



A qualitative exploration of couples' expectations and experiences of adjusting to changes following metabolic and bariatric surgery

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ARTICLE INFO

Keywords:

Metabolic and bariatric surgery
Couples
Joint interviews
Thematic analysis
Qualitative research

ABSTRACT

Purpose: Although metabolic and bariatric surgery (MBS) is an effective weight loss treatment, patients can find it difficult to adjust to changes post-surgery. To-date, there has been limited research into patients' and partners' experiences of managing this journey. This qualitative study explored couples' expectations and experiences of change, where one individual within the couple had undergone MBS.

Materials and methods: Potential participants were identified by staff within a National Health Service (NHS) Bariatric Service. Sixteen semi-structured joint interviews were conducted, with patients and partners interviewed together (N = 32). Interviews were transcribed verbatim and analysed using inductive thematic analysis.

Results: Five themes were identified around; (1) 'the patients' decision to have MBS', including being determined despite others' concerns; (2) 'the importance of feeling supported', which highlighted that partners felt overlooked; (3) 'learning to eat again', encompassing patients and partners adjusting to physical changes following surgery; (4) 'Improved health and quality of life' and acknowledging the importance of maintaining changes and avoiding complacency; (5) changes to 'confidence and body image', including managing unforeseen disappointments following initial expectations of surgery.

Conclusion: Couples discussed how pre-surgery goals often required reappraising after surgery and that partners played a key role in supporting patients in adjusting to necessary physical, social and psychological changes before, during, and after surgery. This suggests that more holistic support is needed to reduce the risk of expectations being misaligned with the changes experienced after MBS, including providing support to important others who can help enhance patient adjustment.

Introduction

Metabolic and bariatric surgery (MBS) can be considered for individuals with obesity or who are overweight, where excessive or abnormal fat accumulation presents a risk to health [39]. Current guidelines in the UK [25] recommend MBS for individuals with a body mass index (BMI) of 35 kg/m² or higher to restrict the amount of food the stomach can hold. MBS can result in substantial and durable weight loss [28], the resolution of obesity-related comorbidities, and improved quality of life in physical and mental aspects [22]. However, there is evidence to suggest that patients can find adjustment following surgery difficult [8]. MBS can also have some undesirable effects, such as body dissatisfaction and stigma [2], and patients report a lack of understanding from others [10]. The long-term efficacy of MBS has also been

questioned with research indicating trends towards weight regain during longer term follow-up [16].

Research suggests that the positive outcomes resulting from MBS are enhanced by the presence of a stable and supportive relationship [7]. Spousal support has been demonstrated to help maintain weight loss and adherence [23], highlighting the importance of the patients' support network in MBS outcomes. However, relational difficulties have been highlighted, including interpersonal challenges such as envy and partners becoming 'the eating police' [34]. Ferriby et al. [9] also reported that whilst sexual contact between couples increased after weight loss surgery, couple's relationship quality tended to decline.

This suggests that there are short-term and long-term positive and negative repercussions of MBS that couples should consider prior to the procedure, to optimise support following surgery. However, there has

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<https://doi.org/10.1016/j.orcp.2025.06.001>

Received 23 July 2024; Received in revised form 3 June 2025; Accepted 8 June 2025

Available online 16 July 2025

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been limited research exploring couples’ expectations of MBS and what their experiences are of the realities of change post-surgery. Moore and Cooper [24] found that couples experienced unpredicted intimacy difficulties following MBS, suggesting that couples were not prepared for this outcome of surgery and that there was a discrepancy between what they expected and what the change was. The current research aims to extend previous research by specifically exploring couples’ expectations of MBS and the changes that they encountered to help identify where further support might be needed.

Methods

Ethics

Ethical approval was granted by the University of Southampton (REF: 47331) and the UK Health Research Authority (Ref: 19/NS/0137).

Design

Qualitative method using semi-structured face-to-face joint interviews with MBS patients and their partners. Interviews were analysed using inductive thematic analysis [5], a widely used and flexible approach [27]. It provides a detailed, rich, and intricate account of data, identifying themes and patterns across different research participants, as well as highlighting similarities and differences, and generating unanticipated perceptions. When implemented well it can produce trustworthy and insightful conclusions [5].

Participants and recruitment

Participants were recruited from one UK National Health Service (NHS) bariatric service, with potential participants initially identified by a dietician and a clinical psychologist in the bariatric team. Patients had to be at least 12-months post-surgery at the time of the interview and co-habiting at the time of the MBS and the interview. Both of the couple had to consent to participating in the study and be fluent English speakers. Sixteen couples were recruited to the study, equalling 32 participants in total.

Procedure

Interviews were conducted by KR between October 2019 and December 2019. Eligible participants were given a study information leaflet and expressed interest by contacting their health provider or the researcher (KR). Participants were then contacted via telephone to discuss the study and obtain verbal consent. Study information was reviewed, and written consent and demographics obtained for both participants prior to interview. Interviews took place at the couple’s home and lasted 55–90 minutes. Couples received a £30 Amazon voucher for taking part, funded by a university student research budget.

Interviews explored couples’ pre-surgery expectations, changes post-surgery and expectations for the future (see [Supplementary material](#)). Change was explored across various domains including physical, eating, emotional, social, relationship, and unexpected changes. Interviews were audio-recorded and transcribed verbatim by KR and two voluntary research assistants. As the current sample was relatively homogeneous (cohabiting couples, one of whom had MBS), data collection concluded after 16 joint interviews and no new themes were generated from the data. This is consistent with the Hennick & Kaiser review [13] suggesting 9–17 interviews are sufficient for saturation. Transcripts were analysed with NVivo 12 [30] using inductive thematic analysis [5]. Analysis was conducted by KR in consultation with the rest of the research team (all White British), which included a trainee clinical psychologist (KR), a clinical psychologist who worked in a bariatric service (LC) and two academic psychologists (CB, KS), one of whom was an experienced qualitative researcher. The primary researcher had prior

knowledge of working in physical health settings but no previous experience of working within a bariatric team, but personal experience of a friend undergoing MBS.

Initial codes were developed by KR and were cross coded by an independent researcher (JM). The two coders discussed similarities and discrepancies between the codes and agreed a coding manual, which continued to be refined as data analysis progressed (see [Supplementary material](#)). Themes were developed by grouping related codes together using NVivo and thematic mapping on paper. Analysis was iterative, with codes and themes being revisited throughout the analysis, in discussion with the research team. A critical realist approach was taken, focusing on real problems experienced by participants whilst recognising the complexities of their social world [37]. A reflexive log was kept throughout the data collection phase to allow the primary researcher to reflect on the process.

Results

Participant characteristics

Most couples were White British, heterosexual, and over the age of 35, with most patients being women. Patients had surgery between 2011 and 2018, with about half having had surgery in the last 18 months (N = 9, 56 %). Type of surgery was evenly distributed between Gastric Band, Gastric Bypass and Gastric Sleeve. None of the partners had undergone MBS. All couples were co-habiting, and most were married (N = 14, 88 %). The mean length of relationship was 16 years (SD = 5.2). See [Table 1](#).

Themes

Five themes and 11 sub-themes were identified (see [Fig. 1](#)).

Theme 1: the patient’s decision to have surgery

Most patients and partners discussed the patients’ determination to

Table 1
Patient and partner demographic data.

DESCRIPTIVES	PATIENTS (N = 16)		PARTNERS (N = 16)	
Individual demographics				
	Mean	SD	Mean	SD
Age	50.5	8.3	51.4	9.0
	N	%	N	%
Gender				
Male	3	19	12	75
Female	13	81	4	25
Ethnicity				
White British or Irish	14	87.5	15	94
White/Black Caribbean	2	12.5	1	6
Sexuality				
Straight/Heterosexual	15	93.7	15	93.7
Gay/Homosexual	1	6.3	1	6.3
Patient surgery demographics				
Type of bariatric surgery				
Gastric Band	5	31	-	-
Gastric Bypass	5	31	-	-
Gastric Sleeve	6	38	-	-
	Mean	SD		
Time since surgery in months (N = 15) ⁺	25.4	23.1	-	-
Weight in kgs				
Pre-surgery (N = 14) ⁺	166.8	(76.8)	-	-
Post-surgery (N = 14) ⁺	96.2	(24.2)	-	-
Total weight loss	40.8	(20.6)	-	-
Body Mass Index (BMI)				
Pre-surgery BMI (N = 9) ⁺	50.1	(8.3)	-	-
Post-surgery BMI (N = 7) ⁺	28.3	(5.7)	-	-

Note.

⁺ Some patients chose not to disclose this information. Descriptives are reported for the N stated.

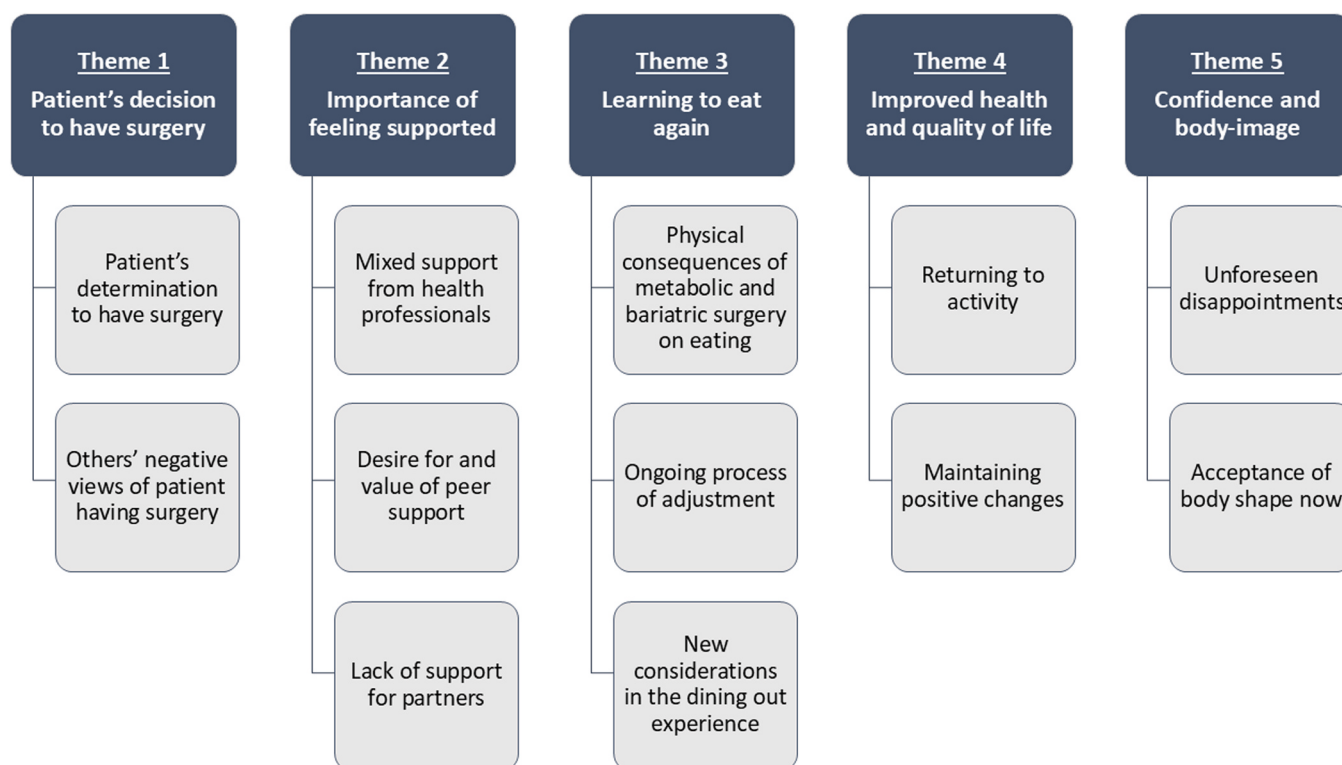


Fig. 1. Thematic map.

have MBS, even when others expressed concerns about this.

Patient's determination to have surgery. Many patients discussed how determined they were to go ahead with MBS due to positive expectations of what the outcomes would be. Most partners described that the patient had a fixed mind-set about going ahead with the surgery.

"... if ... I want to do something, then that's what I'm gonna do. And I'll find a way to do it, even if it means jumping through more hoops and hurdles than I need to." (Patient, Interview 6)

"...other people might not be sure but you made your mind up right from the word go." (Partner, Interview 9)

Others' negative views of patient having surgery. The interviews suggested that the negative views expressed by friends and family about the patient's decision to have MBS did not impact the patient's choice to go ahead. This quote reflects the stance of a friend who worked in the weight loss industry.

"...she [patient's friend] kept saying; "... please don't have it done, please don't have it done" and I said; "I've made my mind up, I've got the appointment. It's happening, so that's it".... She went with it, she wasn't happy, but she went with it." (Patient, Interview 11)

Negative views largely concerned the potential risks of surgery.

"I guess there's always a chance of operations going bad isn't there? And that was a bit of a worry but as I said I'm quite good at just blanking stuff out." (Partner, Interview 6)

In contrast, one partner expressed that they were happy for their partner to have surgery because they trusted that they would have researched their decision.

"...once [patient] has set his mind to do something, he will do it and I knew he would've researched it so I was just happy, so my expectations really were that he would just get on with it. And it would all be absolutely fine." (Partner, Interview 15)

Theme 2: the importance of feeling supported

Couples reflected on the importance of both parties feeling supported during the process of MBS. A common reflection was that there were mixed experiences of the support they received.

Mixed support from health professionals. Most patients described feeling listened to and validated by their GP, but some patients reflected on feeling judged and frustrated when approaching the matter.

"I remember speaking to another doctor about it over the phone for my surgery and he was really quite rude... He's like; "Yeah, you are a big girl then". And I was just like; "Oh my gosh"... But the other doctor I saw was really supportive. Sort of a mixed bag." (Patient, Interview 14)

Similarly, some participants felt well-supported by the MBS team through operation and follow-up. However, some patients felt follow-up support had been inconsistent.

"I had some follow up and then there was a lot of sickness in the department and somehow I got dropped or missed and I didn't have any intervention for about a year. And then it picked up again about a year ago... I contacted [the bariatric team] a couple of times with no reply and just let it go." (Patient, Interview 3)

Generally, post-surgery follow-up was valued by patients as part of the aftercare process.

"I like the aftercare. I didn't think I'd be bothered about that but if you'd paid for it you wouldn't have had that. Because it's on the NHS

it's aftercare for life, it's not just for the first year or anything". (Patient, Interview 7)

The desire for and value of peer support. Peer support was highly valued by most patients and several patients commented that they felt motivated to share their experiences with new patients by attending bariatric support groups, although ability to do this was impacted by practicalities such as having enough notice.

"... when we went it was, PowerPoint slides wasn't it and, you know [the dietician's] fantastic, and [the dietician] and her colleague were really thorough but there was no one that you could talk to that had been through it... and that's why I said to [the dietician]..." "I want to help you to give something back" ... it gives [new patients] the opportunity to ask the questions that you can only ask of somebody that's been through it."

Partners were also an important source of peer support for many patients, through attending appointments together, making joint decisions, and helping with low motivation.

"You've got to have somebody by your side who is supportive and not negative all the time coz that doesn't help. (Patient, Interview 16)

Several patients also commented that their partners helped them to check in on their eating behaviours.

"If I'm eating a packet of crisps... you'll say to me [to partner], how many of those have you had and what are you having?" He won't tell me to do or not do something. But what he's saying is, are you monitoring your own behaviour?" (Patient, Interview 13)

Lack of support for partners. Despite the important role partners seemed to play in supporting patients, partners often felt that there was limited support for them during the patient's MBS journey.

"We had the meetings where I was able to go along, and it was one of the things that I said to [patient] afterwards I said; "It's all about yourself which is fine but there was nothing for me". For what I should expect and what kind of thing was going to happen afterwards. I'd read all about it, you know from what [patient] was given but I just felt I needed a bit more support for the partners really." (Partner, Interview 2)

Several patients recognised the significant changes that their partner had to endure post-operatively, such as learning to adapt to mealtime changes, emotional volatility and the financial implications of buying new clothes and acknowledged the need for both of the couple to feel supported.

"Partners or the people you're living with need to be included in that conversation because it is a big life change, and they need to be part of that rhetoric." (Patient, Interview 5)

However, some patients reflected that the process was not about the partner and that their involvement was less important.

"You could take your partner [to appointments] but it wasn't about him. I didn't want to concentrate on how he felt about it, as long as I knew what I was doing. I don't want to make this whole thing about both of us. It's my thing, it's not my hobby but I can't cater for him all the time." (Patient, Interview 7)

Theme 3: learning to eat again

Many patients discussed how the reality of eating after surgery had

been more difficult that they had anticipated.

The physical consequences of metabolic and bariatric surgery on eating. Patients spoke about the how eating impacted them physically due to the surgical restrictions in place. This included physical difficulties with food getting stuck, being unable to swallow food and vomiting food back up, which patients found "scary".

"She [the dietician] did say to me that it'd be uncomfortable but actually when it very first happened it frightened me to death coz I thought; "oh my god I'm having a heart attack". (Patient, Interview 11)

Many patients also reported pain and discomfort as a side effect of MBS.

"And [partner] said "Well something must've got stuck" and I said "It must've done" but when I spoke to them [the bariatric team] about it they said "Oh that's typical of what it is" you know? But they didn't say that they just said, "There might be some things that you're not able to eat", they didn't say that you'd get this horrific pain." (Patient, Interview 11)

Ongoing process of adjustment. One longer term issue described by patients was the challenge of remembering to pace a meal.

"That's been the biggest problem really isn't it? That still after nearly two years learning to eat slow. I have to remind myself constantly." (Patient, Interview 9)

Another factor was having to experiment with different foods to test if they would be tolerable. This referenced being able to chew, swallow and hold down different food types. Patients described the process of trial and error with a variety of foods post-surgery.

"You've got to work for it yourself. Yeah. To find out what you can eat and what you can't eat. What your body's gonna accept. You just gotta try it and suck it and see." (Patient, Interview 10)

New considerations in the dining out experience. Some patients reported struggles in communicating their dietary requirements to restaurant staff when they went out for a meal, leading to feelings of frustration and worries about how the staff perceived them.

"The only thing that I would like to change is if you buy something in a restaurant that you give me what I've asked for and not have to waste food. I try I do try to explain to them and unfortunately a lot of them just don't listen, so the food goes back. But then I feel sorry for the chef coz they must think they didn't like my food." (Patient, Interview 15)

Several couples described that they had adapted to how they order food since surgery. Some patients noted that they had a starter rather than a main course when dining out, or that they would share with their partner or take any leftovers home.

"If we go out for a meal I'll have a starter and everyone has a main or we bring it home and I don't think it's restricted us, in, that respect." (Patient, Interview 2)

"But what has changed is that you typically don't buy a meal you have some of mine." (Partner, Interview 3)

Theme 4: improved health and quality of life

Couples reported noticeable improvements in the patient's physical health and lifestyle since undergoing MBS. MBS appeared to facilitate a

more positive attitude towards lifestyle choices, which consequently enhanced the wellbeing and quality of life of both parties in the relationship.

Returning to activity. Patients discussed their satisfaction in being able to join in with activities with their families, rather than being restricted by their size. This included a variety of activities from going on roller coasters with their children and developing new hobbies and interests such as running.

“Yeah I think so, like the thing for me is a couple of years ago we went to America didn’t we? And we walked up and down New York and we went on to San Francisco. I’d never ever have been able to do that trip, would I, at all?” (Patient, Interview 16)

Several partners acknowledged that the patient was more able to offer practical support in the home since their surgery.

“You’re able to do more things, you can help me with a hell of a lot more. You know before if we were painting the shed [patient] wouldn’t be able to do it. I’d have done it all myself. But now she can help us and [son] comes and helps us so we’re doing it, we’re doing stuff as a family...” (Partner, Interview 9)

Maintaining positive changes. Although couples evidenced many positive changes to their health and life quality, there was also acknowledgement by both parties that continued success was dependent on monitoring complacency.

“I think it does help people but then the people have got to be willing to stick to it because it’s not an easy fix, by any stretch of the imagination. But you get there and it’s like I say, this is not a quick fix. This is something that will change your life forever and you’ve got to be prepared for that.” (Patient, Interview 1)

Several patients reflected on the prospect of returning to their former selves and the worry that this elicited, which motivated them to continue to adhere to the process.

“...you’ve got to be mindful of how you were before. Not look in the mirror and think, “Oh, well, I lost 10 stone I can start stuff in the face again”. Otherwise, you’re just gonna end up where you were before. And then what was the point of everybody giving their time to help you, if you are not going to help yourself?” (Patient, Interview 10)

The majority of partners echoed the view that the surgery was a mechanism for change only.

“It really isn’t a magic bullet; it’s just a tool to help people.” (Partner, Interview 5)

Several partners stated that they anticipated that MBS would facilitate a healthier lifestyle for the patient, and for themselves. However, they often found that the reality was very different, and weight gain for the partner group was commonly described as an aspect of the surgical journey that they had not considered, and partner’s maintaining their own weight was challenging.

“I had rose coloured glasses thinking; “That’s fine, she’ll be eating less. I’ll be eating less, we’ll be having healthier meals” ... No. I did really well on Slimming World but now... I’ll lose two or three pounds a week and the following week it all goes back on”. (Partner, Interview 2)

“I’d probably say I’d put on a couple of stone I would say myself...So that’s quite a lot of gain, either me eating junk food, cause I’m on the odd occasion once or twice a week I’m eating something cause it’s

just me. If we’re out; ‘Oh I pay for that half a cheeseburger’, you [patient] only ate a little bit so I ate the other half.” (Partner, Interview 9)

Theme 5: confidence and body image

Couples repeatedly outlined that there had been changes to the patient’s confidence and body image following surgery. Couples reports that there had been some expectation that the surgery would promote better body confidence, yet, development of this self-assurance was complex. Although there appeared to be a level of acceptance about the patient’s appearance, reaching that phase had been a lengthy process.

Unforeseen disappointments. A common post-surgery disappointment was having excess skin, which had a secondary impact on the partner. Patients reported that they were informed about excess skin being a problem after weight loss, however, many stated that they did not anticipate how much it would impact on their physical appearance and psychological state.

“It’s fine, I don’t care about the skin, I’ll be thin I’ll be alright, I won’t care about it” and you sign paperwork to say you won’t care about it... I was devastated to the point that I ended up going to Poland and we paid to have some off. And now I want more off.” (Patient, Interview 6)

Many partners reflected on the negative language that the patient used about their bodies after surgery due to disappointments about having excess skin, which often was more negative than when they had been overweight.

“You’d never used to say; “I’m so fat, I’m not having sex because I look disgusting”. Now you’d use that word disgusting quite a bit about your skin. (Partner, Interview 12).

Some patients also outlined that they had not lost the weight that they had expected to lose, which had been demoralising for them. One partner spoke about the disappointment and sadness he felt for his partner.

“I suppose I feel, yeah I feel disappointed for [patient] and you know when you get upset about it. I think you saw, we saw that the bariatric surgery was gonna have an impact for the good and it wouldn’t be this difficult, but it clearly is this difficult.” (Partner, Interview 3)

Acceptance of body shape now. Alongside unpredicted dissatisfactions, a significant proportion of patients described that they felt contented with what they had achieved post-surgery. This was often expressed in terms of how they felt trying on clothes, such as being able to shop in “normal shops”, being able to wear “nice” clothes, or fitting into old clothes.

“I can shop in normal shops. It’s like a whole world just opened up... It’s been nice to feel good about myself and wear nice things again.” (Patient, Interview 4)

Yet, it was commonly reflected that this feeling of contentment had developed through re-evaluation of personal goals.

“But I purposefully made my goals more loose. Because very quickly after having the surgery, I discovered that... I was setting myself up to fail because... I wasn’t immediately a size 12 and weighing x and ... I’m starting to unravel and so actually being a lot more loose with my aim after having the surgery, it’s been a lot more helpful for me.” (Patient, Interview 13)

Many partners also commented on their satisfaction with what the patient had achieved and recognised a positive change in their body

image and confidence.

“She [patient] came out trying some clothes on... And I looked at her face and I just said to her; “That’s really good, you know you look good in that”. And... she goes; “Oh yeah actually I look okay now”. She would never have said that before, never have come out with that face.” (Partner, Interview 12)

Despite these improvements, many patients described comparing their weight loss to others, which caused emotional strain for some patients.

“Everyone’s weight loss journey’s very individual and that was what was starting to panic me, which was why I started seeing [the psychologist] because I was surrounded by lots of competitive people that were unhealthy. And I just felt like I was drowning, I needed the voice of reason.” (Patient, Interview 13)

Discussion

This study explored couples’ expectations of MBS and changes they experienced following surgery. Five themes were identified focusing on; (1) ‘the patients’ decision to have MBS’, including patients being determined to have surgery despite others’ concerns; (2) ‘the importance of feeling supported’ for both patients and partners, which highlighted that partners felt overlooked; (3) ‘learning to eat again’, which highlighted the challenges patients and partners face adjusting to physical changes related to eating following surgery; (4) ‘Improved health and quality of life’, in which couples’ acknowledged the importance of maintaining changes post-surgery and avoiding complacency; and (5) changes to ‘confidence and body image’, including a need to manage unforeseen disappointments following initial expectations of surgery and problems with body-image due to excess skin resulting from weight loss.

Previous research has highlighted that whilst MBS has positive impacts on quality of life and health benefits associated with weight loss [22] patients can find adjustment difficult [8] and need to actively work to maintain benefits [17,33]. Challenges patients experience include adjusting to common post-surgical effects on eating, such as epigastric pain [19], body dissatisfaction over excess skin [3], and disappointments when weight loss was not as anticipated [35]. What was distinctive about the current study findings was couples’ shared sense of disappointment at aspects of change. Despite patients acknowledging that they had been told about post-surgery side effects such as excess skin, couples reflected that the reality of living with them was worse than they expected, with patients and partners highlighting the negative impacts on patients’ body-image. This is in line with existing research that suggests that MBS patients often have unrealistic weight loss and appearance expectations despite being given realistic information about these factors [1,14].

Park [29] found that the more a bariatric patient’s motivation was internally regulated and related to their personal life, the more hopeful they were about the surgical outcomes they anticipated. The patients who took part in this study appeared strongly internally motivated to undergo MBS and maintain changes. Self-determination theory [31] highlights internal motivation as important in driving and maintaining behaviour change and may also be relevant for understanding patients’ distress and frustration around excess skin and eating challenges. These post-surgery outcomes are out of the patient’s control, which may harness greater feelings of discomfort.

It is noteworthy that some patients who had struggled with weight loss disappointment reflected that they had needed to reappraise their weight loss goals to become more flexible, turning their attention away from what they weighed, towards what they could do. For example, by appreciating the functional gains of weight loss, such as increased mobility. Body functionality is a central feature of positive body image

following MBS [36]. Findings also indicate that meaningful change can be found in the patient being able to partake in family life again, such as through joining in activities. This is consistent with the Bylund et al. [6] concept of attaining unity within the family unit by co-creating stability and well-being post-surgery. Developing flexible weight goals and emphasising meaning of increased body functionality may be important intervention targets for preparing and supporting patients’ post-surgery. Both patients and partners emphasised the importance of being supported throughout the MBS journey. Lent et al. [18] found that a supportive social network enhanced a patient’s motivation to implement lifestyle changes after MBS. However, it was reported that many of the patient’s family members lived with obesity and associated comorbidities, highlighting that systemic support might be valuable. In the current study, several partners discussed their inclination to eat leftover food that the patient did not eat and stated they had been impacted by changes to the patient’s dietary changes, giving examples of overeating and weight gain. This is consistent with Madan et al. [21]. These findings highlight the importance of providing education to the partners of bariatric patients as well as patients to help prepare them for changes post-surgery that may impact both themselves and the patient. Consequently, the development of bariatric education, information and care should be shaped by a holistic framework that integrates the needs of the patient, partner, and the wider systemic context. A systematic review of social support following MBS [20] found a positive association between post-operative support groups and weight loss. However, Hameed et al. [12] outlined that there was an unmet requirement for post-operative support groups. Bariatric teams may consider offering information sessions to couples to co-inform the about aspects of surgery, such as excess skin, the impact of surgery on the family network, and the support available to both the patient and the partner, such as peer support groups. Additionally, couples may be able to engage in discussions about the measuring meaningful change post-surgery by acknowledging achievements beyond weight loss, such as re-engaging in vocational activities. It may be of benefit for bariatric teams to invite ‘peer specialists’ and their partners to speak to couples who are about to undergo MBS about some of the considerations they should make before having the surgery. This kind of support was highly valued and desired by participants in the current study. Taking a more lived-experience approach to explaining the impact of MBS and how to adjust to life post-surgery might support patients’ developing more realistic expectations of surgery, by highlighting the realities of post-surgery changes using a ‘credible’ source i.e. someone who has had MBS. It could also support sharing past patients’ ‘tips’ for handling challenges, which could be of practical support following surgery. A digital intervention, developed with people with lived experience of MBS could be a suitable method of dissemination where peer-led support groups are not possible, and enable wider dissemination. However, these suggestions require further research.

Strengths/limitations

A key strength of the study was the use of joint interviews. The process of co-narration in the joint interviews allows views to be shared and can offer valuable information about how couples co-construct meaning [32]. This allowed deeper insight into the importance of partners in the patients’ system and the impact surgery had on them. Nonetheless, a limitation of joint interviews can be that participants may feel reluctant to fully and honestly express their views in front of each other [40]. Further research focusing solely on partners’ perspectives might be beneficial.

The couples in this study were all still in relationships following MBS. However, it has been evidenced that a number of relationships fail post-surgery, with increased incidence of separation and divorce in MBS patients [4]. Whilst the current study identifies potential challenges that may impact couples’ relationships following MBS, it does not tell us about the experiences of patients or their partners when relationships

dissolve following surgery. More research is needed to explore causes of relationship breakdown and to understand potential support needs of patients and partners [15]. Further qualitative research could give insight into this. Furthermore, the sample was predominantly White, female, and heterosexual. Whilst the gender and age of the sample is similar to national demographics of MBS patients [26], the perspectives of the 18–34-year-olds were missing in the current study and warrant further investigation. Demographic data on sexuality of MBS patients is not currently available on NHS England, therefore it is unclear to what extent the current sample compares to national demographics; however, all but one couple was heterosexual. Further research with more diverse groups is required as different groups may have different needs, experiences and sociocultural norms. It is inevitable that the analytical process and subsequent interpretation of the results will have been shaped by the researchers' personal experiences [38] and interviewer's role as both the interviewer and the researcher for this paper. Whilst a reflexive log was kept throughout the study, with interpretations of the data discussed within the research team, it is important to acknowledge this potential bias. Similarly, the views and experiences expressed in the current interviews may not reflect all couple experiences. The patient sample in these joint interviews had apparently high levels of intrinsic motivation, which may have influenced their experiences and their decision to opt into the current study. The study sample was also limited in terms of diversity. Most patients and partners defined themselves as White British, and most patients were females living with male partners. Only one same sex couple was recruited to the study. Although men are known to be a minority group in the field of bariatric research [11], future research should aim to capture the experiences of this under-represented group to inform best practice measures to support male patients and their partners. Further research is needed to explore the experiences of men, the LGBTQ+ community and other ethnic groups, who may have different norms around eating and weight loss.

Conclusion

The current study identified key themes related to expectations and change in the context of MBS, and highlighted that couples' have mixed experiences of support before, during, and after MBS. It suggests that there is a need to support both patients and their partners to help set up realistic post-surgery expectations and goals, and to support adjustment to changes post-surgery. Partners constitute an important source of support for patients but may also be impacted in terms of their health following patient's surgery. Support for both patients and partners may help to promote successful post-surgery outcomes. Additional techniques that may be useful include encouraging goal flexibility, focusing on body functionality, such as returning to activity and other factors, rather than weight loss alone.

CRedit authorship contribution statement

Katherine Rowell: Writing – review & editing, Writing – original draft, Visualization, Validation, Project administration, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Lisa Cant:** Writing – review & editing, Supervision. **Catherine M. Brignell:** Writing – review & editing, Supervision. **Katy Sivy:** Writing – review & editing, Visualization, Validation, Supervision, Resources, Project administration, Methodology, Formal analysis.

Author agreement

All authors have seen and approved the final version of the manuscript being submitted. This is the authors' original work and has not received prior publication. The manuscript is not under consideration for publication elsewhere.

Ethical statement

This material is the authors' original work, which has not been previously published elsewhere. The paper reflects the authors' own research and analysis in a truthful manner. All authors have been actively involved in substantial work leading to the paper and will take responsibility for its content.

Declaration of Competing Interest

None.

Appendix A. Supporting information

Supplementary data associated with this article can be found in the online version at [doi:10.1016/j.orcp.2025.06.001](https://doi.org/10.1016/j.orcp.2025.06.001).

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