1-1-2016

Life After Bariatric Surgery: A Mixed-Method Analysis on Social Support and Quality of Life

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by

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Presented to the Faculty of the

Graduate Department of Clinical Psychology

George Fox University

In partial fulfillment

of the requirements for the degree of

Doctor of Psychology

in Clinic Psychology

Newberg, Oregon

February, 2016

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has been approved

at the

Graduate School of Clinical Psychology

George Fox University

as a Dissertation for the PsyD degree

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Date: 9/28/2015

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Abstract

Obesity is often described as a national epidemic; bariatric surgery is one form of treatment that has become increasingly popular. Bariatric surgery is successful and many patients experience significant weight loss; however, many patients struggle to maintain their new weight. In an attempt to respond to the problem of weight loss maintenance, bariatric surgery programs are incorporating behavioral management-strategies in addition to typical program support. Support groups are often offered by bariatric surgery programs and are commonly focused around psychoeducation, behavioral strategies, and community support. This study provides a mixed-method quantitative and qualitative analysis on life after bariatric surgery, primarily in the areas of program support, social support, support group, and quality of life. A sample of 29 post-operative bariatric surgery patients from a bariatric surgery program completed the SF-36v2 health survey to measure their health-related quality of life and participated in a qualitative interview. Consistent with current literature, the interview and results are organized according to the following themes; program support, social support, support group involvement, and quality

of life. This study adds to the limited field of research on qualitative information regarding bariatric surgery.

Keywords: bariatric surgery, weight loss surgery, support group, SF-36v2 health survey, quality of life, health-related quality of life, well-being, questionnaire, qualitative analysis, interview

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Chapter 1

Introduction

Given that obesity represents the second largest cause of preventable death and recognizing that greater than 34% of all adults and 25% of all children in the United States meet medical criteria for obesity (Ogden, Carroll, Kit, & Flegal, 2014), there has been an increased focus on medical interventions designed to combat this epidemic. Sutton and Raines (2010) stated that surgical weight loss intervention, otherwise known as bariatric surgery, is a highly effective and increasingly common treatment to manage this chronic health condition (p. 271).

Bariatric Surgery

The primary objective of bariatric surgery is to facilitate weight loss and reduce the impact of co-occurring health problems. Obese individuals often experience a multitude of chronic comorbidities, such as diabetes mellitus, coronary artery disease, and specific types of cancers (Sutton & Raines, 2010). Weight loss surgery may have an immense impact on nearly all facets of an individual's life. For example, nutrition, mobility, socialization, and overall quality of life can be positively influenced by bariatric surgery (Sutton & Raines, 2010).

There are four primary types of bariatric surgery performed in the United States and the surgeries are often categorized as restrictive or malabsorptive. Providers of behavioral health services need to understand the procedural differences among surgeries because patients will have surgery specific challenges in the months immediately following the surgery. Laparoscopic gastric banding (LGB) and the sleeve gastrectomy are considered to be restrictive as they limit

food consumption, reduce caloric intake, and lead to an earlier sensation of fullness (Sutton & Raines, 2008). LGB is commonly the least invasive; the surgeon places a small plastic band at the top of the stomach that can be adjusted to allow more or less food to enter the digestive tract. During a sleeve gastrectomy, the surgeon removes a large portion of the stomach, thus restricting the amount of food an individual can eat and reducing caloric intake (Sutton & Raines, 2008). Malabsorptive bariatric surgeries, such as the Roux-en-Y gastric bypass (RYGB) or the biliopancreatic diversion with duodenal switch procedure, involve both a restrictive and malabsorptive function as the stomach size is often surgically reduced and food is re-routed to reduce absorption (Sutton & Raines, 2008). During a RYGB procedure, the surgeon connects a Y-shaped section of the small intestine directly to the newly reduced stomach pouch, which bypasses caloric intake (Sutton & Raines, 2008). RYGB has been used extensively over the last 30 years and is often considered the most effective. However, the RYGB has corresponding risks relative to an open surgical procedure. The biliopancreatic diversion with a duodenal switch, which is also an open surgical procedure, allows food to bypass a portion of the small intestine, thus limiting the absorption of calories (Sutton & Raines, 2008).

Relevant to behavioral health providers, no difference was found in health-related quality of life between laparoscopic and open surgery groups (Mathus-Vliegen & de Wit, 2007). However, one study conducted by Nguyen, N., Slone, Nguyen, X., Hartman, and Hoyt (2009) indicated that patients with open gastric bypass experienced slower improvements in quality of life as compared to those who underwent laparoscopic gastric bypass. Ultimately, it is widely accepted in the field that some differences exist during the first few months among patients who undergo these four bariatric surgery procedures, yet overtime these early changes exert a small

overall effect on weight loss (Mathus-Vliegen & de Wit, 2007). In addition, several articles noted that complications of bariatric surgery have no effect on quality of life among those patients who experienced surgical complications and those who did not (Mathus-Vliegen & de Wit, 2007).

In exploring the long-term effects of weight loss surgery on bariatric surgery patients as compared to normal weight individuals, Mathus-Vliegen and de Wit (2007) found improvements in general wellbeing, health distress, depression, perceived attractiveness, and self-worth which remained significant among gastric banding bariatric surgery patients within the first year after surgery. Substantial increases were also evident in physical fitness and productivity at work (Mathus-Vliegen & de Wit, 2007). Additionally, as patients began to reach four years after bariatric surgery and as dramatic weight loss began to subside, changes in general wellbeing plateaued; yet, health distress, depression, physical appearance, and self-regard continued to improve (Mathus-Vliegen & de Wit, 2007).

Although research has clearly demonstrated the effectiveness of bariatric surgery, Rudolph and Hilbert (2013) noted that 20% of patients experienced less than expected weight loss and/or had difficulty maintaining the loss over time. They went on to suggest that post-operative behavioral management might be a potential and key factor for maintenance of post-surgical weight loss (p. 292).

Given the complexity and life-changing implications of bariatric surgery, patients often have ongoing needs for support from the surgical program staff, social support from family and friends, and support from previous patients, which often occurs through bariatric surgery support groups and psycho-social support to raise awareness regarding changes in quality of life.

Program Support

Some research has found that bariatric surgery patients reported a decline in perceived support after the first year of surgery, which may be explained by diminishing attention from medical staff, nutritionists, and the social network (Sabbioni et al., 2002). In an attempt to proactively increase support, Livhits et al. (2010) found that some bariatric surgery programs pre-operatively identified patients with inadequate support networks, and encouraged patients to increase their resources, including participation in the program's support group. Even with encouragement to increase resources beyond the specific program staff, the importance of staff support continues to be a salient factor in the patient's experience. Specifically, Mathus-Vliegen and de Wit (2007) found that patients who perceived, long-term support from the physician and dietician sustained improvements in quality of life among post-operative bariatric surgery patients. More recent research (Forsberg, Engström, & Söderberg, 2014) affirmed the importance of patients' perception of supportive relationships with program staff. In a qualitative analysis, Forsberg et al. (2014) found that relationships with program staff contributed to patients' experience of safety and closeness. Thus, they concluded that supportive relationships between patients and staff may be an essential component of a positive outcome.

Social Support

Social support has been shown to be one of the strongest predictors of successful weight loss among post-operative bariatric surgery patients (Livhits et al., 2010). Voelker (2004) noted that stigmatization of obese individuals begins at an early age, and overweight children are often socially ostracized. Consequently, it is not unexpected that research demonstrates that obese individuals tend to struggle with their interpersonal relationships (Voelker, 2004). It is also

hypothesized that social support may help weight loss after bariatric surgery because the patient who is well supported is better equipped to deal with lifestyle changes and the various stressors that often challenge post-operative bariatric surgery patients (Livhits et al., 2010). Similarly, Clark, Saules, Schuh, Stote, and Creel (2014) found that post-operative patients who described an improvement in the quality of their relationships also experienced greater weight loss, thus illuminating the role of quality relationships in patients' support networks. A positive correlation between the support received from family and friends, weight loss, and physical activity has also been established in the research field (Canetti, Berry, & Elizur, 2009).

Specifically, Canetti et al. (2009) identified the importance of spousal support on successful weight loss and noted that spousal support, when compared to more general social supports, has a larger impact on health-related coping (p. 115). Conversely, Lufti, Torguati, Sekhar, and Richards (2006) established that single and divorced patients with laparoscopic gastric bypass had a greater probability of achieving successful weight loss, when compared to their married counterparts; the researchers further clarified this finding by noting that married patients may have less time for physical activity. Research by Clark et al. (2014) found higher rates of sexual dysfunction among this population than in typical marriages. These findings imply that sexual functioning may be a proxy for a healthy relationship which could consequently impact successful weight loss.

As shown in the previous section, the research has clearly demonstrated that social connection is an essential component in facilitating both the physiological and psychological components of bariatric surgery success. In extending social support beyond family and friends, Sarvey (2009) noted that support groups provide an excellent opportunity for bariatric surgery

patients to extend their social network. Although support and encouragement from friends and family play a vital role, support offered in groups consisting of individuals with shared experiences can be a uniquely effective source of support (Santos, Pasquali, & Marcon, 2012). Reinforcing the potential benefit of support groups, Sutton & Raines (2010) suggested, "future research is needed to examine the role of the support group in nurturing the psychological components of the whole person and the longitudinal nature of the person's emotional and social function following a surgical weight loss intervention" (p. 55).

Bariatric Surgery Support Groups

Support groups are commonly used by bariatric surgery programs with the primary goal of addressing weight loss and maintenance strategies (Sutton & Raines, 2010). It is widely reported that post-operative bariatric surgery patients who attended support groups were more likely to achieve successful weight loss as compared to those who did not (Livhits et al., 2011) and there was a positive association between the number of support group meetings attended and weight loss (Rudolph & Hilbert, 2013, p. 298). Specific to the Roux-en-Y gastric bypass surgery, one study highlighted the important function of pre-operative and post-operative support groups (Sockalingham, Hawa, Wnuk, Strimas, & Kennedy, 2011). In regards to qualitative analysis on the role of group support, Nakamura and Mamary (2013) conducted a pilot study on *My True Body*, a group intervention tailored for bariatric surgery patients. They realized that patients found group discussions and the relationships formed within the group to be particularly valuable; "support, camaraderie, trust, accountability, and a sense of belonging emerged as key facets of these newly created relationships that promoted self-discovery" (p. 281).

Sutton and Raines (2008) noted lower than expected social and emotional functioning reported by post-operative bariatric surgery patients who participated in support groups. They went on to hypothesize that the lower scores may stem from the narrow focus on medical or weight loss topics during support group meetings (p. 276). Thus, the researchers highlighted the opportunity for support groups to include psychosocial development strategies (Sutton & Raines, 2008). Importantly, an early study showed that although the mood of bariatric surgery patients did not vary as a function of support group attendance, patients attending group sessions lost more weight compared to those who did not (Hildebrandt, 1998). Consistent with these findings, the bariatric surgery center support group used for this study included both psychoeducational information and time for social and emotional group processing.

Sutton and Raines (2010) stated that, "further research is necessary to examine the psychosocial factors and outcomes from surgical weight loss interventions beyond the quantitative measure of a decrease in body mass" (p. 53). Consequently, this study also addressed quality of life with the intent of encouraging a more holistic approach for management of post-operative bariatric surgery patients.

Quality of Life

"The World Health Organization defines health as a state of complete physical, psychological, and social wellbeing" (Mathus-Vliegen & de Wit, 2007, p. 94). Extensive research has shown obesity significantly impacts the physical, psychological, and social aspects of one's life (Tayyem, Ali, Atkinson, & Martin, 2011). Specifically, Wee, Davis, Husky, Jones, and Hamel (2013) found that obesity is a stigmatizing condition often associated with adverse psychosocial consequences that negatively affect quality of life (p. 231). Research has illustrated

that severe obesity was correlated with lower rates in marriage, intellectual capacity, and lower levels of socioeconomic status (Mathus-Vliegen & de Wit, 2007). The social stigma surrounding obesity was often associated with bias in the areas of education, employment, socialization, and health care treatment, which may explain the lower ratings in quality of life (Wee et al., 2011, p. 231).

Wee et al. (2011) suggested that social stigma and public distress were the most important factors impacting lower satisfaction with quality of life. Santos et al. (2012) explained that obese individuals avoid social contact as a possible reaction to the social stigma that is often experienced, and that this lack of social networking has an adverse impact on quality of life. Recognizing that quality of life is often compromised for individuals with obesity, researchers have specifically focused on the psychological and social consequences of obesity (Mathus-Vliegen & de Wit, 2007). Sutton and Raines (2010) found that depression, low self-esteem, prejudice, and social bias were common psychosocial consequences of obesity.

In response to the quality of life deficit, researchers note "it is critical that we collectively recognize the social and emotional needs of this group of patients and implement strategies to enhance individual wholeness and well-being after surgical weight loss intervention" (Sutton & Raines, 2010, p. 55-56). Fortunately, there is extensive research indicating that post-bariatric surgery weight loss correlates with an increase in quality of life and lessening of obesity-related psychosocial stress (Sutton & Raines, 2007). In exploring the potential impact of surgery, Wee et al. (2011) found that obese individuals who pursued weight loss surgery indicated quality of life scores similar to those patients with serious chronic illnesses. Weight loss alone does not fully explain the improvement in overall quality of life after bariatric surgery (Sabbioni et al., 2002).

Quality of life continues to improve even after weight loss goals have been attained (Mathus-Vliegen & de Wit, 2007).

Qualitative Analysis on Bariatric Surgery Patients

Natvik, Gjengedal, and Råheim (2013) explain that qualitative research has begun to uncover the many challenges experienced by bariatric surgery patients; specifically, the difficulty in grasping extensive body transformations, changes in family relationships, and feelings of vulnerability. Qualitative research has also identified that patients often feel a sense of renewed sense of control and food decision-making around the time of surgery. Wysoker (2005) discovered that patients contend that bariatric surgery gives them structure and reinforces control; however, this sense of control is shown to decrease with time (Natvik et al., 2013). Additionally, in Ogden, Avenell, and Ellis' (2011) qualitative analysis, they demonstrated that successful surgery patients embraced this newfound control and considered the surgery a tool, whereas patients who were unsuccessful with the surgery often perceived control as a battle between the mind and body. Natvik et al. (2013) clarified within their qualitative research that patients' abilities to cope and their feelings of stability were challenged by the rapid, extensive, and continual changes to the body and mind after bariatric surgery; it was noted that patients often navigate through a self-defining and existential process. Warholm, Øien, and Råheim's, (2014) qualitative analysis specified, "their stories described meeting a gentler world when they were lighter and thinner, a world where they were not stigmatized" (p. 7). Furthermore, patients reported the repeated experiences of "appearance bias" was taxing and difficult to accept (Warholm et al., 2014).

It is apparent that qualitative analysis can capture deeply personal, extensive, and in-depth data while providing valuable information for clinicians. In regards to long-term quality of life among bariatric surgery patients, one study reaffirmed that research has yet to encapsulate this elusive phenomenon, partly due to the emphasis on quantitative rather than qualitative research (Stolzenberger, Meaney, Marteka, Korpak, & Morello, 2013). Additionally, there is a need for further research to address a more holistic approach to program management that involves psychosocial support and well-being (Sutton & Raines, 2007).

This current study reflects the nature of qualitative research, as such no objective hypotheses were proposed; rather, this mixed-method quantitative and qualitative analysis aimed to explore the complex and unique experiences of post-operative patients and which specific aspects either encourage or challenge quality of life after bariatric surgery. Qualitative interviews were conducted on post-operative bariatric surgery patients who attended support group. The goal of this study was to contribute to the field of qualitative research, by gathering additional information regarding potential reasons for the improved quality of life among bariatric surgery patients. The semi-structured interview was organized according to previously identified factors that were associated with an improved quality of life, program support, social support, and support group meetings. In addition, this research included the most commonly used assessment of health-related quality of life, the SF-36 version 2, to gather concurrent quantitative data. The goal for utilizing a quantitative measure was to gather more descriptive data on the various aspects of quality of life among this patient population.

Chapter 2

Method

Participants

For this mixed-method analysis on life after bariatric surgery, a sample of 29 Salem Hospital Bariatric Surgery Program post-operative patients volunteered to participate in this study. Salem Hospital is located in Salem, Oregon and the bariatric surgery program has served over 950 patients since their establishment in 2006. The age of the patients ranged from 37 to 74 years (M = 53.6, SD = 9.8). Eighty-six percent were female and 14 % were male. Eighty-six percent of the patients were European American, approximately 3% identified as Hispanic or Latino, approximately 7% identified as Native American or American Indian, and approximately 3% identified as other. In regards to type of surgery, approximately 83% of patients received Roux-en-Y gastric bypass while approximately 17% of patients received the sleeve gastrectomy. It should be noted that no patients in the study had the laparoscopic gastric banding surgery. Sixty-nine percent of patients were married or in a domestic partnership, while approximately 10% identified as widowed, approximately 10% identified as divorced, approximately 3% identified as separated, and approximately 7% identified as single or not married. The elapsed time since surgery ranged from 2 weeks to almost 7 years. The number of support group meetings attended ranged from 3 to 100 sessions.

Instruments

Medical Outcomes Short Form 36 version two (SF-36v2; QualityMetric, 2002) was used. The SF-36v2 health survey is psychometrically sound, offers population norms, and is

widely used with the population of the morbidly obese (Sutton & Raines, 2010). The questionnaire is composed of 36 questions that are divided into two indices: physical health and mental health, and covers eight health domains: physical functioning, bodily pain, role-physical, general health, vitality, social functioning, role-emotional, and mental health. The participants were asked to subjectively rate their experiences within the past four weeks and respond to each question based on a Likert scale. The questionnaire required 5 to 10 minutes for completion. The SF-36v2 norm-based grading and scoring program was used to evaluate the collected surveys. Ware (2004) noted that the reliability of the SF-36v2 met the minimum standard of 0.70, and in most cases, exceeded a 0.80 reliability coefficient. Ware (2004) also stated that the reliability of the respective physical and mental summary scores usually exceeded a 0.90 reliability coefficient (Ware, 2004). Considering validity, Ware (2004) explained that research reaffirmed content, concurrent, criterion, construct, and predictive validity. Essentially, the questionnaire captured health-related quality of life from the patient's perspective. A demographic survey was also conducted. The structure of the qualitative interview questions is referenced in Tables 1-13 seen below in Chapter 3.

It is also important to note that research around patient-reported outcomes on bariatric surgery patients, such as quality of life questionnaires, often has design limitations, which affects the data interpretation (Coulman et al., 2013). Highlighting the perceived lack of validity, a meta-analysis conducted by Tayyem et al. (2011) indicated that health-related quality of life measures lack content validity and that a bariatric surgery-specific instrument based on empirical research would facilitate a more sound evaluation of the impact of obesity on health-related quality of life. Regardless of the limitations, "perceived health and the subjective ratings of well-

being and physical, emotional, and social functioning have become an essential complement to objective indicators of health" (Mathus-Vliegen, de Weerd, & de Wit, 2004, p. 489).

Procedures

The informed consent, the demographic survey, the qualitative interview, and the administration of the SF-36v2 were approved by the Institutional Review Board (IRB) of the Salem Hospital and the Human Subject Research Committee (HSRC) of George Fox University. Participants were recruited at support group meetings by the graduate student support group leader. During the one-on-one interviews, an informed consent was distributed and signed, a demographic survey was collected by a paper questionnaire, and a paper copy of the SF-36v2 was administered during interview appointments. All participants had the option to decline or cease questionnaire completion. Confidentiality was maintained including comments regarding health-related quality of life and support group attendance. Twenty-three face-to-face interviews were conducted and six phone interviews were conducted due to geographical distance from the hospital. For the phone interviews, the informed consent, the demographic survey, and the SF-36v2 were completed face-to-face, while the qualitative information was gathered by phone. The recorded interviews were transcribed and the SF-36v2 was scored using the *QualityMetrics* scoring software. The researcher trained the team of independent coders regarding how to categorize the qualitative data within the respective themes. Subcategories within the four themes were identified and sorted according to frequency. The qualitative data was first categorized by the independent coders and then verified by the primary researcher. Lastly, the responses were analyzed and aggregated within the four common themes: program support, social support, support group, and quality of life.

Chapter 3

Results

In regards to the quantitative data, the study yielded few results. The number of support group meetings attended and the amount of weight lost reflected a moderate positive correlation (r (27) = .352, p >.05); however, when analyzed in a loaded regression, results indicated that the measurement of time since surgery was a greater predictor for weight lost (β = 0.974, t (27) = 1.65, p >.05). In addition, when this population was compared to the SF-36v2 normed population, the majority of this population was at or above the norm on all eight domains: physical functioning, bodily pain, role-physical, general health, vitality, social functioning, role-emotional, and mental health.

In contrast, the qualitative interviews yielded a large amount of data. The results are organized by theme and then interview questions are displayed in Tables 1-13 below. Lastly, Table 14 is provided to demonstrate a summary of poignant statements gathered from the qualitative interviews.

Program Support

Table 1

What has been Your Experience with the Program? What has been Supportive to Your Success?

Category	Number of References
Specific staff such as the surgeon, the physical therapist, the nutritionist, the psychologist, the nursing staff were very supportive *Staff are responsive to questions* *Surgeons guide the patient and their family through the process* *Feelings of comfort and being "taken care of" by the staff*	26
Experienced support and are impressed by the program	15
Support group was particularly important	5
Facebook Group was particularly important	5
The program provides abundant information	5

Table 2

What has been Challenging to Your Success?

Category	Number of References
Adjusting to the Psychological Changes *Fear of unknown or "not knowing what to expect"* *Going back to old habits* *Experiencing a variety of emotions* *Being in the spot light*	12
Difficulty meeting the requirements of the program *Extensive lab work and doctors' visits* *Pre-operative liquid diet* *Meeting the protein and fluid guidelines*	10
Overwhelmed by information or too many opinions	6
Difficulty getting enough exercise	6
Nothing was challenging about the program	4
Adjusting to life events *Holidays* *Going back to work* *Traveling*	4

Table continues

Table 2 (continued)

Weight regain	2
Experiencing pain	2
Complications with insurance coverage	2

Table 3

How have You Felt Support, before and after the Surgery, by the Program, the Physicians, and the Staff?

Category	Number of References
Felt supported before and after surgery	15
Experienced difficulties after surgery *Felt there was too much time between appointments, appointments getting pushed back or rescheduled* *Had to be "pushy" in order to get help from staff* *Lack of emotional support from staff*	10
Felt supported before surgery but felt less support after surgery	6

Social Support

Table 4

How Many People can You Call on for Support and How Are They Connected to You?

Category	Number of References
Family	23
Friends	21
Support Group and friends from the group	8
Co-workers	6
Church	5
Facebook Group	3
Doctor, Staff, and Program Mentors	3
Other Support Groups *Cancer* *Single Women*	2

Table 5

How Supportive Have Your Immediate Family Members Been with the Surgery?

Category	Number of References
Received support/goes to family member/s when needing support	17
Received judgment and/or stigma, surgery is the "easy way out"	6
Family member/s had worry or fear before the surgery	6
Engages in meal planning with family member/s	5
Received support from family after they learned more about the surgery	4
Did not tell family member/s	4
Received positive feedback about appearance from family member/s	2
Experienced jealousy from family member/s	2

Table 6

How Supportive Has Your Spouse Been with the Surgery?

Category	Number of References
Received support from spouse and/or goes to spouse when needing support	13
Spouse made changes in lifestyle with the patient	8
The surgery created tension in the relationship	3
Spouse had hesitation, worry, or fear about the surgery	3
Spouse become insecure about the patient's weight loss	3

Table 7

How Supportive Have Your Friends Been with the Surgery?

Category	Number of References
Received support from friend/s and/or goes to friend/s when needing support	15
Experienced jealousy, feeling as if friend/s is sabotaging	6
Felt more support from a friend who also had the surgery	5
Engaged in healthy lifestyle choices together	5
Received positive feedback about appearance from friend/s	4
Feeling that friend/s do not understand or won't take the time to listen	4

Table 8

Have any Relationships Changed since Your Surgery, and if so, Why?

Category	Number of References
Experienced no change in relationships	13
Experienced less support, jealousy, sabotage	7
Experienced more support from others after the surgery	6
Met new friends/engaged in more opportunities to meet new people/interacting in relationships with more confidence	6
Experienced a deeper bond, comradery, admiration for other/s after the surgery	4
Made positive changes in parenting and in their children's nutrition	3
Experienced more positive feedback and/or attraction/flirtation with another	2
Relationship with food has changed/no longer using food as a coping mechanism	2

Support Group

Table 9

How Supportive Has the Support Group Been with the Surgery?

Category	Number of References
Positive experience/supportive to their weight loss journey	15
Concerns with group management	10
Size of group is too large	
Members complain too much or dominate conversation	
Being in a group with members that have a shared experience	9
Facebook Group	6
Established friendships with members of the group	3
Post-operative patients feeling as if they can't share their challenges as they don't want to discourage the pre-operative patients or that the information is too repetitive for the post-operative patients	3
Good information and resources are provided	3

Table 10

Why Do You Continue to Participate or Attend Support Group?

Category	Number of References
Source of information - questions are answered, learning new info, getting updated	12
Accountability - keeps me on track/focused, keeps my disciplined, great reminders, reinforces success	11
Responsibility to the community/group - to maintain relationships with other members, to give back and share knowledge with the pre-operative patients	11
Being in a supportive atmosphere - comradery, receiving encouragement, and hearing success stories	11
Shared experience	7
Disappointment that post-operative patients don't continue to attend group	2

Table 11

What Support Group Topics Have Been the Most Meaningful for You?

Category	Number of References
Mindful eating/emotional eating was helpful	11
Simply hearing people's experiences was helpful	8
Mindful eating specialist was not helpful	5
The nutritionist	4
The cosmetic surgeon	4
The physical therapist	2
Vulnerability	2
Sleep Hygiene	2

Quality of Life

Table 12

How Have You Coped When You Haven't Felt Supported?

Category	Number of References
Haven't felt unsupported	10
Turned to social support	9
Self-reliance	7
Turned to food or had the urge to	5
Engaged in hobbies/activities	5
God, prayer, faith, church	4
Exercise	3

Table 13

What Has Been the Most Significant Impact the Surgery Has Had on Your Quality of Life?

Category	Number of References
Increase in activity/mobility	17
Other health improvements	12
Improvement in self-confidence/self-image	9
Hope	8
Psychological insights, healing, reflections	8

Table 14

Summary Selection of Poignant Interview Statements

Program Support
Roger* - *"It is such a great program and it's well thought out and supportive. I feel that I have a level of comfort with the staff. I can call and talk to them about any issues I am having and I feel very taken care of."*
Tina* - *"I think the biggest help was the emotional help from the psychologist. The problems are still in your head even though you've worked on the body."*
Alice* - *"The surgeon was able to explain everything to me and my partner. He (partner) was against this whole thing and without his (surgeon) support and backup I didn't know how I was going to do it. The surgeon's input to my significant other was the biggest thing. It made him feel confident and it made me feel confident."*
Susan* - *"Well the round of doctor's visits. I felt like no part of me went un-examined, heart, mind, knees, and even sleep."*
Deborah* - *"I have fibromyalgia. You can't think too clearly, and there have been some days where I wasn't able to meet my protein goals or my liquid goals."*
Dana* - *"Just the apprehensiveness about reaching my goals with the weight loss. The fear of disappointing the office staff and not meeting my goals."*
Shari* - *"I couldn't eat like before, I hadn't really dealt with the emotional piece. Which comes back too, I don't really think they prepare you enough after."*

Carol* - *"The staff were very supportive before surgery, but I feel that they were even more supportive after surgery."*

Charlotte* - *"I felt before they were very kind, very generous. But afterwards, I got the impression it was, how do we push people through?"*

Social Support

Jane* - *"My mother has also had the surgery, and she came up for my surgery and took care of me. We talk on the phone at least once a week and share what is going on physically, mentally, emotionally. I actually have a deeper bond with my mother now."*

Meredith* - *"In the beginning, not supportive at all. They thought I was insane, and that I could just live my regular life. And so my bottom line was 'if you don't support me then don't talk to me.' But then after they saw the miracle, they were extremely supportive."*

Joe* - "*They've been very supportive. They encouraged me, they asked me questions, they were glad that I made the step and that I did it, and just general enthusiasm for it."*

Elizabeth* - "*I haven't told my immediate family. They would have tried to talk me out of it."*

Chelsea* - "*I did have one sister that was really against me getting the surgery. I don't, hmm, well, I don't know if it was because she was worried about me getting a surgery, but I also wondered if she was sort of jealous that I decided to make a change and lose weight."*

Julia* - *"My spouse had a hard time understanding my desire to get the surgery. He was agreeable with my decision, but he says things like, 'Well we can't go there to eat because you can't eat that.' He focuses on what I can't do because of the surgery so that limits things we can do together. Basically, he focuses on the negative aspects of the surgery. We have also had arguments at home because he throws out statements like, 'I knew you would want to leave me because you have lost weight.' So he has felt insecure and threatened at times."*

Tamera* - *"He has been very supportive. He's always asking, 'Can you do that?', 'Are you sure you should be doing that?', 'Here, let me get that for you', 'What do you need to be eating so I can make sure that you have the right things?', 'What do need to be eating so I can try and eat the same stuff?"*

Charles* - *"My friends are awesome, they have been nothing but supportive. When we meet up, they are more than willing to eat at places that have good options for me."*

Sarah* - *"The dynamic of the relationship changes after you have had surgery because you're no longer the fat girl in the group anymore and now all of a sudden your thin friends feel threatened… They almost try to sabotage you and get you to eat. It's like they have always had*

something to hold over you, so now they will either try to sabotage you or cut out from the friendship."
Support Group
Cheryl* - *"I really enjoy the support group. It is great to be with other people that are going through or who have gone through what I have. Facebook page is great too. People have been very responsive to posts and questions."*
Amanda* - *"The support group has been great. Some of my closest friends, I have met there. We had so much fun getting ready for the gala (put on by the bariatric surgery center), and getting dolled up, because a lot of us never got to go to prom, so that was a lot of fun. The Facebook group is also helpful because I can access recipes that others have tried."*
Crystal* - *"Wonderful, especially the website. I mean, you go on Facebook and have a question and you don't even have to wait for answer, there are six of them right there. Or something you forgot. Or when I had a hard time during the holidays, everyone understood. They were all going through the same thing. They understand the exact situation you were describing."*
Lisa* - *"It's nice for me to hear people who are farther along the path than I am and see their continued success. It is very encouraging and inspirational."*
Richard* - *"It reminds me of all the things I should be doing, that are easy to let slip. It's a supportive atmosphere and it keeps me disciplined."*
Tracy* - *"I also feel a sense responsibility to attend, because I was once a pre-surgery patient and I enjoyed hearing from people who have had the surgery."*
Joan* - *"I feel a comfort in asking questions or stating my feelings about something or my problems that I couldn't get from my husband, where he's not going to understand what I've gone through. It's just that personal connection with someone who has been there, done that."*
Quality of Life
Shawn* - *"The coping process is just trying to keep my eye on the future and reminding myself that I can't go back to those processes again. I've lost over a hundred pounds once before, then gained it all, plus more, back. I don't want to be there again, ever."*
Anna* - *"I know that I can keep going because this is to get me healthy, I got to take care of me because if you don't take care of yourself, nobody else is going to. I pray a lot too. I just feel 'we can do this.' I'm one of those people that doesn't take no for an answer. It's going to work."*
Jackie* - *"Well I used to turn to food and just because I have the tool, that doesn't mean that switch goes off in your mind. Sometimes I just break down and cry. And if I feel like I have to eat, for that comfort, I make sure that it's good. I don't keep crap at my house. I try not deal*

with my emotions at food. Usually I go to housework; I try and get something accomplished."

Emily* - *"I am become more aware of my upbringing, growing up I was told to 'finish my plate because they are starving children in the world', and we fried everything. I have a whole new life. I am more active than ever before. I am able to go to the coast and walk on the beach. I have more friendships, I can go out and do things, I can clean my house, and I can go grocery shopping."*

Martha* - *"I would say that my self-confidence, just feeling better about myself, because I know I look better. I can wear clothes that are more appealing, it is really hard to find attractive clothes in plus sizes. I now have an ability to be more active and more willingness to try new things. But most importantly, I take care of myself more, I put myself as my priority now."*

Steven* - *"Knowing that I am going to live for a long time and that I can move. There is only one of my goals that I haven't accomplished yet and I'm still working to get there, and that's to get on the floor with my grandchildren."*

Trish* - *"I would say that with the surgery, I was able to get rid of all my other medical issues. I had high blood pressure, type II diabetes, high cholesterol, and sleep apnea and all of these issues are resolved."*

Roger* - *"I don't want to shoot myself anymore. I have hope. A year ago I was hopeless, what was the point? I couldn't move; I couldn't get out of bed, I couldn't do anything. It was hopeless."*

Karen* - "*The way I look at myself in the mirror. I mean, it took a while because you still see yourself as big, but to look at myself in the mirror and to see my belly button and to feel like a normal person. We see ourselves as not normal. To get dressed and go outside and not worry, or to walk across and not think, 'oh, they're looking at me because I'm too heavy.' So, it's the confidence of not having to think like that anymore."*

(- names are pseudonyms to protect the privacy of the participant)*

Chapter 4

Discussion

The primary purpose of this study was to explore the complex experiences of post-operative bariatric surgery patients in their journey toward health and quality of life. *(* - names are pseudonyms to protect the privacy of the participant).*

Program Support

In terms of what constituted a positive experience within the bariatric surgery program, patient responses were consistent with the literature in affirming the value of program support. Specifically, patients valued the access, information, and comfort they received from the staff composed of surgeons, nurses, nutritionists, physical therapists, psychologists, and administrative personnel. If the patient didn't experience program support, they reported feeling frustrated by program requirements, and/or perceived lack of understanding of their needs.

A majority of patients reported the support was consistent before and after their surgery. In addition, numerous patients indicated that staff members were responsive to questions, even "silly" or "embarrassing" questions, and were easy to contact. Patients also appreciated the depth of information and the resources that were provided, such as the support group and the online support group. The surgeons' explanations of surgical procedures to the patient and family members were widely appreciated as these relieved fear and even the stigma around the surgery. Alice* explained,

> The surgeon was able to explain everything to me and my partner. He (partner) was against this whole thing and without his (surgeon) support and backup I didn't know how I was going to do it. The surgeon's input to my significant other was the biggest thing. It made him feel confident and it made me feel confident.

Aspects of the program that were considered challenging included the extensive fulfillment of requirements, such as extensive lab work, the pre-operative liquid diet (which was typically two to three weeks in length), the protein and hydration goals for daily intake, and the exercise guidelines. Additionally, even though some patients valued the abundance of information, others felt overwhelmed by the details and the variety of opinions.

> Tara* - Listening to all the voices; everybody has their opinions. Whether it was in a support group meeting or on the Facebook page, if I said "I'm feeling sad" I just wanted to feel sad and I know everybody tries to be helpful, I heard a quadrillion different voices. That was a difficult part, trying to figure out who had my best interests.

There was also a discrepancy among the group in terms of feelings of support before and after surgery. Although many patients experienced support during their pre-operative and post-operative interactions with the program, some patients experienced less support and even described difficulties. For example, the program staff needed to reschedule patient appointments, a few patients felt a need to be "pushy" in order to receive help, and some patients considered the staff to be less emotionally supportive after surgery. Jessica* reported,

> After 6 months post-surgery, I feel the support disappears and that can be somewhat frustrating. I feel like the impression is, if there are no problems, then we don't need to

check in with that patient. I was also frustrated that my one year anniversary follow-up appointment keeps getting pushed back.

Social Support

Within this population, social support networks consisted of program staff, family members, friends, co-workers, and religious affiliates. A majority of patients experienced support from their significant others, family members, and friends. Their supporters often displayed their approval by complimenting the patients' appearance, joining them on their path to health by exercising with them, modeling their eating restrictions, and grocery shopping with the patients' diet in mind.

In contrast to those receiving support, other patients encountered stigma due to the surgery, jealousy, hurtful comments, and a lack of understanding by their support network. Stigma was often centered on the notion that undergoing bariatric surgery was "cheating" or "taking the easy way out." Some patients did not disclose any information to their family members, friends, or co-workers due to fear of disapproval or desire to avoid tension in a relationship. Many relationships were able to adapt to the fear or worry regarding the surgery once the support person learned more or gained a deeper understanding of the process. Numerous patients noted that their skeptical support person actually became more approving over time once he or she was able to observe the benefits of the surgery. The value of the surgeon communicating with skeptical individuals was also greatly appreciated.

Patients with family or friends who adapted, or even made changes with the patient, experienced a smoother transition into life after bariatric surgery. Enjoying a deeper bond, engaging in new relationships with more confidence, and receiving positive feedback, attraction,

or flirtation from others reflected meaningful responses. In other instances, patients who suffered jealousy or even sabotage often felt as if family members, friends, or spouses offered or encouraged inappropriate food choices. In addition, many patients sensed that the "dynamic" of the relationship changed once they lost weight. Below are examples:

> Sarah* - The dynamic of the relationship changes after you have had surgery because you're no longer the fat girl in the group anymore and now all of a sudden your thin friends feel threatened… They almost try to sabotage you and get you to eat. It's like they have always had something to hold over you, so now they will either try to sabotage you or cut out from the friendship.
>
> Nancy* - Like the week before my surgery, she baked an apple pie and set it right where I run into the entire time. It was a Dutch apple pie, which is my favorite.
>
> Christina* - I think the tension mostly is created when he brings something into the house and I ask him not to.

In terms of spousal relationship, many patients reported their spouses' response to be positive, as evidenced by consistent and healthy meal planning which secondarily reinforced parenting and child nutrition. In contrast, new and improved appearances spurred spousal insecurity as explained in the following excerpts:

> Jaime* - We have also had arguments at home because he throws out statements like, "I knew you would want to leave me because you have lost weight."
>
> Charlotte* - My ex-husband, he was fearful that if I started losing weight people would find me attractive and I would leave him, and I wasn't going anywhere. It made it impossible to stay with him.

> Joan* - He has joked about things like, “don’t get too skinny,” and that he doesn’t really want me to wear fitted clothing. I don’t know if he is worried that I will leave him, or if he is just jealous of people complimenting my looks.

Support Group

In general, patients reported that fellow support group attendees and online support group participants were invaluable members to their respective support networks. A majority of the sample reported the support group provided psychoeducational, social, and emotional benefits, such as sharing similar experiences which reinforced a successful weight loss journey. Many group members explained their appreciation for the online support group as this web interface offered support 24 hours a day, seven days a week. Within this online support group, patients asked questions, accessed a library of recipes, and posted updated pictures.

From this study, one unique aspect of the support group meetings was the combination of pre-operative and post-operative bariatric surgery patients which lent to richer discussions, a deeper knowledge base, and the opportunity for pre-operative patients to grasp a potential glimpse of future possibilities. However, some patients raised concerns related to the large group size, ranging from 20-50 members each session, and the domination of conversation by some of the group members. Some post-operative patients reported a hesitation to share their challenges, as they did not want to discourage the pre-operative patients. A criticism of the psychoeducational materials was that the content placed a greater focus on the pre-operative patient. Additionally, many patients expressed disappointment that some of their pre-operative peers chose to discontinue group attendance following their surgeries.

When patients were asked why they continued support group interaction, many explained that the group offered a wealth of knowledge, encouraged accountability, and engendered a sense of responsibility to contribute or to give back to the group. Following are some excerpts from the interviews:

> Richard* - Because it reminds me of all the things I should be doing, that are easy to let slip. It's a supportive atmosphere and it keeps me disciplined.
>
> Tracy* - It is always nice to check-in, to hear any of the latest updates. I also feel a sense responsibility to attend, because I was once a pre-surgery patient and I enjoyed hearing from people who have had the surgery.
>
> Tina* - Because I feel like I need the support and it helps me keep face, I want to keep grounded so I go to the support group. Plus, I feel like I can help other people because they need to know that they're not alone and that it's possible.

Quality of Life

Patients reported that the greatest challenges were in the extensive adjustment and multitude of psychological changes including fear of the unknown, the consistent need to resist old habits, the vastness of emotional experiences, and the overwhelming feeling of public attention. For example, Audrina* explained,

> Something I didn't necessarily expect or I guess see coming was this wave of emotions. I spent my life hiding and not being in the spot light, so it was hard for me to deal with the extra attention and even though it was all positive attention like compliments and stuff, I feel a little uncomfortable being in the spot light.

Common life events such as socializing during holidays and special events, returning to work, and traveling strained some patients' ability to cope. Yet, most patients felt supported by others or relied upon their personal coping strategies and self-reliance. For example, Anna* stated,

> I know that I can keep going because this is to get me healthy, I got to take care of me because if you don't take care of yourself, nobody else is going to. I pray a lot too. I just feel we can do this. I'm one of those people that doesn't take no for an answer. It's going to work.

Other coping mechanisms patients found useful included participation in hobbies or activities, physical exercise, and turning to their religion. During times of stress, however, some patients' coping skills were challenged by the urge to eat.

The majority of patients consistently reported that the most significant gain following their bariatric surgery was the increase in mobility and physical activity. Additionally, patients indicated progress in overall health to include reduction or resolution of comorbid medical conditions. Trish* stated,

> I would say that with the surgery, I was able to get rid of all my other medical issues. I had high blood pressure, type II diabetes, high cholesterol, and sleep apnea and all of these issues are resolved.

Many patients described meaningful improvements in self-confidence and self-image. Martha* reported,

> I would say that my self-confidence, just feeling better about myself, because I know I look better. I can wear clothes that are more appealing, it is really hard to find attractive clothes in plus sizes. I now have an ability to be more active and more willingness to try

new things. But most importantly, I take care of myself more, I put myself as my priority now.

Lastly, themes of hope and enhanced psychological insights frequently surfaced, as shown in the samples below:

Roger* - I don't want to shoot myself anymore. I have hope. A year ago I was hopeless, what was the point? I couldn't move; I couldn't get out of bed, I couldn't do anything. It was hopeless.

Karen* - The way I look at myself in the mirror. I mean, it took a while because you still see yourself as big, but to look at myself in the mirror and to see my belly button and to feel like a normal person. We see ourselves as not normal. To get dressed and go outside and not worry, or to walk across and not think, "Oh, they're looking at me because I'm too heavy." So, it's the confidence of not having to think like that anymore.

Summary of Consistent and Inconsistent Findings

Although many patients expressed satisfaction with the level of program support before and following surgery, a portion of sample patients experienced a decline post-surgically. This is consistent with other research findings as bariatric surgery patients perceived a waning of social support after the first year of surgery, perhaps reflecting less attention from medical staff, nutritionists, and the patients' social environment (Sabbioni et al., 2002). However, compared with existing research, most appreciated closeness to the staff; qualitative analysis demonstrated that patients often felt safe and close to program staff (Forsberg et al., 2014). In terms of marriage signifying a protective or risk factor, this study gathered varied information which is congruent with the discrepancy in existing research.

Current study results paralleled those of Nakamura and Mamary's (2013) pilot study on group intervention as their qualitative analysis also identified "support, camaraderie, trust, accountability, and a sense of belonging" as valuable support group dynamics for bariatric surgery patients (p. 281). On the contrary, current study conclusions failed to duplicate Rudolph and Hilbert's (2013) results of a statistically-significant positive correlation between the number of support group meetings attended and the amount of weight loss, for the measurement of time after surgery was a stronger predictor for weight lost.

In regards to quality of life, Ogden et al. (2011) reported the occurrence of emotional eating after surgery; it was recognized that surgery addressed the physical component of weight management; yet, unaddressed mental aspects persisted. This notion was also apparent in the current sample; Jackie* stated, "well I used to turn to food and just because I have the tool, that doesn't mean that switch goes off in your mind."

However, comprehensive analysis of all qualitative results consistently revealed a positive response to the surgery and affirmed the long-term benefits. These results are congruent with the large body of research supporting a correlation between post-bariatric surgery weight loss and an increase in quality of life (Sutton & Raines, 2007). Although many surgical patients experienced novel challenges regarding relationships shifts and the need to adopt effective coping skills, they generally reflected on their journey with a sense of accomplishment, gratitude, and a refreshed hope for the future. These reflections were consistent with other qualitative analyses; "the participants expressed a sincere feeling of gratitude for what they described as a second chance to live" (Natvik et al., 2013, p. 1206). Moreover, in Wysoker's (2005) qualitative

study participants not only expressed satisfaction with their surgery but they also collectively offered that they wished they had proceeded years earlier.

Implications of Current Findings

One of the most significant implications of this study was the reinforcement of the bio-psycho-social perspective. This theoretical framework focuses on a holistic understanding of the individual and provides an all-encompassing conceptualization for patient health. This perspective was illustrated by the qualitative responses as they demonstrated the biological, psychological, and social aspects of the surgery that aided in successful weight management. With increased implementation of bariatric surgery, it is imperative for bariatric surgery programs to first identify bio-psycho-social needs of patients and subsequently offer resources. The program in this study remains committed to meeting the unique needs of patients as the medical staff continues to offer multiple support group sessions monthly and two staff psychologists with specialization in bariatric surgery. This program is also opening a new Obesity Institute that will offer more resources and support for post-operative patients as well as obese patients that do not qualify for bariatric surgery. A primary objective is to address long-term weight management among their post-operative bariatric surgery patients. Increased appointment accessibility with a medical provider, who is specialized in obesity medicine, to address metabolic issues and with psychologists to address behavioral interventions are additional goals of this new weight management program.

This research identified social consequences of surgery, which can alter relationship dynamics. The growing field of qualitative analysis of bariatric surgery can provide a foundation for constructing resources, interventions, and further educating psychologists and program staff

on the distinctive needs of this population. For example, Clark et al. (2014) stated, "interventions to improve relationships pre- and post-weight loss surgery may increase both quality of life and weight loss outcomes" (p. 670). Updated resources are also essential as many program support groups deliver psychoeducational tools and resources. Ultimately, as many bariatric surgery patients continue to manage weight long-term, it is critical for bariatric surgery programs to provide their patients with a multitude of resources. With the increase in psychologists specializing in the area of bariatric surgery and with information gathered from this study, it is evident that this population represents a diverse culture with very unique and specific needs. Qualitative research on bariatric surgery patients offers direction towards enhancing awareness and allocation of resources for patients, programs, family, and friends.

Limitations

An apparent study limitation is the lack of diversity. This study may have limited generalizability as it used a convenience sample from a single bariatric surgery program, which included primarily European-American females living in a semi-rural area of the Northwest. Although adequate for qualitative research, the relatively small sample size limited opportunities for additional statistical analysis regarding relationships between variables or predictive modeling. The use of phone interviews for a small percentage of the sample may have differentially affected the participant responses. Finally, it is possible that selection bias could be a factor considering that more successful patients are likely those to continue attending group, particularly those with long-term attendance, which might influence their responses.

Gender differences have been demonstrated in terms of coping; women in particular encountered greater psychological difficulty with scarring and excess skin that is often

experienced after surgery and significant weight loss (Warholm et al., 2014). Sutton and Raines (2008) have also noted that women with bariatric surgery indicated lower mental functioning than their male counterparts (p. 276). The generalizability may also be limited as this study represented a smaller number of male opinions.

Future Research

In the field of qualitative research on quality of life and bariatric surgery, only one study evaluated longitudinal pre-operative and post-operative data within the same sample (Warholm et al., 2014). To better understand the journey of the bariatric patient, compiling data before and after surgery would allow researchers to more accurately identify changes amongst bio-psycho-social facets. Future qualitative analysis detailing support group structure and function could provide the nation's bariatric surgery programs with greater standardized guidelines, evidence-based interventions, and psychoeducational tools. Prior and post-outcome assessments of newly established interventions would also strengthen their effectiveness. Lastly, Sutton and Raines (2008) have also proposed the need for future research on the effects of the type of support group, such as face-to-face or online, and the need for gender-specific strategies.

Conclusion

Compared to previous qualitative research studies exploring the impact of bariatric surgery, this study offered a more detailed analysis of four major components identified in the research, program and social support, benefit of support groups, and impact on quality of life. Furthermore, this study discovered areas of need for development of future resources such as educational material for family and friends, online bariatric surgery support forums, and psychoeducation to be presented during support group meetings. As rates of nation-wide obesity

and bariatric surgery continue to grow, there is a corresponding need to increase our awareness and develop resources to help patients maximize the benefits of a potentially life-changing intervention.

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Appendix A

Curriculum Vitae

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University of Oregon
Eugene, Oregon
GPA: 3.83, Cum Laude

SUPERVISED CLINICAL EXPERIENCE

8/2014 to 4/2016
18 hrs/wk

Practicum II-Pre-internship Practicum
SITE: Villa Medical Clinic
LOCATION: Newberg, Oregon
SETTING: Primary Care
SUPERVISOR: Laura Fisk, PsyD.; Consultants: Celeste Flachsbart, PsyD., Kris Kays, PsyD.
POPULATIONS: Socioeconomic diverse populations of children, adolescents, adult, and geriatric patients

TREATMENT: population health, mood and anxiety, substance use, co-occurring medical diagnoses, personality disorders, cognitive and developmental disorders, behavior planning, pain management, crisis response, end of life issues, individual and group interventions
DESCRIPTION:
- Provide behavioral health consultation, including evidenced-based practice interventions for patients experiencing multiple co-occurring disorders across a broad diagnostic range
- Utilize Cognitive-Behavioral, Acceptance-Commitment, and Person-Centered strategies as well as psychoeducational tools to address broad diagnostic range
- Administer psychodiagnostic assessments for cognitive and behavior functioning
- Integrate treatment planning and interventions with on-site primary healthcare providers to provide collaborative patient care management
- Assist primary healthcare health system to incorporate a fully integrated behavioral health consultation
- Respond to patient crisis, escalation, and immediate behavioral issues
- Train healthcare providers and other medical staff on the model of behavioral health consultation
- Present to providers and clinic staff on issues of escalation in the workplace and conflict resolution
- Provide organizational consultation with team building strategies, system value assessment, and conduct employee and provider satisfaction surveys
- Connect with local resources, agencies, and mental healthcare providers for patient referral purposes
- Presentation of client cases to Clinical Team comprised of a licensed psychologist, master's level clinicians, and peers

9/2013 to 6/2014
18 hrs/wk

Practicum I
SITE: School-Based Behavioral Health, Rural School District Consortium
LOCATION: Yamhill, Oregon
SETTING: Yamhill-Carlton High School
SUPERVISOR: Elizabeth Hamilton, PhD.; Consultant: Carlos Taloyo, PhD.
POPULATIONS: Socioeconomic diverse populations of students, parents, and staff of K-12 multi-systemic school setting
TREATMENT: mood and anxiety, adjustment difficulties, family systems, ADHD, panic, crisis management, learning disability, Asperger's/Autism, adoption
DESCRIPTION:
- Provided evidence-based short-term psychotherapeutic interventions, primarily Cognitive-Behavioral, Acceptance-Commitment, and Person-Centered psychotherapy for at-risk students and learning disabled students
- Conducted system-based intake interviews with parents, staff, and students, diagnostic formulation and maintain clinical notes

- Administered psychodiagnostic assessments and wrote comprehensive reports concerning cognitive, achievement, and personality factors as part of a multi-systemic Individual Educational Plan team
- Provided support and immediate strategies for crisis intervention through psychoeducational group meetings, individual risk assessments, and parent, student, and staff consultation
- Presentation of client cases to Clinical Team comprised of a licensed psychologist, master's level clinicians, and peers
- Weekly group and individual supervision that includes case discussion and conceptualization and development of treatment plans
- Established and managed working relationships with administrators, staff, parents, and other healthcare providers

1/2012 to 5/2012
5 hrs/wk

Pre-practicum
SITE: George Fox University, Newberg, Oregon
LOCATION: Newberg, Oregon
SETTING: College Counseling
SUPERVISORS: Carlos Taloyo PhD., Michelle Block PsyD.
POPULATION: Two adult university students
TREATMENT: adjustment difficulties, family systems, psychoeducation
DESCRIPTION:
- Provided individual outpatient Person-Centered psychotherapy for two undergraduate student volunteers
- Conducted intake interviews, treatment plans, and diagnoses
- Presented written reports, case presentations, and consultations with supervisors and clinical team members
- Sessions were videotaped, reviewed, and discussed in individual and group supervision

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SUPPLEMENTAL SUPERVISED CLINICAL EXPERIENCE

4/2012 to 7/2015
2 hrs/bi-wkly

Bariatric Surgery Support Group Facilitator
SITE: Salem Hospital Bariatric Surgery Center
LOCATION: Salem, Oregon
SETTING: Hospital-based surgery center
SUPERVISOR: Dale Veith, PsyD. and Steve Besing, PhD.
POPULATION: Adult bariatric surgery patients and their family members
TREATMENT: stress management, mindful eating, coping with change, changes in family relationships, changes in friendships, changes in intimate relationships, sleep hygiene, depression management, coping with anxiety, physical therapy and the value of exercise, mindfulness and meditation, establishing and reinforcing values, self-esteem, vulnerability, shame, body image, substance use
DESCRIPTION:

- Facilitated a psychoeducational and process group for pre- and post-operative bariatric surgery patients and their family and friends
- Developed psychoeducational materials and presented information to 20-50 individuals on average
- Collaborated with multidisciplinary treatment team and received supervision

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SELECTED PROFESSIONAL & EDUCATIONAL EXPERIENCE

8/2015 to 4/2016
1hr/wk

Peer Supervisor/Program Clinical Mentor
SITE: George Fox University, Newberg, Oregon
SUPERVISOR: Kris Kays, PsyD.
POPULATION: 2nd year graduate student
DESCRIPTION: Provided weekly supervision for a second year PsyD. practicum student working in a rural school district. Discuss diagnosis, case conceptualization, treatment planning, presentation skills, theoretical orientation, and professional development. Received supervision.

1/2013 to 4/2016
2 hrs/wk

Clinical Team
SITE: George Fox University, Newberg, Oregon
SUPERVISORS: Kris Kays, PsyD., Celeste Flachsbart, PsyD., Carlos Taloyo, PhD., Elizabeth Hamilton, PhD.
DESCRIPTION: Team meets weekly to present and discuss clinical cases and psychological assessments from various clinical perspectives

8/2014
40 hrs/1 wk

Workforce Development for Integrated Behavioral Healthcare Training
LOCATION: George Fox University, Newberg, Oregon
DESCRIPTION: Attended a week long (40hrs) intensive training on the primary care model and the role of the behavioral health consultant. Completion and certification was based on knowledge of screeners and tracking tools used in primary care, evidence-based interventions for common medical disorders, record keeping and billing in the integrated care setting, quick and efficient communication and consultation skills, strategies for working in a medical collaborative treatment team, the fundamentals of psychopharmacology, and the unique ethical issues that are common in the integrated care setting.

9/2012 to 4/2016
Monthly meetings

Oregon Psychological Association (OPA) Student Committee
NOTED WORK: Co-wrote an article, *Life as a Graduate Student*, published in the Oregon Psychological Association newsletter. Facilitated a panel conference session at the 2014 OPA Conference.
DESCRIPTION: Work with a team of professionals to develop student communication, coordinate poster submissions, awards, organize student

breakout sessions for the OPA annual conference, and promote membership and awareness of the organization

5/2013, 5/2014 **Providence Health Fair**
LOCATION: Portland, Oregon
DESCRIPTION: Hosted an annual anti-bullying booth and provided psychoeducational resources to children and adolescents about processing, confronting, and preventing bullying

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RESEARCH EXPERIENCE

2/2013 to 4/2016
2 hrs/bi-wkly **Research Vertical Team**
SITE: George Fox University, Newberg, Oregon
SUPERVISOR: Mary Peterson, PhD., ABPP.
TEAM: Various areas of team interests and focus; health psychology, veteran and military personnel, systems, integrated care, substance abuse, psychologist advocacy, suicidality, strength-based psychology
DESCRIPTION: Discuss, evaluate, and assist team members' research

8/2013 to 9/2015 **Doctorate Dissertation Research**
TITLED: *Life after Bariatric Surgery: A Mixed-Method Analysis on Social Support and Quality of Life*
SITE: Salem Hospital, Salem, Oregon
SUPERVISOR: Mary Peterson, PhD., ABPP.
DESCRIPTION: Created original questionnaire for face-to-face qualitative interviews. Conducted 29 qualitative interviews with post-operative bariatric surgery patients. Gathered quantitative data by administering a quality of life survey. Presented project at the annual APA conference in Toronto, Canada for the Division 49: Group Psychology and Group Psychotherapy.
DISSERTATION DEFENSE: Defended dissertation on 9/29/2015 and received a full pass.

Poster Presentations

Speck, C., Sanders, E., Peterson, M. (August, 2016). *Changes in Relationship Dynamics after Bariatric Surgery: A Qualitative Analysis.* Poster will be presented at the annual meeting of the American Psychological Association. Denver, Colorado.

Hartman, T., **Speck, C.**, Terman, J., Wynsma, E., Peterson, M. (August, 2016). *Mother to Mother: A Qualitative Analysis of a Peer Program for New Homeless Mothers.* Poster will be presented at the annual meeting of the American Psychological Association. Denver, Colorado.

Fish, R., **Speck, C.**, Drake, G., Peterson, M. (August, 2016). *Exploring Graduate Students' Knowledge, Skills, and Attitudes of Current Legislative Advocacy.* Poster will be presented at the annual meeting of the American Psychological Association. Denver, Colorado.

Davis, S., Terman, J., **Speck, C.**, Malone, M., Goins, N., Turgesen, J. (May, 2016). *Assessment of Pediatric Behavioral Health Services in a Primary Care Setting.* Poster will be presented at the annual meeting of the Oregon Psychological Association. Portland, Oregon.

Speck, C., Sanders, E., Peterson, M. (August, 2016). *Changes in Relationship Dynamics after Bariatric Surgery: A Qualitative Analysis.* Poster will be presented at the annual meeting of the American Psychological Association. Denver, Colorado.

Speck, C., Roshak, J., Peterson, M., Gathercoal, K. (August, 2015). *Life after Bariatric Surgery: A Qualitative Analysis on Social Support and Quality of Life.* Poster presented at the annual meeting of the American Psychological Association. Toronto, Canada.

Speck, C., Barr, B., Davis, S., Peterson, M. (August, 2015). *Correlation of Yoga, Massage, and Use of Medication among Chronic Pain Patients.* Poster presented at the annual meeting of the American Psychological Association. Toronto, Canada.

Speck, C., Roshak, J. (May, 2015). *Case Study: A Qualitative Analysis on a Married Couple's Journey with Bariatric Surgery.* Poster presented at the annual meeting of the Oregon Psychological Association. Eugene, Oregon.

Speck, C., Hamilton, E., Knows-His-Gun, K., Lowen, J. (May, 2015). *A Summary Analysis of the Implementation of Evidence-based Psychosocial Interventions within an Interdisciplinary Rural School District Partnership.* Poster presented at the annual meeting of the Oregon Psychological Association. Eugene, Oregon.

Miller, K., Hamilton, E., Davis, S., **Speck, C.**, Hamilton, S. (May, 2014). *The Effects of Computer-Assisted CBT for Rural Elementary Children with Anxiety*. Poster presented at the annual meeting of the Oregon Psychological Association. Portland, Oregon.

UNIVERSITY INVOLVEMENT

9/2014 to 4/2016 **Co-Founder of the Clinical Health Psychology Network**
George Fox University Graduate Department of Clinical Psychology

- Created centralized student network that advances the exchange of professional resources and clinical tools while providing peer-to-peer encouragement and professional camaraderie
- Co-lead bi-annual meetings and facilitate discussions on topics of health psychology
- Contribute to support on-line among the student group and post current research, articles, resources, screeners, and evidence-based interventions

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SELECTED PROFESSIONAL TRAININGS

Online Trainings

Military Population Trainings

10/2015 **The Impact of Deployment and Combat Stress on Families and Children - Part I and Part II**
Center for Deployment Psychology

9/2015 **Epidemiology of PTSD in Military Personnel and Veterans: Working with Service Members and Veterans with PTSD**
Center for Deployment Psychology

8/2015 **Prolonged Exposure Therapy for PTSD for Veterans and Military Service Personnel**
Center for Deployment Psychology
William Brim, PsyD., Jenna Ermold, PhD., David Riggs, PhD.

8/2015 **Cognitive Processing Therapy for PTSD in Veterans and Military Personnel**
Center for Deployment Psychology
Laura Copland, MA, LCMHC, Priscilla Schultz, LCSW

7/2015 **Identification, Prevention, and Treatment of Suicidal Behavior for Service Members and Veterans**
Center for Deployment Psychology
Michelle Cornette, PhD., Regina Shillinglaw, PhD., Jenna Ermold, PhD., Marjan Holloway, PhD.

6/2015 **Military Cultural Competence**
Center for Deployment Psychology
Jenna Ermold, PhD.

5/2015 **Improving Care for Veterans with PTSD**
National Center for PTSD, VA Palo Alto Health Care System

Josef I. Ruzek, PhD., Jessica Hamblen, PhD.

Integrated Healthcare Trainings

5/2015 **Competencies for Psychological Practice in Primary Care**
American Psychological Association
Nancy Ruddy, PhD., Benjamin Miller, PsyD., Christopher Hunter, PhD., Barbara Cubic, PhD.

11/2015 **Hospital Performance Metrics Advisory Committee and Metrics & Scoring Committee Joint Learning Session on Behavioral Health**
Oregon Health Authority, Legacy Health, Yamhill CCO, Trillium, St. Charles Health System
Chris Farentinos, PhD., Laura Fisk, PsyD., Justin Keller, JD., Lynnea Lindsey-Pengelly, PhD., Robin Henderson, PsyD.

Clinical Trainings

6/2015 **An Introduction to Relational Frame Theory**
Eric J. Fox, PhD.

Conference Sessions

3/2016 **Working with Multicultural Clients with Acute Mental Illness**
George Fox University, Newberg, Oregon
Sandy Jenkins, PhD.

2/2016 **Okay, Enough Small Talk. Let's Get Down to Business**
George Fox University, Newberg, Oregon
Trevor Hall, PhD.

2/2016 **Neuropsychology: What Do We Know 15 Years after the Decade of the Brain?**
George Fox University, Newberg, Oregon
Trevor Hall, PhD.

10/2015 **Let's Talk About Sex: Sex and Sexuality Applications for Clinical Work**
George Fox University, Newberg, Oregon
Joy Mauldin, PsyD.

10/2015 **Relational Psychoanalysis and Christian Faith: A Heuristic Dialogue**
George Fox University, Newberg, Oregon
Marie Hoffman, PhD.

3/2015 **Spiritual Formation and Psychotherapy**

George Fox University, Newberg, Oregon
Barrett McRay, PsyD.

11/2014 **"Facetime" in an Age of Technological Attachment**
George Fox University, Newberg, Oregon
Doreen Dodgen-Magee, PsyD.

10/2014 **Learning Disabilities: A Neuropsychological Perspective**
George Fox University, Newberg, Oregon
Tabitha Becker, PsyD.

10/2014 **Understanding and Treating ADHD**
George Fox University, Newberg, Oregon
Erika Doty, PsyD.

5/2014 **Integrated Chronic Pain Treatment in Primary Care Settings**
OPA Conference, Portland, Oregon
Kim Swanson, PhD., Scott Safford, PhD.

5/2014 **Integrating Care: Does One Model Fit All?**
OPA Conference, Portland, Oregon
Ryan Dix, PsyD., Peter Grover, PhD., Lynnea Lindsey-Pengelly, PhD., Sondra Marshall, PhD., Brain Sandoval, PsyD.

3/2014 **Evidenced Based Treatments for PTSD in Veteran Populations: Clinical and Integrative Perspectives**
George Fox University, Newberg, Oregon
David Beil-Anderson, PhD.

1/2014 **DSM 5: Essential Changes in Form and Function**
George Fox University, Newberg, Oregon
Jeri Turgesen, PsyD. and Mary Peterson, PhD.

9/2013 **Primary Care Behavioral Health**
George Fox University, Newberg, Oregon
Brian Sandoval, PsyD. and Juliette Cutts, PsyD.

4/2013 **Global Perspectives on Psychology and Integration**
CAPS Convention, Portland, Oregon
Terri Werson, PsyD., Naji Abi-Hashem PhD., Linds Bubod EdD., Thomas Idiculla PhD., Winston Seegobin, PsyD.

4/2013 **Cultural Humility: Acknowledging Limitations in One's Multicultural Competencies**
CAPS Convention, Portland, Oregon

Joshua Hook, PhD., Don Davis, PhD., Everett Worthington, PhD.

4/2013 **Pick Me! Preparing for Psychology Internship Selection**
CAPS Convention, Portland, Oregon
Keith Houde, PhD., Joel Gregor PsyD., Carlos Taloyo, PhD., Robert Weniger, PsyD., Jamie Azen, PhD.

3/2013 **The Person of the Therapist**
George Fox University, Newberg, Oregon
Brooke Kuhnhausen, PhD.

1/2013 **Afrocentric Approaches to Clinical Practice**
George Fox University, Newberg, Oregon
OHSU Avel Gordly Center for Healing
Danette C. Haynes, LCSW and Marcus Sharpe, PsyD.

ASSESSMENT & POPULATION SCREENERS

Adaptive Behavior Assessment System - 2 (ABAS-II) - Parent Form (Ages 5-21)

Adaptive Behavior Assessment System - 2 (ABAS-II) - Teacher Form (Ages 5-21)

Adult ADHD Self-Report Scale

Alcohol Use Disorders Identification Test **(**AUDIT)

Altman Self-Rating Mania Scale

BASC-2 - Adolescent 12-21

BASC-2 - Child 6-11

BASC-2 - Parent Rating Scales (PRS)

BASC-2 - Self-Report of Personality (SRP) - Child 8-11

BASC-2 - Teacher Rating Scales (TRS)

Brief Social Phobia Scale

Conners 3, Parent Rating Scales

Conners 3, Self Report

Conners 3, Teacher Rating Scales

Drug Abuse Screening Test (DAST)

Eating Attitudes Test

Expressive Vocabulary Test - 2

Generalized Anxiety Disorder - 7

Geriatric Anxiety Inventory

Geriatric Depression Scale

Goldberg Bipolar Screening Questionnaire - 5

Gray Oral Reading Tests - 5 (GORT-5)

Hartford Hospital Separation Anxiety Screener

Hospital Admission Risk Management System (HARMS-8)

Millon Adolescent Clinical Inventory

Montreal Cognitive Assessment (MoCA)

Mood Disorder Questionnaire

Patient Activation Measure (PAM)

Patient Health Questionnaire

Patient Health Questionnaire for Teens

Peabody Picture Vocabulary Test - 4

Pediatric Symptom Checklist

Pediatric Symptom Checklist - Parent

Primary Care PTSD Screen

PTSD Checklist - Civilian Version

Suicide Behaviors Risk Questionnaire - Revised

Tool for Assessment of Suicide Risk Adolescent Version Modified (TASR-Am)

Vanderbilt ADHD Diagnostic Parent Rating Scale

Vanderbilt ADHD Diagnostic Teacher Rating Scale

Wechsler Abbreviated Scale of Intelligence - 2 (WASI-II)

Wechsler Intelligence Scale for Children - 4 (WISC-IV)

Wender Utah Rating Scale

Wide Range Achievement Test 4 (WRAT-IV)

Wide Range Assessment of Memory and Learning- 2 (WRAML-II)

Woodcock Johnson III - Tests of Achievement

Woodcock Johnson III - Tests of Cognitive Abilities

Yale-Brown Obsessive Compulsive Scale - Self Report

PROFESSIONAL AFFILIATIONS & HONORS

4/2015 to Present	**Collaborative Family Healthcare Association, Student Affiliate**
9/2012 to Present	**American Psychological Association, Student Affiliate** - Member of APAGS
9/2012 to Present	**Oregon Psychological Association, Student Affiliate** **-** Member of the OPA student committee
5/2010 to Present	**Psi Chi National Honors Society** - Secretary of Philanthropic Services (2010-2011)

REFERENCES

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