Coping with the interpersonal stresses of bariatric surgery: An interpretive study of women’s experiences

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Received 4 November, 2015; Accepted 15 February, 2016

The purpose of this interpretive inquiry was to gain understanding about how women cope with the interpersonal stresses associated with bariatric surgery. In-depth interviews were conducted with 13 women who had undergone bariatric surgery. Data were analyzed using constant comparison processes. Analyses revealed that participants managed stress associated with bariatric surgery using five forms of coping, including: seeking and providing social support; opting not to disclose the fact of their surgery to others (“voluntary nondisclosure”), “screening,” reframing the problem, and educating others about bariatric surgery. Insomuch as participants adopted diverse forms of coping and fitted the form of coping to the situation at hand, their approach to tolerating the interpersonal stresses arising from their surgeries reflected “coping flexibility.” Although several of the coping strategies adopted helped participants to manage interpersonal stresses associated with bariatric surgery, others created additional stresses in their lives or left them feeling ambivalent. Findings can inform bariatric support group discussion content or individual psychological interventions with patients who are struggling to manage interpersonal stresses confronted during the bariatric journey.

Key words: bariatric surgery, coping, interpersonal stresses, women, qualitative.

INTRODUCTION

In 2013, an estimated 179,000 individuals in the United States underwent bariatric (weight loss) surgery (American Society for Metabolic and Bariatric Surgery, 2014), which is widely regarded as an effective tool to treat obesity in individuals who have been unable to successfully achieve and maintain weight loss in nonsurgical ways (Livhits et al., 2011). Most patients undergo bariatric procedures primarily for health-related reasons (e.g., weight loss, co-morbidity reduction, and increased life expectancy) (Munoz et al., 2007), but appearance-related concerns also may be a deciding factor for some individuals (Libeton et al., 2004). Although much work has explored the positive outcomes of bariatric surgery, limited work has considered the notion that the bariatric experience also may be characterized by varied forms of stress. That bariatric surgery engenders some challenges for those who pursue it is perhaps not surprising. Individuals who seek surgical treatment for obesity have been characterized as depressed, anxious, impulsive and as having low self-esteem and a diminished quality of life. In some cases, they may struggle with disordered eating patterns such as binge eating or restrictive dieting (van Hout et al. 2004). Further, bariatric surgery represents a major,
medical procedure and requires extensive post-surgery lifestyle changes (e.g., related to diet and exercise patterns) (van Hout et al., 2006). As such, bariatric patients may find that their surgery experiences are marked by difficulties such as physiological complications, psychological problems, struggles to adhere to post-surgery diet and exercise routines, body image concerns (e.g., associated with “extra flesh” remaining after substantial weight loss), and interpersonal challenges (e.g., marital troubles/divorce, changes in social and friendship groups, social isolation, jealousy over weight loss) (Ogden et al., 2006; van Hout et al., 2004, 2006).

The present analysis is part of a broader interpretive inquiry exploring how women experience and navigate the stresses and challenges associated with bariatric surgery. Woven throughout our participants’ narratives were compelling stories of how they came to cope with or manage the interpersonally negative or stressful interactions surrounding the bariatric experience, which is the focus of the present work. The experiences of women were considered because women represent more than 80% of the individuals who seek bariatric surgery (Farinholt et al., 2013).

RELATED LITERATURE

Bariatric surgery in sociocultural context

Within contemporary Western sociocultural contexts, being obese represents a social stigma and may be seen as a signal that one has failed to adequately control the body (Puhl and Heuer, 2009; Rich and Evans, 2005). Here, obesity is associated with negative cultural stereotypes – including the notion that obese individuals are unattractive, lazy, unmotivated, lacking in self-discipline and incompetent (Puhl and Brownell, 2001). In turn, these stereotypes support a cultural bias that leads to prejudice against obese individuals (Puhl and Brownell, 2001; Puhl and Heuer, 2009).

At the same time, dominant obesity discourse promotes a medicalized conceptualization of obesity and focuses on preventing or “fixing” the “problem” of obesity (Cooper, 2010). Individuals adopting this perspective frame body weight as a matter of individual responsibility that can be regulated through diet or exercise, or when these routines are not successful, bariatric surgery (Campos et al., 2006; Cooper, 2010; Rich and Evans, 2005). Thus, within dominant obesity discourse, obesity is treated as a “problem requiring a solution,” undermining the value of larger bodies, locating the responsibility for obesity within the individual, and inadvertently supporting the cultural stigma of obesity (Cooper, 2010, p. 1020).

It has been suggested that more obese women than men seek bariatric surgery because, as compared to men, obese women are more likely to be subjected to obesity-related stigma and bias (Bocchieri et al., 2002b).

Obese women’s vulnerability to stigma and bias may be understood within the context of hegemonic femininity. Hegemonic femininity is constructed within the confines of a White, heterosexual, class-based structure and perpetuates a singular ideal of female beauty. This singular ideal privileges thinness and tonedness and amalgamates, minimizes and devalues physical differences (Bordo, 2003; Krane, 2001). Striving to achieve this ideal is an important part of one’s feminine gender performance. Thus, women whose bodies subvert this singular ideal may be susceptible to disapproval and discrimination.

Bariatric surgery in interpersonal context

Individuals in bariatric patients’ lives may experience difficulty adjusting to patients’ post-surgery bodies or weight losses. For instance, marital partners of bariatric patients may experience feelings of insecurity and the fear of abandonment if they perceive that their spouses are becoming more attractive (Bocchieri et al., 2002a). These concerns may prompt the spouse who did not undergo surgery to feel jealous (Magdaleno et al., 2011). For some patients, the partner’s jealousy may create an undesirable imbalance in their most immediate of relationships, undermining the gains accrued in their quality of life following surgery (Magdaleno et al., 2011) and even jeopardizing the relationship (van Hout et al., 2006).

Responses of jealousy over weight loss supported through bariatric procedures have been observed among friends and (non-spouse) family members, as well. Individuals who experience feelings of jealousy towards a patient may try to sabotage the patient’s continued weight loss or maintenance efforts by exhorting the patient to eat more or by expressing concerns that the patient has lost too much weight (Sogg and Gorman, 2008). Further, as patients undergo dramatic body and life changes after surgery, the equilibrium of the friendship, family, or social groups may be disrupted. For instance, individuals involved in relationships in which bariatric patients formerly played the role of the “fat one” may need to renegotiate relational dynamics (Sogg and Gorman, 2008).

Bariatric patients also undertake significant lifestyle changes after their surgery, and these changes may have implications for their interpersonal relationships, particularly if they share their household with others. Sogg and Gorman (2008) report that patients often experience guilt about changing their dietary behavior post-surgery, as doing so may demand that others in their household alter their cooking or eating patterns.

After the surgery, some family members or friends may be concerned about the patient’s dietary changes in so much as they are losing their “eating buddy” (Sogg and Gorman, 2008). Family members and friends also may
feel threatened by the patient’s rapid weight loss or the need to limit social activities that revolve around food (van Hout et al., 2006). In other cases, friends and family members may choose to serve as the patient’s “food police” by monitoring what the patient eats, which may negatively affect the life quality for the patient (Sogg and Gorman, 2008).

Finally, the dramatic weight losses that accrue postsurgery may demand that bariatric patients develop new social skills, such as coping with increased respect and positive attention from others (Bocchieri et al., 2002a). Some patients realize lack of the basic skill of responding to a compliment (Sogg and Gorman, 2008). Furthermore, patients are frequently expected to assume the often unwanted role of “weight-loss surgery ambassador” to family and friends.

**Coping with the stresses of bariatric surgery**

Coping is widely understood as the cognitive and behavorial strategies that individuals employ to help them manage or tolerate situations that are appraised as stressful (Folkman and Lazarus, 1980; Lazarus and Folkman, 1984b). The transactional model of coping (Lazarus and Folkman, 1984a, b) considers an individual’s subjective appraisal of a situation as stressful rather than the mere incidence or gravity of an event, itself. The model holds that the process of coping has the potential to temper the impact of stress on an individual’s well-being. Coping attempts are thought to be carried out with the aim of addressing the problem inciting the distress (problem-focused coping) or regulating the emotions associated with the stressor (emotion-focused coping) (Folkman and Lazarus, 1980).

Although, the theoretical differentiation of coping as problem-focused or emotion-focused has been widely adopted throughout the coping literature, using these categories (and other nomenclature developed to typify coping strategies) to describe coping can be problematic. For instance, in some situations, problem- and emotion-focused coping may be integrated, making their distinction difficult (Folkman and Lazarus, 1988; Lazarus, 1993; Zaumseil and Schwarz, 2013). In other cases, the use of these categories may mask key differences within the categories, such as how adaptive or mal-adaptive a coping strategy may be in certain situations (Folkman and Moskowitz, 2004). Indeed, some coping responses may be effective with respect to one outcome and produce a negative impact with respect to another (Folkman, 1992; Zeidner and Saklofske, 1996).

Relatedly, much of the coping literature is underpinned by the assumption that within a certain context, given ways of coping may be particularly valuable in supporting emotional well-being, and thus, may be used to develop interventions to assist people to cope more effectively. Evaluating coping effectiveness, however, is a challenging task (Somerfield and McCrae, 2000). The transactional model of coping proposes that coping processes are neither inherently good nor bad, but rather, must be evaluated within the context of the specific stressful situation in which they are enacted (Lazarus and Folkman, 1984b). It therefore follows that “attention must be given to the quality of the fit between coping and the demands of the situation” (Folkman and Moskowitz, 2004, p. 754).

To date, researchers have given limited consideration to the coping processes invoked by individuals who have undergone bariatric surgery, in spite of the fact that this lived experience has been characterized as stressful and challenging. However, research has explored how stress and coping impact weight loss after bariatric surgery, with findings demonstrating that patients who have more confidantes and prior success in losing weight may be better equipped to cope with surgery-related stresses, and thus, may experience more weight loss (Ray et al., 2003). Further, research has examined how bariatric patients who experience excessive (hanging) skin after weight loss (Börserud, 2013) -- and thus, psychological distress, such as body dissatisfaction and negative self-image (van Hout et al., 2008) -- may cope by seeking body contouring surgery (Kitzinger et al., 2012) or by attending bariatric support programs, hoping to gain practical and emotional support to restore normal physical and psychological functioning (Abela et al., 2011). Although these studies lend insights about bariatric patients cope with personal stresses associated with the surgery experience, researchers have yet to explore how patients manage interpersonal stresses resulting from the surgery. Thus, with the present work, we contribute understanding of how individuals cope with the interpersonal stresses incited by the bariatric surgery experience, which research suggests can be quite demanding. Such an exploration is valuable, as coping strategies can be taught (Folkman and Moskowitz, 2004), and therefore it is a productive undertaking to illuminate those strategies that may be helpful in mitigating various stresses within given contexts. We drew upon in-depth interviews with women who have undergone bariatric surgery to inductively identify themes illustrating the coping strategies invoked to tolerate or manage sources of interpersonal stress experienced in relation to the surgery. An interpretive approach was employed to explore these issues because the transactional model emphasizes how the meaning an individual assigns to a stressful event gives rise to how he/she copes with that event. As such, a subjective report, such as a narrative account, is the most apt means of gaining a rich understanding of the coping process (Kelso et al., 2005).

**MATERIALS AND METHODS**

In-depth, face-to-face interviews were conducted with 13 women who had undergone bariatric surgery within the past 36 months. Upon obtaining approval from the institutional review committee,
we recruited our sample from a bariatric surgery support group sponsored by a university hospital system in the western region of the United States.

Four participants had undergone sleeve gastrectomy surgery, and nine participants had undergone gastric bypass surgery. Time elapsed since surgery ranged from 5 weeks to 35 months, with a mean of 12.4 months. Consistent with prior work (Libeton et al., 2004; Munoz et al., 2007), participants cited varied factors prompting their decisions to have bariatric surgery, including health problems associated with being overweight (n = 12), appearance concerns related to being overweight (n = 1), and the fact that they had been unsuccessful in achieving and/or maintaining weight loss using other strategies (n = 8). Participants ranged in age from 26 to 66 years (mean = 53.0 years). Twelve participants identified themselves as “Caucasian,” and one identified herself as “Hispanic.” Nine participants were married, and the remaining participants were not romantically involved. Although nine participants were mothers of teen and/or adult children, only two participants had children living with them at the time of their surgical procedures.

Prior to the interview process, written informed consent was obtained from all participants. Interviews were conducted in private locations selected by participants (e.g., participants’ homes, a private conference room located at the hospital sponsoring the support groups). An in-depth, semi-structured approach was adopted for the interviewing process. Interview questions focused upon participants’ (a) decisions to undergo bariatric surgery, (b) interpersonal interactions related to the surgery (stressful or otherwise), and (c) responses/coping strategies invoked to manage interpersonally stressful experiences that emerged in relation to the surgery. Questions were framed in an open-ended format. On average, interviews lasted between 60 and 75 minutes, but a handful lasted nearly 3 hours. All interviews were audio-taped, and sampling continued until saturation in meanings was realized.

Interviews were transcribed and unitized, such that data were divided into meaningful chunks of text. Next, constant comparison processes were used to inductively identify themes related to coping with the interpersonal stresses of the lived bariatric experience (Corbin and Strauss, 2008). Open coding was used to isolate key concepts in the data and to cluster them together under more abstract, superordinate categories (Corbin and Strauss, 2008). These concepts and categories formed the basis for the development of a coding guide that was applied to the data. Throughout this process, we searched the data for additional meanings, modifying the coding guide as needed. Next, axial and selective coding were used to explore the data for patterns and relationships. Key to this process was a consideration for how certain interpersonal experiences gave rise to specific coping strategies. During the final stages of the coding process, we positioned our findings within the existing literature, employing the strategy of dialectical tacking (Geertz, 1983) to explore the interplay among the data, our interpretations, and prior work.

The trustworthiness and dependability of data collection and analysis were established through journaling (reflexivity) and peer review. The researchers also engaged in dialogue throughout the coding process, contemplating meanings and relationships discovered within the data until joint understanding was realized. The second author also checked the first author’s application of the coding guide to a random sampling of the data (three transcripts). Interrater reliability was 88.66% and was calculated by dividing the number of agreements about coding decisions by the total number of coding decisions made. Disagreements regarding coding decisions were negotiated between the authors.

**EMERGENT THEMES**

**Strategies invoked to cope with the interpersonal stresses of bariatric surgery**

At times, participants’ interpersonal interactions complicated their lived experiences of bariatric surgery, inciting stress in varied ways. To manage this stress, participants invoked diverse forms of coping, including: seeking and providing social support; opting not to disclose the fact of their surgery to others (voluntary nondisclosure), “screening”, reframing the problem, and educating others about the lived experience of bariatric surgery. The frequency of each coping strategy across participants as well as participants’ coping profiles (the assortment of coping strategies used by each participant) is presented in Table 1. In this table and throughout the following discussion, pseudonyms are used to refer to the participants.

**Table 1. Participant coping profiles.**

<table>
<thead>
<tr>
<th>Participant</th>
<th>Seeking and providing social support</th>
<th>Voluntary nondisclosure</th>
<th>Screening</th>
<th>Reframing the problem</th>
<th>Educating others about the lived experience of bariatric surgery</th>
</tr>
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<tbody>
<tr>
<td>Wanda</td>
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<td>X</td>
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<tr>
<td>Betty</td>
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<td>Helen</td>
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<td>X**</td>
<td>X</td>
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<td>Lois</td>
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<td>Rachel</td>
<td>X</td>
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<td>Frances</td>
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<tr>
<td>Marilyn</td>
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<td>X**</td>
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<tr>
<td>Barb</td>
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<td>Linda</td>
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<td>Connie</td>
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<td>Joanne</td>
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<td>Aurora</td>
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*These participants both sought and provided social support. **Among these participants, engaging in voluntary nondisclosure created additional complicating issues.
fitted the form of coping invoked to the situational demands at hand, their approach to tolerating the interpersonal stresses arising from their surgeries aligns closely with the concept of “coping flexibility” (Lester et al., 1994). Flexible coping is commonly understood as coordinating or “fine-tuning” the coping strategies used to “meet the specific demands of different stressful situations” (Cheng, 2003, p. 425; Lester et al., 1994).

In the following discussion, we richly characterize each of the coping strategies used by participants to manage the interpersonal stresses associated with their bariatric surgeries. Additionally, and consistent with the premises of the transactional model of coping and the notion of coping flexibility, we consider the situational demands—that is, the interpersonal stresses—that prompted the use of each coping strategy. We employed inductive processes to identify the coping strategies discussed and did not attempt to fit our themes into existing coping nomenclature of problem- and emotion-based coping; rather, meaningfully characterizing the participants’ experiences, from their perspectives, was the aim of this work.

**Seeking and providing social support**

Several participants actively sought social support or actions undertaken to assist them in meeting the demands of a particular situation (Tolsdorf, 1976) to navigate interpersonal stresses they encountered along their bariatric journeys. Typically, social support was sought from health professionals and was informational in nature (Thoits, 2011), which is similar to findings from work exploring how fathers cope with stress following the birth of a preterm infant (Sloan et al., 2008). Participants referenced the role of health professionals in sharing knowledge on the social stresses that bariatric surgery may prompt, such as shifts in relationship dynamics, social isolation, and awkward post-surgery interactions surrounding food. Participants sought this information by asking directed questions of their health care providers (e.g., during appointments) but also in less overt ways, such as by planfully attending support group meetings featuring health professionals addressing the interpersonal aspects of the lived bariatric experience.

Seeking social support positioned participants to cope with interpersonal stresses of bariatric surgery in varied ways. As Frances’s comments below reflect, seeking informational support from health professionals heightened participants’ awareness of the potential interpersonal stresses they may encounter during their bariatric journeys, deepened their understanding of them, and normalized their concerns about the potential impact of their surgery upon their interactions with others:

In one of the [support group classes], [the psychologist] talked about unexpected consequences of the surgery. During the class, [the psychologist] provided a hand-out for us, and I took as many notes probably that night as probably I’ve ever taken. She talked about lots of things... changes in relationships with friends and colleagues and even spouse, how, sometimes, people can become promiscuous when they have this new body that’s attractive, she talked about how divorce rates go up among couples when one partner loses a significant amount of weight, it can be threatening to the other person. She gave us some strategies for how to deal with that. [frances] What did you take away from the psychologist’s remarks that night? I guess they made me feel pretty normal and that there were things that I could say and attitudes that I could have and relate them to a kind of humor to defuse how it made me feel taken advantage of, or weak, or powerless. So, I guess, I appreciated the strategies [she] provided. (Frances)

Also, implicit in Frances’s remarks is the capacity of informational support provided by health care providers to help participants build an arsenal of strategies to deal with potentially uncomfortable or threatening interpersonal situations arising from bariatric surgery. As Frances suggests, developing a storehouse of strategies was empowering to participants and provided them with concrete tactics they could invoke in real-life situations that at times could be demeaning or humiliating. Linda’s comment below also reflects how informational support sought from health professionals helped participants to anticipate and manage “tricky” interpersonal situations that may arise in relation to their surgeries:

Sometimes, I would find myself in awkward social situations after the surgery, like people wondering why I wasn’t eating very much in social situations. At first, I wasn’t sure how to handle these situations. I was talking to [psychologist] about this....She said, “Just tell people, ‘You wouldn’t believe what I ate before I came, and I’m really not that hungry.” (Linda)

Individuals are not only recipients of social support, however, they also are providers of support (Brown et al., 2003). Thus, drawing upon their own lived experiences with bariatric surgery, participants extended informational and emotional social support (Thoits, 2011) to other bariatric patients struggling with the personal and interpersonal aspects of the surgery. As Frances’s comment below reflects, extending support to others could be therapeutic for the providers of the support, and thus, constituted a coping strategy of sorts:

My friend and I have been studying Dr. Brené Brown’s work on shame. We are trying to bring in an element of scripture into it, and combat shame in that way. We are meeting each week and doing that. That’s been very helpful in some of my struggles. And, it’s very supportive. It’s a safe place. [frances] And, so what is the goal with the writing? I think it is to help, first of all, to help ourselves, and in the process, to develop something to help others. [frances] How will you share it? Maybe we’ll hold some workshops. We are just talking about how we might use some of this that we’re learning and benefitting from, to benefit other women in Christian circles. It is wonderful to give back. (Frances)

Here, Frances alludes to the possibility of “paying forward” the positive benefits she has accrued as a result of her own lived experiences. Similarly, Marilyn spoke about the way in which helping others within the support group “fed her soul.” That providing social support may benefit the self in ways that can promote healing is consistent with prior work (Brown et al., 2003; Krause and Shaw, 2000; Lietz et al., 2011) and with the notion that giving of oneself can prompt feelings of purposefulness and mattering (Taylor and Turner, 2000).

**Voluntary nondisclosure**

Most participants shared that they voluntarily concealed the fact of their surgery from at least some people in their lives, including acquaintances, colleagues, friends, and even close family members such as siblings, parents and adult children. Although, in some cases, voluntary nondisclosure about the decision to undergo bariatric surgery was prompted by a desire not to worry or concern loved ones, frequently, it was invoked as a “self-preservation” or “coping” strategy. Here, participants’ decisions not to disclose to others the fact of their surgery were motivated by a desire to protect themselves from future, distressing situations. Thus, voluntary nondisclosure represents an example of what Aspinwall (2011) has characterized as “proactive coping” in that it allowed participants to “anticipate potential stressors and to act in advance either to prevent them or to mute their impact” (p. 334).

Varied interpersonal stressors moved individuals to invoke voluntary nondisclosure as a proactive coping mechanism. In some cases, participants feared that sharing their plans for surgery with others would represent a barrier to their success in that others would not offer their support or would try to prevent them from...
carrying out their plans to have surgery:

Well, my parents are still alive, and we did not tell them. And, I did not tell my children until after I had my surgery.

The reason is, I really wanted to succeed, I just did not want to tell them. I had a friend who went to Mexico and had the surgery done, and my husband just flipped out. He said, "You’re not gonna go to Mexico." So, there was something I thought if others knew about my decision to have the surgery, they might try to stop me.—(Wanda)

In other instances, the decision not to reveal one’s status as a bariatric patient was driven by observations of other bariatric patients’ negative interpersonal experiences and the desire to sidestep similar experiences for the self. For instance, often, participants specifically sought to elude biases about their weight—including the notion that their weight was a product of their own making (cf. Cooper, 2010)—and the misperception that, in having bariatric surgery, they had taken an ‘easy’ route to weight loss. For these participants, nondisclosure afforded the capacity to avoid potentially aversive emotional experiences (cf. Aspinwall, 2011), and in particular, stigmatizing biases about weight and the decision to have bariatric surgery. Thus, consistent with prior work considering the coping experiences of gay and bisexual men living with HIV/AIDS, these participants sought to cope by concealing their status as a member of a stigmatized class (e.g., bariatric patients) (Siegel et al., 1998).

For others, being subjected to cautionary tales implicating that they, like other bariatric patients, would fail to maintain their post-surgery weight losses incited the decision not to disclose their status as a bariatric patient. Here, withholding information about their surgeries from others gave participants added strength and confidence, emboldening them to defy others’ expectations that they would not succeed in meeting their post-surgery weight goals. Similarly, in the excerpt below, Betty alludes to the protection afforded her by sharing information about her surgery in a selective manner, underscoring the notion that, for participants, voluntary nondisclosure could, at times, be invoked as a means by which to successfully manage interpersonal stresses arising from bariatric surgery:

I pick and choose who I tell. Because I could get myself really down if I tell certain friends or family members that [sic] are going to beat it to death. You know, instead of just saying, "Well, good for you," and high-five it. Good luck with that. And, I know who’s going to be jerks, and so I choose just not to share it with them. So, I have not had much negativity about it (Betty).

For some participants, however, invoking nondisclosure as a coping strategy “solved one problem” but created another problem or complicated already stressful situations (cf. Folkman, 1992; Zeidner and Saklofske, 1996). For example, in Aurora’s case, nondisclosure prompted others to make erroneous speculations about her weight loss that she found hurtful (e.g., that she had cancer or had developed an eating disorder). For Marilyn, nondisclosure incited uncomfortable social situations.

The initial hard part was working with my clients…so trying to let them know, without letting them know, because I did not want to like broadcast to the world I had to have surgery, you know, to lose weight. I did not want them to have to know, so I’d go out to eat with them and they’re like, "Oh, are you feeling okay?" I’m like, "No, I’m just full." And they’re like, "You did not eat anything." And I’m like, "I did." (Marilyn). For other participants, not disclosing to others the fact of their surgeries was a personal affront (or a pattern of such affronts). For instance, Wanda recounted how she distanced herself from others who diminished her spirit by either telling her that she would fail at maintaining her post-surgery weight loss or by chiding that, after her surgery, she would become a “wrinkled up old lady that [sic] was thin and was not going to feel good and was not going to look good and would have no energy.” Similarly, African American women coping with breast cancer have been found to avoid people who brought “down their spirits” as a means by which to manage their health-related stress (Henderson et al., 2003, p. 644). In other cases, the affronts that prompted screening among our participants involved a breach of trust, such as in the case of Lois, who distanced herself from a friend who disclosed to others the fact that Lois had undergone bariatric surgery after she had shared this information in confidence. In some instances, participants who screened negative influences from their lives replaced these deleterious influences with more positive ones, surrounding themselves with people who provided them with the affirmation they felt they needed as they traversed the challenges of the bariatric surgery process:

I’m a lot more aware of unhealthy people and the effect they had on me…Before the surgery, when I was so unhappy with myself, and I was so judgmental of myself that I allowed other people to be the same way…I’ve really backed away from that kind of energy and those types of people…So, I’ve gotten much closer and much deeper with a very small group of people, and I’ve distanced myself from the larger group of people that I used to be a part of, and it’s awesome, I love it. It feels more…comfortable and real. (Aurora).

Distancing the self from “toxic” influences while at the same time deepening constructive relationships was a productive coping mechanism that afforded participants the opportunity to move toward the expression of their more “authentic” selves (Leary, 2003). Here, authenticity in the self-reflective adaptive functioning because acceptance (from the self and from others) was attained “simply by being oneself” and acting in accord with one’s “normal inclinations” (Leary, 2003, p. 53). To the extent that this sort of screening behavior provided a restorative space to shelter the self from harm and to substitute negative influences with affirming ones, it is similar to the “selective affiliation strategies” invoked by men coping with the stigma of HIV/AIDS and homo- or bisexuality; here, men living with HIV/AIDS limited their social networks to supportive individuals who embraced their identities (Siegel et al., 1998).

Reframing the problem

Participants also coped with the interpersonal stresses of the bariatric experience by “reframing the problem,” contextualizing or rationalizing hurtful comments or a given situation so as to deflect personal responsibility or to redirect disappointment when invalidation was experienced. To the extent that reframing the problem entailed “reorganizing” how one looks at a problem to improve one’s personal situation, it is conceptually similar to
“cognitive restructuring” (Skinner et al., 2003). In reframing the problem, participants relied upon two broad strategies that they adapted to fit specific situations.

The first reframing strategy invoked by participants to cope with the interpersonal stresses of bariatric surgery involved locating accountability for a hurtful or invalidating situation with a party or circumstance beyond the self, a strategy that also has been adopted by female adolescent cancer patients grappling with potential fertility loss (Quinn et al., 2013). Implicit here is the notion that in seeking to make sense of the world, people often make attributions, attributing undesired experiences or emotions to causes external to the self (Jaspers et al., 1983). The first reframing strategy often was adapted to confront the stress of not being recognized by others for one’s post-surgery weight-loss successes. Frequently, participants coped with this form of snub by situating these (perceived) insults as other people’s “problems”:

So, my weight loss has been ignored. It is not that my son’s wife has been nasty, she just ignores me, and, which is her problem. I’ve had to step back and say, it’s not my problem. (Wanda). In other instances, participants coped with the lack of acknowledgment for their weight loss successes by positioning these slights within the context of cultural anxieties surrounding women’s weight, and in particular, within the notion of women’s weight as a “taboo” topic (Knight-Agarwal et al., 2014).

Participants also adopted the first reframing strategy to manage stress associated with denigrating exchanges and breaches of trust. Here, participants attributed hurtful interactions to the “wrong doers” social locations and ways of seeing, situating the root of the problem outside the self and thereby relinquishing responsibility for the affront:

My boss is aware of the surgery, and she has been horrible. She calls me out in front of other people who do not know about the surgery, just to see how far she can push me. She’ll hand me a bag of Hershey’s kisses in front of the room and then ask me why I’m not eating any, when she knows about my surgery. But, you know, she is struggling with her weight, too, and she has not been successful in the years that I’ve known her, so I’m trying to be compassionate to the feelings that my weight loss might have on other people….I try to let it go because it’s like, well, it must be her issues more….At the same time, it’s kind of hard when people are jerks, so you want to tell them where they can stick it. (Aurora).

In reflecting upon this interaction, Aurora positioned her boss’s behaviors within the context of her boss’s own weight history and her boss’s possible jealousy over the changes that Aurora had made in her life (cf Sogg and Gorman, 2008), thereby reframing the problem such that the responsibility for the negativity of the interaction rested with her boss and not herself. As Aurora’s remarks reflect, however, reframing this situation did not completely assuage her tension; she remained somewhat ambivalent about her boss’s behavior toward her.

With the second reframing strategy, participants sought to mitigate interpersonal stresses associated with bariatric surgery by considering or reorganizing their priorities, reminding themselves that their satisfaction with their surgery outcome did not rest upon others’ validation of them, but rather, their improved health outcomes:

I had lost 40 pounds, and people were not saying very much. And so, that was disappointing to me. And, I had to…say, “It does not really matter if they say or they do not say and why they do or why they do not. This is not about people complimenting you, it’s about your health. And, you’re doing this for yourself, not for everybody else.” (Frances).

Privileging the health outcomes of bariatric surgery was not always wholly effective in resolving stress stemming from others’ responses or lack of responses to participants’ post-surgery appearances. At a later juncture in Frances’s narrative, she referenced “twirling like a little girl” when her colleagues “finally” acknowledged her weight loss, suggesting the salience of these positive reviews of her appearance to her sense of self (Stone, 1962), regardless of her efforts to downplay the importance of such comments in the face of her improved health status.

Educating others

Several participants noted that others in their lives misunderstood bariatric surgery and their life experiences as a bariatric patient, erroneously assuming that bariatric surgery was an “easy” or inappropriate solution to weight loss and/or providing unsolicited, unwelcome, and inaccurate counsel about how they should manage their diets, post-surgery. In many cases, these assumptions reflected dominant cultural biases about obesity that positioned body weight as matter of personal responsibility and obesity as a sign of failure to properly control the body (e.g., through diet and exercise) (Campos et al., 2006; Cooper, 2010; Rich and Evans, 2005).

To cope with the stress induced by being the target of these misperceptions and this misguided advice, participants provided information to others about bariatric surgery in an attempt to clarify and/or dispel misunderstandings. Similarly, in prior work, gay and bisexual men living with HIV/AIDS have been found to attempt to shift social discourse contributing to their stigmatization (Siegel et al., 1998), suggesting, perhaps, that individuals who are the targets of misperceptions or prejudice may turn to education or social activism as a means by which to cope. In some cases, participants, themselves, shared information with misinformed others in their lives, frequently referencing knowledge claims that they had assimilated as a result of the social support they had sought from health professionals, thereby leveraging the benefits of multiple coping strategies:

My youngest daughter was not supportive when I first told her about the surgery…She was angry that I was going to take the easy way out, and if I would just discipline myself, I could do this…She said…”You just need to get yourself to the gym” and “You need to just buckle down and have discipline…” And, I really chalked it up to lack of education. I felt like the things she was saying to me, she was clueless about….I felt like I needed to educate her about it. But, her opinion was not going to deter me from doing it….I said, “It’s really not the easy way out….I’m going to have to do six months of classes, I’m going to have to re-learn ways to eat, this is not about willpower, I have tons of willpower. I can do whatever the heck I decide I want to do. And, every time I’ve tried to lose weight, I can lose weight, but I have issues with food. I have genetic components to this. For my health, if I do not do something, my life’s going to be shortened. And, it’s not the easy way out….It’s a tool that I’m going to be able to use.” I talked to her about lots of different things…as I was going through classes, I would tell her, “Today, they taught us about eating out, about portion control, about unexpected consequences that are going to happen because of this.” (Frances).

When asked how her daughter responded to this sharing of information, Frances commented, “I feel like she came around…she’s been very supportive. She’s been encouraging to me. Now, she tells me she’s proud of me.” Thus, to the extent that Frances’s daughter experienced a paradigm shift in her thinking and began to offer support whereas before she had posed challenges, it could be said that Frances’s efforts to cope with this particular trial through the strategy of education were effective.

In other instances, however, participants’ efforts to cope with education did not bring about increased understanding and empathy among those whom they sought to edify:

This is an old, old friend…There were a lot of things that went into her concerns. Some of them are irrational…. “Oh my God, you never going to be able to eat again! You’re never going to be able to enjoy food again!” You know, “Why would you have an operation to cut out your stomach”? I tried to explain where she had...
misconceptions. But it has not really sunk in... she still thinks, that, at dinner, I'll be able to eat like four bites of food even though, that's not, of course, the case... I tried to educate her... she does not always listen carefully. She's pretty egocentric, but, she's not important enough to make a difference. (Helen).

In Helen's remarks above, she references the failure of her educational efforts to bring about attitudinal change in her friend, drawing upon a previously discussed coping strategy and reframing the problem by attributing it to a source outside of herself—her friend's egocentric tendencies and lack of openness to others' perspectives. To further assuage the stress incited by the situation, she discounts the importance of this particular friend in her life, locating culpability with the invalidating party, effectively "discrediting the discreditor" (Siegel et al., 1998, p. 110).

Some participants also encouraged misinformed parties to join them at appointments with health professionals or support group meetings, where accurate information was dispensed and misperceptions could be clarified. As Betty explains below, leveraging the support of health professionals in this way helped to normalize certain lived experiences of bariatric surgery for her husband who, to her dismay, tended to police her post-surgery eating behaviors (Sogg and Gorman, 2008). In this way, the remarks of health professionals rendered Betty's experiences more understandable for her husband, helping the couple to achieve a more mutual understanding or definition of the situation (Goffman, 1959) and relieving some of the tension incited by the misunderstanding:

"My husband has been to all the support group meetings. Sometimes he thinks I should do something better than I am doing. He gets on me, like, "That looks like an awful lot of pasta. Are you supposed to have that much pasta?"... But, in these meetings, he'll hear other people say things... And, I'll just kind of look at him like... "See? That's just how it is!"... So, when he comes with me to doctor's appointments and to the support group, he hears... And, he hears the doctor say, "She's doing great." Whatever she's doing right now, let her do it how she's doing it. She's doing great." So, I think that helped him understand more. (Betty)

**DISCUSSION**

With the present work, the authors richly characterized the varied coping strategies that female bariatric patients use to help them to tolerate the interpersonal stresses stemming from their surgeries. Findings illuminated five coping strategies adopted by participants to manage these stresses: seeking and providing social support, voluntary nondisclosure, screening, reframing the problem and educating others. These strategies were adopted across the sample, but, to some degree, both these strategies and the interpersonal stresses that prompted them were shaped by participants' social locations. For instance, younger participants described being subjected to social pressures that were not a part of older participants' narratives (e.g., being pressured to engage in drinking games, post-surgery). And, married participants recounted how their husbands contributed to various interpersonal stresses (e.g., staging resistance against their decision to have surgery, policing their post-surgery eating behaviors) that shaped the coping strategies adopted (e.g., engaging in voluntary nondisclosure, encouraging the spouse to join them in an educational pursuit).

The coping strategies identified in this work were inductively-generated, but, in several cases, were similar to strategies invoked by individuals coping with other health-related stressors (e.g., HIV/AIDS, cancer, infertility, etc.). Of interest were the similarities between the coping strategies adopted by our participants and those invoked by men living with HIV/AIDS in the 1990s (Siegel et al., 1998). Both groups adopted strategies of voluntary nondisclosure, screening and educating others, suggesting that groups managing stresses that stem from stigmatizing health conditions (e.g., HIV/AIDS, obesity surgery) may turn to similar coping strategies. At the same time, findings amplify understanding on coping strategies noted in prior work but also adopted by our participants; for instance, although researchers have acknowledged that individuals may rely upon social support from health professionals when grappling with assorted health-related stresses (Graungaard and Skov, 2007; Katowa-Mukwato et al., 2015; Sloan et al., 2008), the mechanisms by which this support is sought or the ways in which this support works to alleviate these stresses have not been well-articulated. The present work contributes a new depth of insight into these issues, at least with respect to the lived experience of female bariatric patients facing interpersonal stresses.

Findings also revealed that for participants, as the transactional model of coping would suggest, the interpersonal stresses associated with bariatric surgery were subjectively experienced in differing ways and thus, prompted different coping strategies (Lazarus and Folkman, 1984a, b; Folkman and Moskowitz, 2004). More specifically, participants adopted multiple forms of coping and modified their coping strategies in accordance with the situational demands with which they were faced, providing support for the concept of coping flexibility (Cheng, 2003; Lester et al., 1994). That the majority of participants' adopted multiple forms of coping that were fitted to the situation at hand is of interest, as coping flexibility has been related to greater well-being and enhanced adjustment among individuals facing stressful health experiences (Lester et al., 1994). Although, no attempt was made in the present study to assess overall participant well-being, analyses did reveal how the coping strategies identified were experienced by participants as meaningfully "responsive to their personal and situational contingencies," allowing them to manage their stress effectively (Lazarus and Folkman, 1984; Taylor and Stanton, 2007, p. 382).

As noted, however, not all the participants' coping efforts were effective in addressing the interpersonal tensions that they encountered in relation to their surgeries. For instance, participants' efforts to reframe the problem or to enlighten misguided others about the lived experience of bariatric surgery occasionally left them feeling ambivalent, rather than emboldened. Further, the adoption of a voluntary nondisclosure strategy sometimes yielded negative impacts, solving one problem, but creating another, as prior coping research suggested.
may sometimes be the case (Folkman, 1992; Zeidner and Saklofske, 1996).

However, because the participants who experienced complications as a by-product of their nondisclosure also employed other coping strategies — including those frequently associated with positive outcomes — it is possible that some of the negative consequences of voluntary nondisclosure may have been abated to some extent.

As such, taken together, findings provide evidence to support the notion that “coping matters” for female bariatric patients — that is, how these women confront various interpersonal stresses in their lives can minimize, or, at times, further complicate or amplify the impact of difficult circumstances on their lives and well-being (Skinner et al., 2003). Thus, findings have implications for practice, and in particular, may be useful in informing bariatric support group discussion content or individual psychological interventions with patients who are struggling to manage interpersonal stresses faced during the bariatric journey. Understanding how other similarly-situated individuals have managed commonly-confronted interpersonal stresses associated with the bariatric experience may provide individuals a forum for reactive as well as proactive or anticipatory coping, or efforts to manage stressful situations that have occurred in the past (reactive coping) or that may occur in the near future (proactive or anticipatory coping) (Aspinwall, 2011; Schwarz and Knoll, 2003). Further, it may be instructive to disseminate some information about bariatric patients’ coping strategies and needs to family members and significant others of bariatric patients so that these individuals can better empathize with and provide support for bariatric patients; one participant noted that such information might be shared with family members or friends (potential “supporters”) in the form of a hand-out or a flyer. Finally, targeted therapy may be helpful for patients whose own coping efforts did not resolve all their stresses or tensions; perhaps the directed support of a professional could complement individual coping strategies. The present work is limited in its focus on the realities of largely middle-aged, White women who were involved in a support group and who had undergone bariatric surgery within the past three years. As such, in the future, it will be valuable to build upon the present work by considering how individuals other than middle-aged, White women cope with the interpersonal stresses of bariatric surgery. For instance, it would be valuable to consider how younger women or women with diverse ethnic backgrounds may cope with the interpersonal stresses of bariatric surgery. It may be that women of varied social locations have differing interpersonal experiences in relation to the bariatric journey, which in turn, may prompt differing coping strategies. Or, it may be that the coping strategies invoked in response to similar interpersonal stresses may differ by the social location of the participant.

Additionally, including the experiences of individuals who were not involved in a support group — or who had chosen to drop out of a support group — also could be valuable, as the participants in this study (who were recruited through a support group) all had access to a particular type of support, which in turn, may have inclined them to cope in a particular way (e.g., to seek social support through the support group). It also would be helpful to consider the experiences of individuals who had undergone surgery more than three years prior, so that we could consider how coping strategies ebb and flow as time passes. Finally, because the present work did not formally evaluate how coping shaped participant well-being, in the future, it will be important to assess if and how the coping strategies identified in the present work are related to quality of life issues, and, more specifically, to what extent they abate the various interpersonal stresses experienced. The use of quantitative methods may be appropriate for such an inquiry.

**Endnotes**

1. Barb was the only participant who did not adopt multiple forms of coping to address the interpersonal stresses associated with bariatric surgery. Although speculative, it seems that her adoption of a singular strategy was somewhat related to the fact that, as compared to the other participants, she experienced fewer interpersonal stresses, and thus, may have had a lower perceived need for managing such stresses.

**ACKNOWLEDGEMENTS**

The researchers would like to acknowledge Drs. Mary Lynn Damhorst and Linda Arthur Bradley for their feedback on a draft of this manuscript and the guidance they provided at various stages throughout the research process.

**Conflict of Interests**

The author has not declared any conflict of interests.

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