences of feeling unheard or dismissed. At a service level, these findings highlight the importance for UK healthcare providers to consider how environmental factors, such as physical space, impact patients' psychological experiences. Exploring ways to enhance these elements, may restore patient trust and therefore reduce the appeal of going abroad for surgery.

A key finding from this study was the participants' narratives around their post-operative experiences following bariatric surgery abroad. Previous research has highlighted that patients often feel unsupported after surgery, expressing a need for greater encouragement from both bariatric team members and peers (Lloyd et al., 2018; Liu, & Irwin, 2017). In contrast, participants in the current study described a very different experience. They spoke highly of the support they received, emphasing both its accessibility and emotional depth. A key factor was the immediacy of communication through platforms such as WhatsApp, which allowed them to contact the bariatric team "anytime" and remain connected with peers they met during their surgery. This timely and personalised response appeared to create a powerful sense of connection, reassurance and care.

One of the ways that the participants in the current research made sense of the success of surgery, was in terms of access to peer support. Prior studies have shown that individuals who receive empathetic, non-judgemental follow-up, and access to peer and clinical support, reported feeling more committed to sustaining health-related behavioural changes after surgery (Lewis et al., 2015). In contrast, those who experienced stigma, judgement and marginalisation, whether in healthcare setting or personal relationships, often felt abandoned and devalued (Lewis et al., 2011; Puhl & Heuer, 2009). The experience of participants in this research feeling heard, valued and connected, might help to understand how their long-term success of maintaining weight loss, may be because they felt supported.

Interestingly, in the current study, none of the participants reported regaining weight. One possible explanation is that they did not see the surgery as a cure but reported they viewed surgery as a "tool", to support their weight loss journey. This mindset may have psychologically prepared them for the sustained behavioural changes required long-term, framing the surgery as a part of their broader effort, rather than a stand-alone solution. Previous research suggests that many patients view bariatric surgery as a definitive solution to end their struggle with eating (Karlsson et al., 2003). This raises important questions about the psychological processes in the pre-surgical phase, particularly what might prevent some individuals from fully acknowledging the ongoing effort required to maintain weight loss. These insights point to the importance of reframing bariatric surgery during pre-operative care, emphasising it as a supportive mechanism rather than a quick fix. By setting realist expectations, patients may be better equipped to engage in long-term lifestyle adjustments needed for success. However, this may be challenging in the current climate of aggressive marketing associated with bariatric tourism. As Mahase (2024), highlights, many overseas surgical providers promote highly appealing, expediated packages that include travel and accommodation, potentially obscuring the seriousness of the procedure and reinforcing the perception of bariatric surgery as an easy, immediate solution rather than a complex, lifelong commitment.

These insights advance current understanding by demonstrating that the quality of emotional support influences not only patients' recovery but also their initial decision-making. Healthcare systems that focus primarily on procedural efficiency and the provision of information, may

overlook fundamental psychological needs, including empathy, connection and ongoing relational support. The presence of this relational dimension in the current study, may therefore explain why weight gain did not emerge as a prominent issue, despite its frequent emphasis in previous research and the expectation that it would feature more strongly (Heinberg et al., 2020; Kofman et al., 2010; Magro et al., 2008).

5.3 GET Theme 2: Reaching a breaking point to regain control

A key finding of this research was that participants appeared to reach a psychological and emotional breaking point in their weight loss journeys. A moment of clarity where they felt they could no longer continue as they were and needed to act decisively to regain control of their health. Participants described an acute sense of urgency, emphasising that they had to "sort this now" before their health deteriorated further. This urgency for some appearing to be rooted in the fear of developing additional obesity related conditions.

This process can be understood through the Health Belief Model (HBM) Rosenstock (1966), which proposes that health-related behaviours are influenced by individuals' evaluation of perceived risks, benefits and barriers (Balkhi et al., 2021). It appears the participants perception of risk of developing additional obesity related conditions, influenced them to act "now". Their decision-making process also appeared to be influenced by how they weighed potential losses against possible gains, as outlined in the Prospect Theory (Kahenman & Tversky, 1979). The fear of losing future health and quality of life was so profound that it overshadowed concerns about surgical complications, making the decision to proceed feel both necessary and urgent. In addition, this sense of urgency was intensified by participants' perceptions of the UK system as unresponsive. In line with the Scarcity Mindset Theory (Mullainathan & Shafir, 2013) this may have produced a "tunnelling" effect, whereby individuals became focused on addressing needs rather than engaging in long-term planning. The opportunity to access surgery abroad quickly, was therefore experienced as a means of meeting these perceived pressing demands.

Whilst these theoretical frameworks are useful for understanding the cognitive aspects of health behaviour, they do not fully account for the emotional tipping points revealed in this study. The findings suggest that the decision to seek bariatric surgery abroad is rarely a purely rational calculation of risk and benefit. Instead, it is often driven by intense emotional urgency and a need to gain control.

In this study, participants also described the challenges of weight management prior to surgery and how overwhelming life circumstances, such as bereavement and menopause impacted them**.** This aligns with previous research, which has shown that intense emotions linked to external stressors such as grief, can lead individuals living with obesity to use food to soothe or supress emotions (Leach, K. 2006). However such maladaptive coping mechanisms carry important implications for

long-term outcomes. Indeed, Sarwer and Polonsky, (2016) emphasised that when these emotional drivers remain unaddressed, they can increase the risk of weight regain after bariatric surgery. The present study extends this understanding by showing that these challenges were often cumulative, after years of struggle, rather than isolated events. This suggests that for many participants, their decision to pursue bariatric surgery abroad was not solely about physical health, but also about escaping cycles of distress linked to unprocessed emotions and unresolved life circumstances.

Participants in this study took ownership and control by independently researching bariatric surgery abroad. Rather than remaining passive within the healthcare system they experienced as slow and unresponsive, they positioned themselves as informed decision makers, actively seeking information on surgeons' qualifications, success rates and even mortality statistics. Social media played a key role in this process, providing access to *"real life"* patient stories that shaped participants' choice and gave them a sense of reassurance. These findings align with Lunt et al (2014), who identified surgical expertise as one of the most prominent factors motivating individuals to travel abroad for bariatric surgery. This study suggests that the process of self-directed research itself held psychological meaning for participants and functioned as both a coping strategy and a form of empowerment, allowing them to reclaim agency in their healthcare choices. Considering this, it may be valuable to consider how the positive potential of social media could be used even further, in supporting patient's future management of health and well-being.

The women's narratives illustrated how decades of unsuccessful efforts can lead to profound emotional exhaustion and a sense of personal defeat, creating the conditions for a decisive turning point. In this context bariatric surgery abroad emerged not just as a rational solution to weight loss difficulties, but as an emotional response to years of struggle and stigma. The experience of ongoing challenges with loosing weight through conventional methods such as diet and exercise is well documented in previous research (Balkhi et al., 2021; Greaves et al., 2017; Olateju et al., 2023) and was echoed in this study.

The stigma and frustration with repeated failure to lose weight, contributed to participant's secrecy about undergoing surgery. This secrecy was linked not only to previous experiences of judgement, but also to a desire for autonomy and control over their decision. These findings align with existing research highlighting the stigma experienced by individuals living with obesity, including within healthcare settings (Puhl & Heuer, 2009) and the influence of stigma on health decision-making (Conner & Norman, 2015). The current study builds on these findings, suggesting that the desire to escape these experiences and reclaim a sense of agency, was just as influential as the concerns about physical health in driving participants to act.

In addition, the secrecy, created further challenges. At a personal level, it intensified feelings of loneliness and at a relational level, it left gaps in support networks, as friends and family were excluded. This is particularly significant given that research consistently shows that social support from friends and family is a key factor in both pre and post surgical adjustment, as well as long-

term weight-loss maintenance following bariatric surgery (Livhits et al., 2011). These findings highlight the pivotal role that Counselling Psychologists have in supporting clients before and after surgery, helping them to map existing support networks and identify potential gaps. Such psychological work can reduce isolation, address fear of stigma and prepare individuals for the changes that often accompany significant weight loss.

5.4 GET Theme 3: “No regrets” and “worth it in the end”

This study’s findings align closely with existing research of the psychological gains following surgery (Al-Kadi & Al-Sulaim, 2024; Bramming, et al., 2021; Gullaam Rasul et al., 2022; Law et al., 2023; Lin et al., 2025). Women spoke of increased self-confidence, improved mood and greater engagement in social relationships. Several reflected-on feeling “happier” and more “confident” both in themselves and in social situations, demonstrating the powerful impact of surgery on their sense of self and everyday life.

In addition to psychological gains, participants described improvements in physical health following bariatric surgery. Many reported that they no longer required previous medications such as antidepressants, inhalers and sleep machines. These accounts mirror findings in qualitative research that examined the pre-surgical challenges faced by individuals living with obesity, including physical limitations and their wider social implications (Gullaam Rasul et al., 2022). The same study also explored the positive changes that occur in patients’ lives because of bariatric surgery, such as increased mobility and higher self-esteem, which align closely with the current research. The alignment between these findings and previous research highlights that for many women, the experience of surgery is more that just the physical change, as it can present profound renewal in confidence and emotional wellbeing.

However, alongside these gains, participants also described the complex process of physical and psychological adaption following bariatric surgery abroad. The experience of adaptation varied widely. For some, the physical challenges were profound, while others adjusted more quickly and easily. Participants also revealed a perceived gap between physical change and psychological integration, as they struggled to negotiate a sense of self in relation to a body that felt unfamiliar. From a phenomenological perspective, such disruption reflects a breakdown in embodied continuity, where the familiar relationship between body and self is destabilised, leaving the body experienced as ambiguous or alien (Merleau-Ponty, 1962). These findings suggest that the journey does not end with physical weight loss but continues as an ongoing process of identify negotiation and psychological adjustment. For practitioners, this highlights the need for therapeutic support that addresses both practical challenges and emotional work around integrating a changed body into one’s self-concept. This is particularly important for those who may return home without consistent access to structured aftercare, a challenge made more significant by the isolation, stigma and secrecy identified in this study.

This highlights the critical role Counselling Psychologists can play in both the preparatory and follow-up phases of bariatric surgery. By facilitating a thorough exploration of the psychological risks and benefits, practitioners can help patients make informed decisions and develop realistic expectations. This may involve reflecting on behavioural patterns, identifying pre and post surgical eating habits and developing healthier coping mechanisms for emotional distress. Supporting patients to make sense of how they respond differently after surgery can foster greater emotional resilience and long-term psychological wellbeing.

5.5 Summary and Conclusion

The findings in this study align with existing research showing that participants were motivated to pursue bariatric surgery abroad in the hope of improving their health and longevity. This reflects broader patterns identified in the literature, where improved health outcomes are consistently cited as a primary motivator for seeking weight-loss interventions (Sarwer & Polonsky, 2016). Roman, et al., (2022) argue that these motivations are central to the rapid growth in medical tourism, as individuals seek effective and timely solutions beyond their national healthcare systems. Williams and Ólafsdóttir, (2023) further suggest that the COVID-19 pandemic intensified this trend by heightening public awareness of health and wellbeing. In its aftermath, individuals began placing greater value on interventions that could reduce their risk of future illness, with bariatric surgery becoming increasingly viewed as a proactive step toward improving long-term health.

More broadly, this study demonstrates that the decision-making process surrounding bariatric surgery abroad is multifaceted, influenced not only by health concerns but also by emotional, social and systemic factors. Participants' accounts revealed a complex interplay between frustration with domestic healthcare limitations, the psychological burden of repeated dieting failures and the powerful influence of stigma and secrecy. The decision to undergo surgery abroad was experienced as both practical and deeply personal and an attempt to regain control, autonomy and hope, after years of struggle. Ultimately this research suggests that deciding to pursue bariatric surgery abroad is rarely a single, rational act but rather a cumulative process shaped by emotional exhaustion, perceived scarcity of options, and the desire to take control of their own health and well-being.

5.6 Evaluation and Suggestions for Future Research

As outlined in the methodology chapter, careful consideration was given to ensuring that all stages of research were conducted in accordance with the BPS (2021) guidelines for good practice. In

addition, attention was paid to achieving rigour and validity drawing, on Yardley's (2000) principles and the quality criteria as outlined by Nizza et al (2021) as a framework to guide the research process. Evaluating qualitative research, however, requires moving beyond traditional quantitative ideas of validity toward the broader notion of trustworthiness (Korstjens & Moser, 2018). Based on the work of Lincoln and Guba (1985, as cited in Korstjens & Moser, 2018), trustworthiness comprises of five interconnected criteria: credibility, transferability, dependability, confirmability and reflexivity, each addressing a different aspect of methodological robustness. Credibility focuses on whether the findings represent a plausible account of participant's experiences, supported by engagement with data and grounded in their narratives. Transferability is the degree to which the findings resonate with other contexts and is strengthened through thick description. Dependability and confirmability involve transparency in the research steps taken from the start of the research to the reporting of findings. Reflexivity is another key criterion involving an awareness of how the researcher's background and assumptions affect research decisions in the qualitative study.

Evaluated against these criteria, this study demonstrates several areas of methodological strengths whilst also presenting limitations. Credibility was supported through the immersive nature of IPA, the use of verbatim extracts and close attention paid to participants' meaning making. The analyse therefore remained grounded in participant's accounts and was strengthened through supervisory discussion. Transferability was aided through detailed descriptions of sampling, recruitment, clinical characteristics, inclusion and exclusion criteria and interview procedure, to enable the reader to access relevance to their own settings. Dependability and confirmability were supported through a clear audit trail documenting interpretative decisions, all strengthened by reflexive journaling.

One of the key strengths of this study lies in its focus on exploring the personal meaning and lived experience of women who chose to undergo bariatric surgery abroad. The use of IPA provided a framework to capture the depth and complexity of these experiences, offering rich, nuanced insights into how participants made sense of their decisions and the psychological and relational challenges they encountered throughout the process. The aim was to give a voice to a group of women whose perspectives have been largely underexplored, illuminating the psychological and relational challenges they encountered when deciding to undergo bariatric surgery abroad. While the insights generated are specific to this group, they may nonetheless resonate with others who have faced similar decisions around weight-loss surgery or medical tourism. Although the small sample size does not permit broad generalisation, this was not the intention of this study. The goal of IPA is to provide in-depth, contextualised understanding rather than generalised outcomes, consistent with qualitative epistemology rather than a positivist approach.

The study required participants to be twenty-four months post surgery. The rationale for this was grounded in literature suggesting that this is the point at which post-surgical weight gain commonly begins to emerge. While the research did not set out to investigate weight gain directly, the design allowed space for it to surface naturally within the participants' narratives. A limitation, however, is

that participants were offering retrospective accounts, which may have impacted the accuracy and reliability of their recollections.

A strength of the sample is that all participants were self-selected into the study, contacting me voluntarily and with no obligation, suggesting they had experiences they considered meaningful and valuable to share. A limitation, however, is the potential for sample bias. It is plausible that those with more positive experiences were more willing to participate, particularly as none of the participants reported weight regain, despite existing evidence suggesting that up to 50% do (Magro et al., 2008). In addition, those with more difficult experiences may have been less inclined to participate due to feelings of shame and regret, both well documented in this population (Lloyd et al., 2018; Tolvanen et al., 2022).

This study also provides a foundation from which future research in this area can be developed. During the research process, it became evident that there is considerable diversity of experiences of bariatric surgery abroad that remains underexplored. For instance, Joy's account, which involved severe complications due to an undiagnosed condition, was particularly extreme. Her willingness to share such a challenging and deeply personal story highlights the potential for others with similarly difficult experiences to contribute important insights. Future research could therefore focus on encouraging individuals to come forward even when feelings of shame, regret or stigma might otherwise discourage participation. Creating safe and supportive spaces for these narratives would enable researchers to capture a wider range of perspectives, including those involving complications, dissatisfaction or significant psychological distress.

Expanding the diversity of accounts would deepen understanding of the emotional and relational factors that shape decision making and long-term adjustment. Future studies may benefit from longitudinal qualitative designs that follow individuals before and after bariatric surgery abroad, capturing changes in motivations and psychological wellbeing over time. Such research has the potential to inform both clinical practise and policy, ensuring patients receive more comprehensive, psychologically informed support before, during and after undergoing surgery abroad.

5.7 Implications for Clinical Practice

My position as both researcher and a practitioner has enabled me to reflect on how the findings from this study can inform therapeutic practice, particularly when supporting women who have undergone bariatric surgery abroad. This research contributes to the existing literature within health psychology and counselling psychology by offering new insights into an underexplored area of patient experience.

By exploring the lived experience of these women, this study provides valuable knowledge that can guide practitioners, such as Counselling Psychologists in their work with this population. The findings highlight areas where targeted interventions may be beneficial, not only for the individual but also in supporting families and wider social networks. In this way, the study represents an important step toward developing informed, empathetic and evidence-based practices that improve psychological care for individuals navigating the complex journey of bariatric surgery abroad.

The urgency of this work is accentuated by wider trends. The World Health Organization (2025) projects that by 2035, nearly one in four adults worldwide will be classified as overweight, with 890 million (16%) living with obesity. Alongside this, medical tourism continues to grow, which is of relevance to the UK healthcare system as increasing numbers of patients return with post-operative complications that must be managed by the NHS. In addition, the rapid emergence of new weight-loss mediations, such as GLP-1 receptor agonists, is also shifting the treatment landscape. Against this backdrop, psychological support remains crucial.

Findings from this study highlight the importance of Counselling Psychologists in addressing the complex emotional terrain of bariatric surgery abroad. While participants frequently described their decision with pride and satisfaction, expressing a strong “no regrets” narrative, this often coexisted with unacknowledged distress or ambivalence. Some minimised the psychological impact of complications or the emotional cost of their journeys, suggesting that beneath the surface, clients may hold conflicting emotions including fear, shame, grief or regret that are not readily disclosed. Counselling Psychologists are well placed to provide a non-judgemental, empathic space where individuals can explore these emotions, alongside tangible gains associated with surgery. This is particularly relevant considering the secrecy and isolation described by participants, many of whom concealed their surgery from friends and family due to fears of judgment or stigma. Counselling Psychologists can therefore help clients process the long-term psychological effects of secrecy, including internalised shame and relational strain. Therapeutic work may focus on fostering self-compassion, reducing shame, and developing or strengthening supportive networks.

Participants consistently reported feeling more emotionally supported and “cared for” by surgical teams abroad compared to the UK healthcare system. This suggests a relational gap in the UK provision. Continuing to integrate Counselling Psychologists into NHS multidisciplinary teams could help address this gap, by embedding models of care that are not only clinically competent but also even more emotionally attuned and compassionate. Compassion and empathy are central to counselling psychology, (BPS, 2021) and attending to whether clients feel heard, valued and understood may be just as critical to decision-making as providing medical information. Counselling Psychologists could also play a role in training and supporting other healthcare professionals to develop skills in relational care, potentially improving patient experience and reducing the perceived need to seek treatment abroad.

Another implication is the importance of expectation-setting. Some participants frame surgery as a "tool" rather than a cure, which may have contributed to their ability to sustain weight loss and avoid relapse. Psychoeducation can therefore help reinforce this distinction, preparing clients pre- and post-operatively to understand surgery as a wider, ongoing process of behavioural change. Supporting realistic expectations, including the challenges of post-operative adaptation, can help reduce disappointment and promote resilience. This is crucial for the population who may pursue bariatric surgery abroad on their own without any psychological input.

The findings of this study also highlight that while rapid access to bariatric surgery abroad may meet participant's urgent physical needs, it can bypass essential psychological preparation and support. This creates a risk that individuals will enter surgery without fully understanding or addressing the underlying emotional drivers of their weight-related behaviours. Counselling Psychologists play a key role in helping identify these psychological underpinnings and supporting patients pre and post surgery. When surgery happens quickly and with minimal psychological preparation, there is little space to consider this. Whilst the NHS pathways were perceived by participants as slower, they do include pre-surgical assessments and multidisciplinary input which allow for these conversations to take place. By recognising the emotional and systemic pressures that lead individuals to reach this breaking point, practitioners can intervene earlier, providing psychological support and practical guidance before clients feel forced to seek rapid solutions abroad. For Counselling Psychologists in particular, this highlights the value of working collaboratively with clients to explore the fears and frustrations and motivations behind their choices, whilst helping them plan for both the physical and psychological adjustments for lasting change.

The women's narratives of increased wellbeing and renewed confidence reinforced the "no regrets" narrative, validating their decision to travel abroad for surgery, even in the face of complications. However this raises important questions about how to support patients both pre and post surgery to ensure they have access to aftercare and emotional support upon returning to the UK. For Counselling Psychologists, these narratives highlight the importance of providing holistic, long-term support that addresses not just the emotional shifts following surgery, but also the ongoing challenges that may persist long after surgery abroad.

5.8 Reflexivity Part 11

It was privilege to hear these women's stories and to be entrusted with their experiences. I was surprised by the findings and pleased I was able to remain objective as a researcher, allowing the participants' narrative to emerge on their own terms. Initially I expected to hear predominantly negative accounts of bariatric surgery abroad, influenced by the dominant media narratives that

first sparked my interest in this topic and by my own experience of supporting client's post-surgery who had regained weight. Instead, I was privileged to witness accounts of success of women who had achieved their weight-loss goals and experienced significant psychological benefits. Across their narratives, a powerful sense of autonomy and control shone through. Despite complications and ongoing challenges, every participant described a strong no regrets stance, affirming they would make the same decision again.

This finding challenged my assumption and taught me the importance of remaining open-minded about people's motivations for pursuing non-conventional routes to health and wellbeing. It reminded me that each person's experience is unique and cannot be fully captured by dominant or generalised narratives. What might appear risky or impulsive from one perspective can from another, represent agency, autonomy and empowerment. As a Counselling Psychologist in training, this awareness has deepened my appreciation of the diversity of human experience and the need to meet each client without preconceptions.

However, my reflections also reinforced that within this population of people living with obesity, there are likely to be some particularly vulnerable individuals, for whom psychological input both before and after surgery is crucial. Such support provides space for reflection on motivations, expectations and emotional readiness. With the growing number of people travelling abroad for surgery, ensuring access to psychological preparation and follow up care feels more important than ever. While participants in this study viewed the NHS procedures as slow and like "jumping through hoops", I was reminded that these processes exist for a good reason. It has increased even further my view that the pre-surgical psychological assessment is an essential and necessary element that should not be excluded when people travel abroad for surgery. If anything it might be even more important given the isolation that some of the women in this study described.

A challenge I encountered during analysing the data, was the participants emphasis on "care", as in the perceived lack of it in the UK versus abroad. I was mindful not to let my interpretation read as accusatory or critical of the NHS, which I know from both professional and personal experience to be a deeply caring institution. At my 20-week scan, I learned that one of my twin daughters would be born with a cleft lip and palate. From that day onwards, our family received exceptional care, support and compassion from the NHS. This experience profoundly influenced how I approached my analysis, with a respect for the dedication of NHS professionals and awareness of the systemic pressures they face. I therefore aimed to interpret the participant's accounts as reflections of their perceived experiences of care, rather than as objective evaluations of NHS practice. Especially in a system under immense strain, where services are often overstretched and underfunded.

At times the analysis felt emotionally demanding when hearing the depth of the participants struggle. I noticed feelings of sadness toward them, especially when they described the physical limitations post surgery. I found discussions with my supervisor and ongoing journalling helped me

process these feeling and maintain a reflective stance. This allowed my analysis to stay grounded in the data rather than based on emotional reactions.

This research has shaped both my professional identify and my personal values as a Counselling Psychologist. It has strengthened my belief in the importance of compassionate, person-centred care in creating spaces where individuals feel safe to explore the meanings behind their choices. It has also reminded me of the importance and privilege of allowing people to share their experiences so we can all learn and deepen our understanding of each other.

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Appendices

Please note these materials have been adapted from the resources available under this assignment criteria on web learn as directed by the course lecturer. They can be found under PY7PB4 Research Project and Critical Skills - Year 2022-23 - under “useful links and resources” https://bblearn.londonmet.ac.uk/ultra/courses/_47830_1/cl/outline

Appendix A: Poster

Appendix B: Participant Information Sheet

Appendix C: Consent Form

Appendix D: Example of an interview schedule

Appendix E: Debriefing Form

Appendix F: Distress Protocol

Appendix G: LUM Ethics Approval

Appendix A: Poster

Recruitment Poster

Have you had Bariatric Surgery Abroad?

I would like to hear your story

If you are;

Female aged 18 or over

Have had Bariatric Surgery abroad 24+ months ago and less than 10 years ago

Would like to share your experience to help others who are considering surgery

Please contact me
If you are interested in taking part or would like any more information
Nicola O'Sullivan (Trainee Counselling Psychologist)
nfo0018@my.londonmet.ac.uk
Participation will involve an informal interview via MS Teams of 1 ½ hour duration.
Interviews will be confidential and your identity will be protected.

Interviews will be confidential and your identity will be protected.

Participant Information Sheet

Title of study: An Exploration into how Female Patients who have had Bariatric Surgery Experience the Decision to have Surgery Abroad: An Interpretative Phenomenological Analysis.

The name of the investigator: Nicola O'Sullivan **-** nfo0018@my.londonmet.ac.uk

The name of the supervisor: Dr. Amanda Visick - a.visick@londonmet.ac.uk

Briefing:

Thank you for taking the time to read this information sheet.

You are being invited to participate in a study exploring the experience of deciding to have bariatric surgery abroad. I am a counselling psychologist in training at London Metropolitan University and as part of my course, I'm required to carry out a piece of research for my doctoral thesis.

The specific goal of this study is to further understand the bariatric patients experience of deciding to have bariatric surgery abroad. Going abroad for bariatric surgery is part of the increase trend in medical tourism, seeing figures sore from 2002 and 2008 (Border, 2020). Very little is known about this experience from the patient's point of view and their decision-making process. I am hoping this research will increase our understanding of the decision to have bariatric surgery abroad, so that people who decide to have surgery are fully informed.

You will be asked to have an informal interview over Teams at a scheduled time in agreement with yourself and myself. It will last approximately 1 hour and will be recorded. Interviews will be confidential, and your identity will be protected. Any data will be processed in accordance with the General Data Protection Regulation 2019 (GDPR). Please follow this link for more information: http://www.londonmet.ac.uk/about/policies/data-protection/. The study is completely anonymous, and you have the right to withdraw at any time during the interview and up to six weeks post interview.

If after participation you wish to access the results from the study, please contact me via the details provided below.

If you have any further questions or are interested in taking part in the study, please contact me at nfo0018@my.londonmet.ac.uk

Appendix C: Consent Form

Consent Form

You are invited to take part in a research study as someone who has undergone bariatric surgery abroad. Please read this form and ask any questions you have before agreeing to be a part of the study.

This study is being conducted by a researcher named Nicola O'Sullivan, a doctoral candidate in Counselling Psychology. Nicola is also a therapist and has experience of working with bariatric patients both pre and post-surgery. In this research my role is purely as a researcher and not as a therapist.

Background Information:

The purpose of this study is to gather information regarding the female experience of deciding to have bariatric surgery abroad. It is interested in the decision-making process.

Procedures:

- I understand that I will be asked to answer questions to a semi-structured interview about my experience of bariatric surgery abroad.
- I understand the interviews will be approximately 1 hour in length via Teams and will be audio recorded.
- I understand my participation in this study is voluntary.
- I understand I have the right to withdraw at any time during the interview.
- I understand I can withdraw anytime up to six weeks post interview.
- I understand if I decide to join the study now, I can still change my mind at a later date.
- I understand that if I feel stressed during the study I may stop at any time and not answer questions I do not feel comfortable answering.
- I understand the study may include providing personal information about myself and that this will be kept confidential and anonymous. I will be invited to choose another name by which I will be represented in the research. The data from the interview will be stored on a device that is password protected and will be destroyed after a statutory period.
- I understand that the benefits of being in this study are that I will be able to help others understand what it is like to personally experience undergoing bariatric surgery aboard and how the surgery has affected my life. This study could lead to future research in helping professionals understand the experience of having bariatric surgery abroad.

Researcher Contact Details:

The researcher's name is Nicola O'Sullivan and can be contacted at **nfo0018@my.londonmet.ac.uk**

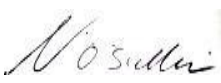
The researcher's supervisor is Dr. Amanda Visick and can be contacted at a.visick@londonmet.ac.uk

Statement of Consent:

I have read the above information. I have received answers to any questions I have at this time. I am 18 years of age or older, and I consent to participate in the study.

Printed Name of the Participant:_____

Participant's Written/electron Signature:_____

Researcher's Written/ electron Signature:_____ 

Example of an interview schedule

This is a semi-structured interview so these are starting questions and additional questions may be asked based on the participants responses.

1. Can you tell me how you are feeling today?
2. Where did you have your operation? /Can you describe the operation you had?
3. What made you decide to have bariatric surgery abroad?
4. What information where you given prior to surgery?
5. What information were you given about the physical benefits of bariatric surgery?
6. What information were you given about the physical risks of bariatric surgery?
7. What information were you given about the psychological benefits of bariatric surgery?
8. What information were you given about the psychological risks of bariatric surgery?
9. What information were you given about possible weight gain post bariatric surgery?
10. What did you do with this information?
11. What questions do you remember asking?
12. Have things worked out as you expected?
13. What thoughts (e.g. about yourself) prompted you to consider bariatric surgery?
14. Were any family members or friends involved in your thoughts or decisions about the surgery and if so, can you tell me about that?
15. If you considered the NHS, what were your experiences of your GPs response to questions? E.g. about BMI or about your eligibility for surgery?
16. Is there anything that you would like to add, or to ask me?

Debriefing Form

Thank you for taking part in this study.

The specific goal of this study is to further understand the bariatric female patients experience of deciding to have bariatric surgery abroad. Little is known about this experience from the patient's point of view and their decision-making process. I am hoping this research will increase our understanding of the decision to have bariatric surgery abroad, so that people who decide to have surgery are fully informed.

If you have any questions or concerns after the study, please do contact Nicola O'Sullivan at **nfo0018@my.londonmet.ac.uk**

Or my supervisor Dr Amanda Visick at a.visick@londonmet.ac.uk

You are welcome to request the results from the study. If you would like this, please contact me via the details provided above.

The following confidential support services can be found below if you feel the participation in this study has raised any concerns or issues for you.

Helplines

The Samaritans - www.samaritans.org

British Psychological Society which has a list of chartered psychologists - www.bps.org.uk

Beat – The UK's Eating Disorder Charity - https://www.beateatingdisorders.org.uk/

Distress protocol

This Distress Protocol has been developed to know the signs to look out for and actions to take if a participant becomes distressed and/or agitated during their involvement in research on patients experience of bariatric surgery abroad.

The two-step protocol to follow is;

Mild distress: Signs to look out for:

1) Tearfulness
2) Voice becomes choked with emotion/difficulty speaking
3) Participant becomes distracted/restless

Action to take:

1) Ask the participant if they are happy to continue
2) Offer them time to pause and compose themselves
3) Remind them they can stop at any time they wish if they become too distressed

Severe distress: Signs to look out for:

1) Uncontrolled crying/ wailing, inability to talk coherently
2) Panic attack - for example, hyperventilation, shaking, fear of impending heart attack
3) Intrusive thoughts of the traumatic event – for example, flashbacks

Action to take:

1) The researcher will intervene to terminate the interview and the debrief will begin immediately
2) Relaxation techniques will be suggested to regulate breathing/ reduce agitation
3) The researcher will recognise participants' distress, and reassure them that their experiences are normal reactions to sensitive topics such as weight
4) If any unresolved issues arise during the interview, suggest that they discuss these with mental health professionals and remind participants that this is not designed as a therapeutic interaction
5) Details of counselling services available will be offered to the participants

Should the researcher deem these steps to not be sufficient, further actions can be taken such as providing participants with contact details for the Samaritans or suggesting they attend their local A&E to ask for the on-call psychiatric liaison officer and notifying their GP. The researcher will ensure to notify their supervisor and where necessary, will report the incident via the London Metrop olitan University procedures.

Adapted from the Distress Protocol, from the resources available under this assignment criteria on web learn as directed by the course lecturer. They can be found under PY7PB4 Research Project and Critical Skills - Year 2022-23 - under "useful links and resources" https://bblearn.londonmet.ac.uk/ultra/courses/_47830_1/cl/outline - © Chris Cocking, London Metropolitan University

Appendix G: LUM Ethics Approval

Date of approval	2Feb24
NB: The Researcher should be notified of the review outcome within two weeks of the submission of the application. If the outcome is re-submission of the application because of requests for further information or suggested adjustments of the project, a further two weeks from receipt of the re-submitted application applies, and so on. A copy should be sent to research@londonmet.ac.uk.	
Signature of RERP chair	

Appendix H: Sample Annotated Transcript (IPA Steps 2 – 3)

Experiential Statements	**Original Transcript**	**Exploratory Noting – Descriptive, *Linguistic*, Conceptual comments**
	Researcher: Yeah, absolutely. And what made you decide to go to have bariatric surgery abroad?	
Frustration with long process to go through for bariatric surgery in UK	**Joy:** And I had started the process of trying to go through the NHS. I could probably be dead with the time that that happened.	Considered UK/NHS but process was too long "dead" to emphasis the severity. *Tone so finite* Didn't want to wait any longer – decline in health. Impact of lengthy delays
	Researcher: Mm hmm.	
Eroded trust in Systemic barriers of NHS	**Joy:** There, there was no rush. They almost seemed, although it was for your health, it was more like a choice, so therefore it was cosmetic, so there was never any kind of rush or desire to try and help you become healthier and, you know, fitter. And you seem to have to jump through a trillion hoops to just get one step forward.	No urgency to help you get healthier Sees BS a way to improve health - Impact she wanted – to be "healthier" and "fitter". *Sounded positive* Not feeling supported by the NHS process. Challenge to get into the UK system *to jump through "trillion hoops" – good metaphor* – lengthy process. Possibly not as many abroad
Feeling frustrated and hopelessness at Systemic barriers of NHS	And then you do something and then they say, oh, well, you can manage that. So I don't think we'll put you on the list now. And so you never seem to make any progress in terms of getting further on, you know, through the process or through their system of requirements.	Putting responsibility on them Seems unfair Frustration at all the requirements you have to go through in the Uk "their requirements" – they hold the control/power
	Researcher: Right. OK.	
Taking control now Personal agency	**Joy:** And it then became we had some spare cash, which is very rare for us and I thought let me do something to help my health and general well-being and looked into a lot of things. I didn't want to go to Turkey because I'd heard of loads of bad stories that had come up from there and also because Lithuania was closer to home and things and I thought, well,	Taking control/ownership/agency To "help" her health and wellbeing Having money enabled her to consider abroad Could do something about it Abroad not her first choice. Didn't want to go abroad but had not choice Negative reports Fear? Taking control – "Research" herself. *Sounded stronger/certain*

Being able to choose surgeon abroad an important criteria like proximity to UK	if I had to ever do anything then that might be closer to home. And when I started researching Lithuania, the clinic had a fantastic reputation and the fact that the surgeon also visited the UK gave me a lot of kind of faith in terms of. **Researcher:** Yeah.Yeah. **Joy:** Kind of backup services or backup contact and then that's when I went down the route to then explore what that would be and see whether I could go down that route to do it. **Researcher:** Right, OK. And that makes sense. A lot of research that you did, and you talked about jumping through hoops to the NHS. So what was your experience of your GP responses to questions that you had about wanting surgery? **Joy:** Yep. He just said, oh, you'll need to try harder to lose weight yourself. And they gave me a diet plan. And I was like, I've done that a million times and they said we'll support you. But then when you phoned and had questions or looked for that support, it wasn't there. And as ironic as it seemed, although I was what they classed as being obese rather than being overweight, I wasn't overweight enough that they wanted to really help me. Because I didn't have a heart condition or I didn't have diabetes and because I didn't have any of these kinds of things then they weren't really interested in me. Although for somebody who's only 5 foot five, I was probably 20 to 23 stone, so quite heavy for a short person and I was very fortunate not to have diabetes. I was very fortunate not to have a heart condition, but I think that was through	<u>Reputation important in decision making</u> Possible choice Finding reassurance in links to UK in terms of geography and surgeon's connections. Patients may want the UK as first choice but can't have. Faith – still taking a chance not 100 certain of outcome Taking ownership, exploring options Having choice - *backup* Negative none supportive UK experience Having to do it alone – *try harder* <u>Frustration –</u> *tried a million times – tried dieting before and not worked* Support appears conditional. Ownership on her. *Tone deflated* Looking for care but it wasn't there *(I feel sad hearing this – she's reaching out being proactive and trying yet its not there)* *Irony – not overweight enough* Strict eligibility criteria Didn't meet the criteria to have BS in UK "not interested" – <u>being dismissed</u> – *Sounded sad* <u>Lack of care</u> Severity of problem Aware of condition and impact of obesity Things could be worse "<u>fortunate</u>"
Reaching out for support from GP in UK but not given		
Experiencing exclusion from NHS support		
Feeling not listened to and alone in weight management journey		

	Researcher: Right. Yeah. **Joy:** Kind of good genes on one side of my family, and because I didn't really have any of these factors apart from a dodgy knee, that wasn't good carrying all the weight about. **Researcher:** Yeah.	Physical impact of being overweight Insight in life before surgery

Appendix I: IPA Step 5 – Sample of Naming the Personal Experiential Themes (PETS) and Consolidating and Organising Them in a Table across cases

Personal Experiential Themes	**Experiential Statements**	***Key word/Quote***	**Participant**
Feeling dismissed and overlooked by the NHS shaped the journey abroad	Feeling frustration with the NHS systemic barriers (p4)	*"You seem to have to jump through a trillion hoops to just get one step forward".*	Joy
	Frustration and uncertainty at the blocks around the NHS system to have BS in the UK (p3)	*"There's a lot of hoops to jump through for the NHS anyway but then at the end of the hoops it's whether or not you get accepted and it's a very long process and then it's if you do get accepted it's then again another 2 plus years before you get the surgery so".*	Mary
	Frustration with long process to go through for BS in UK (p4)	*"I had started the process of trying to go through the NHS…. I could probably be dead with the time that that happened".*	Joy
	UK long waits for medical care compared to fast response abroad (p22)	*"They can't get me in, in the UK, even privately with a ridiculous wait there. And then if, like I said, if you're struggling, you can phone up the dietician, they can talk you through the food"*	Anna
	Having choice as BS abroad give her a chance to improve her health and have a baby (p4)	*"I'm kind of on a time limit now. Because my main reason for losing weight was not only because I was, it wasn't ever to be thin. It was because my health was really suffering, and because I wanted another baby".*	*Mary*
	Feeling frustrated and hopelessness at Systemic barriers of NHS (p4)	*"And so you never seem to make any progress in terms of getting further on, you know, through the process or through their system of requirements"*	Joy

	Not feeling supported by NHS (p5)	*"But then when you phoned and had questions or looked for that support, it wasn't there"*	Joy
Personal agency in weight management, taking control	Taking control now (p5)	"*I thought let me do something to help my health and general well-being"*	*Joy*
	Reaching a breaking point with lifelong struggle with weight, control and lost time (p8)	*"I knew I need to do something…… I just thought I'd need to sort this now…… they'd sort of said that obesity can be like a factor in these illnesses and I just thought if I could do anything now to prevent it I would……. I'd crack on and do it"*	*Anna*
	Could control what she researched (p9)	*"I've seen such good feedback from abroad that I did a lot, a lot of research"*	Billie
	Being able to choose surgeon abroad an important criteria like proximity to UK (p5)	*"The surgeon also visited the UK gave me a lot of kind of faith"*	Joy
	Taking control and researching who treated her was reassuring (p6)	*"I read up about the professor that works at X. He is GMC registered with the UK. And regulated through the UK for practising and things and also teaches the surgery to all the surgeons. So I thought, well, I'm in good hands there"*	Mary
Secrecy and isolation - in order to maintain control over their decision they had to keep secrets	Wanting to keep bariatric surgery abroad a secret (p11)	"*No, I've told nobody about it apart from my husband and my mum. …… I said I need to do it for myself"*	Joy
	Didn't want criticism from some people so kept BS abroad secret (p17)	*"I didn't tell many people initially, just some close friends and they were like, what the hell are you like? Why are you doing that? It's ridiculous"*	Anna
	Keeping secrets (p10)	*"I didn't vocalise the fact that I was having it done like publicly for a long time. So I never said anything about how I was losing weight".*	Mary

	Feeling judged by others that she couldn't follow the traditional weight loss route	*"So like people were saying well if you can lose that weight then why don't you just stick to it and lose more".*	Mary
	Not feeling supported her decision to go abroad (p10)	*"They really really weren't on board".*	Billie
	Friends not in agreement (p11)	*"I don't agree in this operation …. I need you to know that I'm not on board. I will chaperon you but I need you to know that I'm not on board and this isn't me agreeing with you having it done".*	Brianna
	It was hard to go against friends and family in her decision to go abroad for BS (p11)	*"My mum, and everyone was really worried about me. Actually they thought that I was just having it done purely for weight loss and thought that I was being quite selfish …. it was definitely a decision that was very much harder to make with the family members around not supporting me".*	Billie
	Shame in seeking weight loss abroad (p20)	*"I think I think there was a lot of embarrassment around the operation when it came to friends and family. I think my parents were definitely embarrassed that I was even thinking about having it done, let alone go into Turkey to have it done".*	Billie