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ORIGINAL RESEARCH ARTICLE

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"If you're offered help, take it": A qualitative study examining bariatric patients' experience of telephone-based cognitive behavioural therapy

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Summary

The increased recognition of patients' mental health needs after bariatric surgery has resulted in the emergence of accessible psychosocial interventions; however, there is a dearth of literature on patient experience and satisfaction with these interventions. We explored patients' perceptions and experiences of telephone-based cognitive behavioural therapy (Tele-CBT) in this qualitative study. Ten participants from the Toronto Western Hospital Bariatric Surgery Program in Toronto, Canada who completed the Tele-CBT (ClinicalTrials.gov Identifier: NCT02920112) were individually interviewed from November 2014 to June 2016 until thematic saturation occurred (ie, no more new coding groups emerged). Interviews were transcribed, independently coded, checked for discrepancies, and analysed using grounded theory. Four themes emerged: (1) participants were generally satisfied with Tele-CBT (eg, therapeutic alliance, resources provided, relevance of therapy to their own bariatric journey), (2) participants noticed emotional, cognitive, and behavioural changes following therapy, (3) the optimal time to deliver the Tele-CBT was when weight loss plateaued, generally at one-year post-surgery, and (4) participants found the telephone modality convenient. CBT was generally found to be helpful and the telephone format increased convenience and accessibility. Patients reported learning skills and receiving resources that could help them improve their well-being following bariatric surgery.

KEYWORDS

bariatric surgery, cognitive behavioural therapy, patient satisfaction, qualitative, telemedicine

1 | INTRODUCTION

Bariatric surgery is the most effective treatment for severe obesity and related comorbidities[1-3]; however, individual weight loss trajectories vary widely.[4] Weight outcomes are influenced by a complex interplay of factors, which may include eating pathology or other mental health issues.[5-7] Accordingly, the role of adjunctive psychosocial interventions such as cognitive behavioural therapy (CBT) is increasingly being recognized as an important component of bariatric care.[8-9]

A recent systematic review of 44 articles examining pre- and post-operative psychosocial interventions with a cognitive and/or behavioural focus concluded that these interventions can improve eating behaviours and psychological functioning.[10] The optimal timing of these interventions appears to be early in the post-operative period before significant eating pathology and weight regain occur.[10] Although participants appeared satisfied with the interventions, only 10/44 studies assessed satisfaction and using simple measures (eg, a single item).

A number of the studies also examined remotely delivered interventions (eg, telephone or videoconferencing) to increase treatment accessibility[11-19]; however, none of these studies assessed treatment satisfaction. Our research group has tested the feasibility and effectiveness of a six-session telephone-based cognitive behavioural therapy (Tele-CBT) intervention designed to help bariatric patients improve their eating and coping skills.[11-12,15,20] These studies suggest that this intervention is associated with improvements in eating pathology and mood and anxiety symptoms. However, these data need to be complemented by considering patient experiences.

The effects of remotely delivered interventions have been examined for other concerns. For example, telephone-delivered psychotherapy for depression and anxiety appears to be effective in reducing depression and anxiety symptoms across multiple studies.[21-23]A recent systematic review of 15 studies examining interactional differences between telephone vs face-to-face psychotherapy (eg, therapeutic alliance) found that there was little difference between the modalities.[24] However, it is unknown how bariatric patients experience the therapeutic relationship within a remotely delivered context.

Thus, a deeper exploration of bariatric patients' experience of psychosocial interventions, particularly remotely delivered interventions, is warranted. Given the pandemic of the novel Coronavirus disease (COVID-19), rapid implementation of virtual health tools has allowed for the continued care of patients, which may be particularly important for bariatric patients.[25] Understanding how patients experience such remote technologies are increasingly important as use of these treatment modalities expands. Accordingly, the primary objective of this qualitative study was to explore bariatric patients' experience of Tele-CBT, particularly regarding personal changes attributed to CBT, the optimal timing of treatment, and the telephone-based delivery format.

What is already known about this subject

- Psychosocial interventions before or after bariatric surgery can improve eating behaviours and psychological functioning.
- Remotely delivered interventions can increase accessibility to psychosocial treatment, particularly given the COVID-19 pandemic.
- However, no in-depth research has been conducted investigating bariatric patients' experiences and satisfaction with remotely delivered psychosocial interventions.

What this study adds

- Using individual interviews, patients reported positive experiences with a six-session telephone-based cognitive behavioural therapy (Tele-CBT) and described cognitive, behavioural, and emotional changes attributed to the therapy.
- Patients recommended a tailored approach to when Tele-CBT should be delivered and highlighted 12 months post-surgery as an appropriate timepoint, particularly when "bad" eating habits return and weight loss plateaus.
- Generally, patients preferred in-person therapy compared to telephone therapy, but they also noted the practical advantages and greater anonymity afforded by telephone therapy.

2 | METHODS

2.1 | Participants

Ethics approval was obtained from the University Health Network Research Ethics Board (REB ID: 14-7892.6). Participants were patients registered with the Toronto Western Hospital Bariatric Surgery Program (TWH-BSP) in Toronto, Canada who had participated in a larger, separate study examining the effectiveness of Tele-CBT delivered at 1-year post-bariatric surgery (ClinicalTrials.gov Identifier: NCT02920112).[20] These participants completed six weekly, 1-hour CBT sessions over the telephone (74.4% completion rate; n = 32 completers). Sessions were conducted by two supervised doctoral students in clinical psychology. However, this larger study did not include qualitative interviews.

Patients in the present qualitative study were eligible to participate if they were fluent in English, had telephone and Internet access, could provide consent, and if they were not currently experiencing active suicidal ideation, active serious mental illness (eg, psychotic or bipolar disorders) that would preclude engagement in Tele-CBT.[20] Participants were recruited for the present qualitative study after completing Tele-CBT in the larger study. They provided informed written consent prior to the interview. All participants who consented to the study completed the interview. Clinic staff provided study brochures for the larger Tele-CBT study and the present qualitative study to potentially eligible patients at appointments, as recruitment for both studies was concurrent. However, it is unknown how many patients in total were approached for study recruitment. Recruitment occurred between November 2014 and June 2016 until thematic saturation occurred.

2.2 | Data collection

Participants completed individual semi-structured interviews by telephone. The interview questions were adapted from the Client Change Interview (see Supplementary Interview Guide [Data S1]).[26] The interviews were conducted by V. A. S., a Bachelor's level

clinical research coordinator not involved in clinical care but familiar with Tele-CBT research, under the supervision of a psychiatrist with qualitative methodology expertise (S. S.). Participants were asked questions about their experience of therapy (eg, what was helpful, unhelpful, missing), any changes that they may have experienced since the therapy, and their thoughts about the topics covered (see Cassin et al[11] for a description of topics), ideal timing of therapy, and of telephone vs in-person modalities. Each interview was audiotaped, transcribed verbatim by an independent research assistant, and checked for accuracy by the interviewer. Transcriptions were uploaded on qualitative analysis software HyperRESEARCH (Version 3.7.3; ResearchWare, Inc.) for coding and analysis. The interviewer took field notes before and after each interview to record contextual factors (eg, rescheduled interviews).[27] These notes also served as study memos to aid the interviewer's reflection on the interview process and to document any decision-making.[28-29]

Once all interviews were conducted and coding was complete, all participants were individually e-mailed a de-identified summary of the major themes in order to obtain feedback about the accuracy of the findings. All participants agreed to this step during the interview. This process of member checking is intended to enhance credibility of data analysis.[30-31]

2.3 | Theoretical approach and data analysis

Analyses of the transcripts were informed by grounded theory approach in order to explore the social processes of therapy within a specific telephone-based setting.[29,32-33] Thus, data analyses occurred concurrently with data collection (ie, constant comparison with a three-stage coding process).[29,34] This iterative process led to thematic saturation after interviewing 10 patients (ie, no more new coding groups were identified). The study team met following coding of the first two transcripts to discuss independently coded interviews between two investigators (V. A. S. and S. S.). A third investigator (S. W.) helped to resolve disagreements. Initial codes and themes were discussed and agreement was high. Disagreements were resolved, coding continued, and the study team was updated on any emerging themes throughout the recruitment process. Participant responses to the member checking e-mails were reviewed and no changes to the themes were suggested. An overview of all initial themes and subthemes is shown in Table 1. Codes within initial subthemes were collapsed based on similarity (eg, thoughts about the therapist and about Tele-CBT were combined to form the initial major theme of "Thoughts about study", which was finalized under the major theme of "What I liked about CBT"). Some codes were assigned to a different final theme based on overall fit with the final theme (see Table 2 for how example codes were assigned). Certain themes were not relevant to the understanding of patients' experiences of CBT, such as idiosyncrasies of the participant, and were thus not included in the final four overarching themes, which are shown in Figure 1.

3 | RESULTS

3.1 | Participant characteristics

All 10 participants (participants A1-A10) were women. Nine of the participants in the present study identified as White and one identified as East Asian. Their average age was 50.9-years-old (SD = 7.7), pre-surgical BMI was 46.8 kg/m^2 (SD = 5.8), 12-month post-surgical BMI was 32.1 kg/m^2 (SD = 5.4), and number of days from bariatric surgery to the interview was 543.2 days (SD = 42.9). The average length of the interview was 38.2 minutes (SD = 13.9).

3.2 | Four emerging themes after completing Tele-CBT

1. What I liked about CBT

(a) Experience with the therapist

Many of the participants reported having a positive experience and cited their therapist as a contributing factor. For example, Participant A4 stated, "[The therapist] made it easy for me to express myself and she gave me great ideas", specifically for separating eating and watching television at the same time. A6 stated, "I liked being able to open up and [the therapist] was very open and knowledgeable about how I was feeling and what I'd be going through, and it was very helpful to be able to talk to somebody who understood."

(b) Experience with the CBT materials

Participants such as A3 noted the importance of the CBT materials, stating, "In the workbook, it laid out everything, [it] was black and white right there for you so you could stop and actually step yourself right through [it]". A8 added, "I have the workbooks now that, in future, if I ever want to refer back, I have a resource".

(c) Experience with the CBT protocol

A6 said that, "Every week when we discussed something, whatever we discussed seemed to be happening to me at that time". A8 commented similarly on the relevance of the protocol to her experiences by stating that her sessions "covered… some of the areas that I had already faced during the year after surgery and in some cases it reinforced that… some of the attempts at coping worked well". Regarding the helpfulness of specific topics, on average participants rated using thought records as the least helpful, whereas long-term lifestyle changes were rated as the most helpful. A8 rated thought records and changing problem thoughts as not helpful because "Right now, life is good so I'm not facing those kinds of situations". A7 stated, "I don't think of something and have time to sit down and write it out. I just solve the problem right there in my head". With regards to long-term lifestyle changes, A8 listed "Dietary habits, exercise, [and] socialization" as examples. A7 mentioned, "I started to think about getting on my treadmill, ended up talking about it, and then finally doing it".

Some participants mentioned that there was insufficient time for the manual content. A2 said that there was "a lot of information in a

TABLE 1 All initial themes and subthemes from participant interviews (alphabetical by initial theme)

Initial theme	Initial subtheme	Further subtheme (if applicable)
Bad habits	Eating habits	
	Non-eating habits	
Changes due to CBT	Changes in actions due to CBT	
	Changes in thoughts due to CBT	
	Changes not due to CBT	
	Changes brought to attention by other people	
Life stressors	Lack of support	
	Being busy	
	Financial stress	
	Family stress	
	Work stress	
Optimal timing of Tele-CBT	CBT at 1-year post-op	Helpful/unhelpful
	CBT at 6-months post-op	Helpful/unhelpful
	CBT at 6-months pre-op	Helpful/unhelpful
	CBT at another timepoint	
	Not a specific optimal time	
Past therapy experience	(No subthemes)	
Personal bariatric journey	Pre-op journey	
	6-months post-op	
	1-year post-op	
Personality or idiosyncrasies of participant	Idiosyncrasy (eg, likes fruits and vegetables)	
	Personality (eg, self-aware)	
Reasons for pursuing therapy	Influenced by others (eg, to give back to research, to break stigma)	
	Personal benefits (eg, to ensure ongoing success)	
Support (presence of support)	(No subthemes)	
Thoughts about bariatric surgery program	(No subthemes)	
Thoughts about study	Advantages to phone therapy	Comparing to in-person
		Interpersonal advantages
		Practical advantages
	Challenges with content or structure of therapy	
	Challenges with phone aspect of therapy	
	Gratitude for therapy	
	Improvements to Tele-CBT	Improvements to topics
		Number of sessions and time-related
	Helpfulness of topics	
	Thoughts about therapist	
	Thoughts about Tele-CBT	Expectations of Tele-CBT
		Negative thoughts
		Neutral thoughts
		Positive thoughts
		Recommendation to others
Thoughts about surgery and lifestyle changes	(eg, "it's a life-saving surgery")	

Abbreviation: CBT, cognitive behavioural therapy.

TABLE 2 Example codes assigned to initial subthemes and major themes and then finalized into subthemes and four major themes

Example codes	Initial subtheme (further subtheme if applicable)	Initial major theme	Final subtheme	Final major theme
Therapist made me feel comfortable and at ease	Thoughts about therapist	Thoughts about study	Experience with therapist	1. What I liked about CBT
The workbooks were clear	Positive thoughts about Tele-CBT	Thoughts about study	Experience with CBT materials	
I have the workbooks for future reference	Changes in actions due to CBT	Changes due to CBT		
CBT had a lot of information	Challenges with content or structure of therapy	Thoughts about study	Experience with CBT protocol	
Feeling rushed due to lack of time	Negative thoughts about Tele-CBT	Thoughts about study		
CBT was relevant to unique bariatric experience	Positive thoughts about Tele-CBT	Thoughts about study		
Topic was useful	Helpfulness of topics	Thoughts about study		
Topic was not relevant	Helpfulness of topics	Thoughts about study		
I would recommend Tele-CBT to others	Recommendations of Tele-CBT to others	Thoughts about study	Perceived benefits to care	
Roots of bad habits and becoming overweight	Non-eating habits	Bad habits		
Not feeling alone with professional who understands	Changes in thoughts due to CBT	Changes due to CBT		
Challenging thoughts of sabotage by others	Changes in thoughts due to CBT	Changes due to CBT	Cognitive changes	2. How I changed after CBT
Not weighing self everyday	Changes in actions due to CBT	Changes due to CBT	Behavioural changes	
I've learned not to get upset or internalize things	Changes in thoughts due to CBT	Changes due to CBT	Emotional changes	
Personalized or tailored or patient directed therapy	Improvements to Tele-CBT	Thoughts about study	Tailored approach	3. When I need CBT
Not a specific optimal time for CBT	CBT at another timepoint	Optimal timing of Tele-CBT		
Weight loss starts tapering off and weight regain is possible	CBT at 1-year post-op	Optimal timing of Tele-CBT	12 months post-op	
Being unable to read non-verbal cues	Challenges with phone aspect of therapy	Thoughts about study	Prefer in-person therapy	4. How I feel about telephone vs in-person CBT
Prefer in person therapy over by phone	Advantages to phone therapy (Comparing to in-person therapy)	Thoughts about study		
You're more anonymous	Advantages to phone therapy (Interpersonal advantages)	Thoughts about study	Prefer phone therapy	
Can be done at any location	Advantages to phone therapy (Practical advantages)	Thoughts about study		
No preference for in-person or phone therapy	Advantages to phone therapy (Comparing to in-person therapy)	Thoughts about study	No preference	

Abbreviation: CBT, cognitive behavioural therapy.

short amount of time and not a lot of ability to absorb [it]… I do feel that it would be helpful to have additional follow-up sessions even if it was just the 6 weeks, and then maybe one at 8, and then one at 12". In addition, A6 suggested the therapy should be 3 months long since "there's just so many changes in your body and your mind and… so much to take in and grasp and… the therapy is just so helpful". Whether it meant longer sessions or more sessions, many participants wished to have more therapy for the amount of content covered.

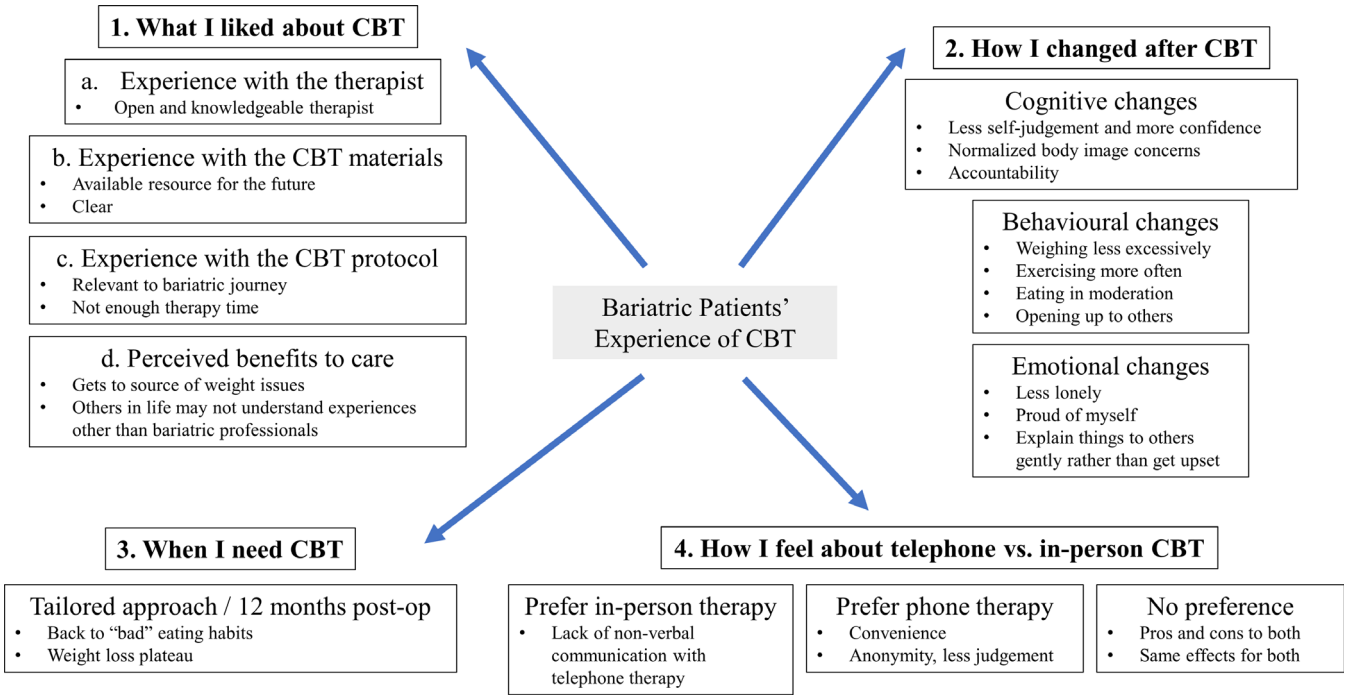

FIGURE 1 Conceptual framework summarizing the main themes from the patient interviews. CBT, cognitive behavioural therapy

(d) Perceived benefit of CBT to bariatric care

When asked if participants would recommend Tele-CBT to other patients at a similar timepoint after surgery, all of them said yes, highlighting the need to address the roots of weight issues and to receive support. A2 mentioned, "I don't think that you're going to get all of the information that you need from support groups or from online information because what got you to that place of being however much overweight is what you need to explore—not necessarily, you know… 'How much protein is in this?'. You need to kind of cut to the source so that you don't get back there". A7 stated more urgently, "If you're offered help, take it because this is a unique experience. This is not something [where] you're going to run into somebody at your workplace or, you know… your social circle—where you're going to find somebody like you… You're going through this journey alone and there are professionals out there who understand what you're going through, and to talk about it with them is more beneficial in the end than anything else".

2. How I changed after CBT

Participants were asked if they found the therapy to be helpful, and all except A5 reported that it was. Even A5, who found Tele-CBT difficult because of the lack of non-verbal communication and amount of content, stated, "Even though I found some of the stuff very difficult to follow… we broke it down into just maybe concentrating on one little segment. That made it easier and I can't say that I didn't learn a few coping mechanisms from it".

Participants were also asked about changes that they had noticed since the therapy, including changes in behaviours, emotions, and thoughts. Some of the participants noted changes due to social support and accountability. A1 stated that with Tele-CBT, "Someone heard me", which made her feel "empowered, like I know I'm not alone and that helps to feel less isolated". A3 added, "I need the discipline of having to answer to somebody and that's what I found". A4 stated, "You can say very easily, 'Well, they just fixed me'… No, it's a lot of work … You have to do all these things, and so there's… accountability to yourself, not to anybody else, and I didn't have that before".

Other participants noted cognitive changes. A3 said, "I found a lot that I was thinking totally wrong when I thought people were sabotaging [me], that in fact they really weren't… It was just my own thoughts around food". A6 added, "I learned I really need not to judge myself so much… I've been judgmental about myself and what I did and my weight and how other people saw me, whereas I'm now… this is me—take me or leave me. I have more self-confidence… I'm feeling more secure and actually going out and dating". Similarly, A10 added, "I've become more gentle in my approach to negative behaviour when I'm on the receiving end. I've stopped using the word 'should' all the time… And I think I was allowing myself to be in a negative cycle, whereas [the therapist] helped me break that cycle". Regarding body image, A8 said, "I was having difficulty with… a mismatch between mental image and body size with the loss of weight… It was reinforced through the therapy that, you know, that's a very normal thing and I was given some suggestions on… how to allow that catch-up to happen". A8 mentioned more general changes to thoughts, as "[Therapy's] giving me a more complete idea of just how everything works together so that I… can understand if something is going on, then I know… why it has a ripple effect on other areas of my life".

Finally, all of the participants except A1 noticed behavioural changes. A2 said, "[The therapist] had me not weigh myself every day, and so… on our last session I joked with her that I was kind of happy because now I can start weighing myself everyday again, but honestly, I haven't. [The scale] is still tucked underneath my bed and I'm not as obsessed on it because I know that I kind of survived without it". A7 mentioned that "The day after I had the job change, I could have got up and I could have not got on the treadmill…. But I got right back on there. I did it right away, which is a big change for me because I'll look for any excuse not to do it". Regarding food, she said, "I feel a lot stronger… I can speak up a bit more about what I need and I can walk away from situations… [in which] the food addict in me really came out". Similarly, A3 noted that she has changed her eating habits at family functions. She said, "[I] take an apple or my own snack with me… I'm proud of myself that I can go to these functions and have some control". A6 described the impact of using food records on her eating and shopping habits, saying, "I'm more conscious of what I'm eating, and I'm more conscious at the grocery store of what I'm buying. Before, when something would upset me, my first thing would be to go for food. I'd go get popcorn and cheezies… eat the whole bowl. Now, if I want something… I might have one or two".

In terms of opening up to others, A10 reported, "I've learned how to explain things to people better and in a gentle, assertive way, rather than get upset or internalizing things… [The therapist] taught me also how to lean on your support people… And so I've been leaning on my husband more… He says like I'm more assertive". Finally, A7 described how therapy helped her open up. She recounted, "I was at an appointment yesterday… and I told [the nurse and dietician] about the CBT, and they said 'Something's different with you… The way you're talking, the strength you have…' I said 'I'm a really lazy person.' They looked at me and said 'No, you're not. Look at all the things you're doing and you did this. This is really hard.' … They said 'This is the first time you spoke about your feelings about the surgery,' and I said 'Yeah, because I actually had to talk about it more'".

3. When I need CBT

When asked when after surgery it would be helpful to do CBT, there were various responses. A8 stated, "Probably in the 3 to 4 months after surgery would be good because by that time, you're off the more regimented diet and starting to make decisions". Similarly, A4 suggested CBT at 7 to 8 months post-surgery because that is when "You're getting a little braver… getting into a bad habit by that time". Some participants advocated for a tailored approach. A2 mentioned, "Personally, I don't think it's a number on a calendar. I think the reason [CBT] was good for me for the time that it hit me is because I reached my goal… Until that time, my focus was on 'We're losing weight' and not necessarily on the focus of correcting my thoughts long-term".

However, the most common response was approximately 12 months post-surgery. A3 noted that, "I was really pumped and motivated and focused and everything the first year because I was losing weight, and then once that started to slow down, that's when I started to struggle". A6 stated, "Let's say you hit the 9-month, you start to plateau and that's when you need the help to keep going and to keep positive, and the cognitive therapy does that". A10 added that after "One year to eighteen months, you can start gaining [weight] and your old habits can start returning". Thus, while the timepoints varied, the reasons for optimal timing of CBT were largely the same (ie, a return to "bad" habits and weight loss plateau).

4. How I feel about telephone vs in-person CBT

Participants commented on how in-person therapy was preferred to telephone therapy. For example, A2 said, "Sometimes our words and our body language or our expressions say… different things… It would have been better just to have that visual of somebody, knowing that you're putting your words and your trust in them". She added that, "Initially over the phone, it was a challenge because I am more of a social individual, so it was tough for me to make a connection with somebody over the phone. My counsellor… she's very, very approachable and within time… [this challenge] definitely lessened…" With regards to telephone therapy, A8 mentioned that due to the lack of seeing nonverbal cues, "My preference would probably be in-person if it could be done… reasonably, but also understanding geographically where I live, the teleconference would definitely be acceptable". Similarly, A9 reported that "I would have had a richer experience if I could be in-person… Maybe meeting once with [the therapist] face-to-face would have been nice… just to know who [she] was at the other end". With regards to her preference, she said, "For convenience, the telephone works better just because my schedule's really crazy busy, but if I had a preference—not thinking just of convenience—I think I would have liked the in-person better, but I'm grateful for it anyway".

Despite the general preference for in-person therapy, participants also reported that telephone therapy offered unique benefits. A1 mentioned, "There's really no need to have to see the person's face… there's less judgement… Somebody's body language doesn't deter you from being honest". Similarly, A10 stated, "I think it's more anonymous. So, for people who don't want to go to someone's office and wait in a waiting room… that's positive. It's also very positive for remote locations, it's positive for if the weather is bad, if transit is delayed". She added that due to the lack of non-verbal communication, there were some positives to this, stating, "I think that a lot of people who've been overweight, a lot of their lives are very shy… They may have experienced, sort of, discrimination when it comes to health care, and so… they may be hesitant to be fully open… But when you're over the phone with someone, there's a little bit of anonymity… so you're more likely to be more open". When asked what she preferred, she said, "For bariatrics, I would do telephone".

Finally, there were four participants who noted an indifference to telephone vs in-person therapy. A4 stated, "Whether you see them in-person or whether you see them on the phone—to me that's the same". A3 also mentioned the convenience related to phone therapy. She said, "Not that I live hugely far away, but [the city's] a very busy city and very hard at busy times to get around in. So, it allowed me to participate in this program". She added, "I wouldn't say… like, the

one-on-one [in-person] counselling I've had has had any more effect on me than the… Tele-CBT has".

4 | DISCUSSION

There is a lack of in-depth data regarding patient experience with remotely delivered psychosocial interventions for bariatric surgery concerns.[10] This study is the first to qualitatively examine these experiences. Four overarching themes were identified among participants who were asked to share their experience of receiving Tele-CBT 1 year after bariatric surgery[20] (Figure 1). First, CBT process and structural components such as the therapeutic alliance, the amount of therapy time, the resources provided, and the relevance of topics to patients' specific needs influenced patient satisfaction. All 10 participants recommended CBT for other patients. Second, participants noticed a variety of emotional, cognitive, and behavioural changes, which they attributed to therapy. These changes included feeling less lonely, thinking less self-critically, weighing less excessively, exercising more, improving eating habits, and relying more on supports. Third, according to participants, the optimal time to receive CBT is when patients hit a "plateau" when weight loss slows down and eating can return to "bad" habits. Some participants noted that this period is unique to each individual and thus timing of CBT delivery should be individually tailored. Most participants also identified 1-year post-surgery as the optimal time point for CBT. Finally, while some participants noted the lack of non-verbal communication during telephone therapy as hindering the therapeutic process, others reported that it facilitated disclosure due to the visual anonymity. Despite the varied preferences for in-person vs telephone therapy, participants highlighted the accessibility of telephone therapy in terms of convenience and reducing barriers.

The present findings contribute to the literature regarding patient experiences with psychosocial interventions for bariatric surgery patients. Participants highlighting the accessibility of the telephone modality is in line with recent findings,[35] which found that in previous Tele-CBT studies,[12,20,36] among demographic and clinical predictors of response, patient rurality index was the only significant predictor of Tele-CBT response (ie, more rural patients had a greater response). Robinson et al[14] also examined the use of a skills-based post-surgical intervention delivered via telephone, videoconference, or in-person, based on patient preference. They found that 12 of the 13 patients preferred telephone or videoconferencing compared to in-person, and one patient preferred a combination. Perhaps given the option of different modalities, patients receiving Tele-CBT may be less inclined to feel like they are "missing out" on non-verbal cues if they begin with in-person therapy and later switch to telephone due to the practical advantages. The current adoption of videoconferencing platforms due to COVID-19 could help accommodate patients who prefer both audio and visual cues.

In terms of timing of intervention delivery, the varied responses in the present study concerning the weight-loss "plateau" are in line with the variety of weight loss trajectories identified by Courcoulas et al.[4] Participants' tailored suggestion is in line with the stepped care approach of personalized weight management following bariatric surgery, which focuses on providing more intensive psychological interventions when patients continue to have difficulty with weight.[37] The common recommendation of CBT at 1-year post-surgery is also in line with data that suggest maximum weight loss occurs within the first year after surgery,[4,38] signalling an appropriate time when skills may be needed.

Furthermore, a review by Youssef et al[39] examined patient care experiences in the context of integrated care models for patients with comorbid physical and mental health issues. The cross-cutting theme in Youssef et al was the importance of the design of therapeutic spaces such as environments and processes that promote privacy, confidentiality, and a non-judgmental care philosophy, which can serve to reduce stigma and improve access to care. This is echoed by the importance of therapeutic alliance to participants in the present study, and the anonymity and convenience afforded by the telephone modality. Furthermore, Youssef et al found that when patients' unique needs were met, it promoted active patient engagement and helped build relationships with care providers. The present study also found that when the therapist understood the patient, adjusted the therapy to the individual's needs, and provided new ideas, it helped the patient learn new skills and facilitated the patient's self-expression.

4.1 | Implications for future research

Given that some participants found certain CBT strategies more helpful than others, dismantling studies using only cognitive or only behavioural strategies may illuminate which elements of the treatment are most helpful. Future studies of this CBT protocol could also compare different treatment modalities to determine if this affects patient experiences and treatment adherence.[23] Additionally, although therapeutic process factors such as alliance were discussed broadly, specific elements such as empathy could be examined in further qualitative research and/or with measures of alliance.[40] Findings by Irvine et al[24] suggest that such interactional factors differ little between telephone vs face-to-face psychotherapy. However, this must be replicated within a bariatric population, especially given unique considerations, such as weight bias in healthcare that may result in avoidance of care.[41] Furthermore, questions such as how personalized psychotherapy could be practically delivered need to be addressed in future research, particularly within the constraints of a government funded service. Understanding how patient experiences are optimized with this personalization is an important next step.

4.2 | Strengths and limitations

The findings of this study need to be considered in light of its strengths and limitations. The interviews were conducted over the telephone and so nonverbal expressions could not be interpreted.[27] The interviews were conducted individually, which potentially allowed

for greater disclosure compared to group interviews but precluded exploration of shared experiences.[27,42] Member checking helped to ensure that participant experiences were accurately reflected. However, given the one source of information (patient self-report), there is a lack of data triangulation (eg, asking the spouses of patients about changes in patient behaviour) and a lack of method triangulation (eg, collecting group data).[30] Furthermore, full researcher triangulation is lacking (ie, analysis of all transcripts by multiple researchers). Finally, the experiences shared by this small sample of female, mostly White participants who had completed CBT may not be representative of other patient experiences. Although male patients were eligible to participate in the larger Tele-CBT study,[20] the vast majority (91%) of participants recruited in that study (n = 45) and 100% of treatment completers (n = 32) were women. Four male participants partially completed the Tele-CBT protocol but withdrew due to time constraints, personal life stressors, and other reasons.[20] Previous Tele-CBT studies also recruited predominantly female samples (83%-87.5%).[11,12,15] However, this is similar to large bariatric trials[43-44] and reflects a limitation found in bariatric surgery research. Feedback from treatment non-completers could illuminate other reasons for dissatisfaction with CBT.

5 | CONCLUSION

Ten post-bariatric surgery participants who completed Tele-CBT in a larger, previous study[20] and were subsequently interviewed in the present qualitative study were generally highly satisfied with Tele-CBT, noticed a variety of positive changes following the therapy, found the timepoint of delivery appropriate at 1-year post-surgery, and had varied preferences regarding the modality of delivery (telephone-based vs in-person therapy). These results must be interpreted with caution given the small sample size. However, no in-depth qualitative research has been conducted thus far regarding the experiences of bariatric surgery patients with psychosocial interventions. The rich data collected from the interviews indicated some nuances, such as the lack of non-verbals in telephone-based therapy potentially hindering as well as facilitating communication, and provide some recommendations for refining the treatment, including the addition of follow-up booster sessions to maintain progress.

CONFLICT OF INTEREST

No conflict of interest was declared.

AUTHOR CONTRIBUTIONS

Authors Stephanie E. Cassin, Susan Wnuk, Chau Du, Raed Hawa, Sagar V. Parikh and Sanjeev Sockalingam contributed to the conception and design of the study. Author Vincent A. Santiago conducted the interviews, analysed the data, and wrote the first draft of the manuscript. All authors contributed to the interpretation of the data, editing of the manuscript, and final approval of the manuscript.

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REFERENCES

1. Chang SH, Stoll CR, Song J, et al. The effectiveness and risks of bariatric surgery: an updated systematic review and meta-analysis, 2003-2012. *JAMA Surg*. 2014;149(3):275-287. https://doi.org/10.1001/jamasurg.2013.3654.
2. Colquitt JL, Pickett K, Loveman E, Frampton GK. Surgery for weight loss in adults. *Cochrane Database Syst Rev*. 2014;8:CD003641. https://doi.org/10.1002/14651858.CD003641.pub4.
3. National Institute for Health and Care Excellence [NICE]. Obesity: Identification, assessment, and management. (NICE Clinical Guideline No. 189). https://www.nice.org.uk/guidance/cg189/chapter/1-Recommendations. Accessed August 27, 2020.
4. Courcoulas AP, Christian NJ, Belle SH, et al. Weight change and health outcomes at 3 years after bariatric surgery among individuals with severe obesity. *JAMA*. 2013;310(22):2416-2425. https://doi.org/10.1001/jama.2013.280928.
5. Devlin MJ, King WC, Kalarchian MA, et al. Eating pathology and associations with long-term changes in weight and quality of life in the longitudinal assessment of bariatric surgery study. *Int J Eat Disord*. 2018;51(12):1322-1330. https://doi.org/10.1002/eat.22979.
6. Meany G, Conceição E, Mitchell JE. Binge eating, binge eating disorder and loss of control eating: effects on weight outcomes after bariatric surgery. *Eur Eat Disord Rev*. 2014;22(2):87-91. https://doi.org/10.1002/erv.2273.
7. Nasirzadeh Y, Kantarovich K, Wnuk S, et al. Binge eating, loss of control over eating, emotional eating, and night eating after bariatric surgery: results from the Toronto Bari-PSYCH cohort study. *Obes Surg*. 2018;28(7):2032-2039. https://doi.org/10.1007/s11695-018-3137-8.
8. Kalarchian MA, Marcus MD. Management of the bariatric surgery patient: is there a role for the cognitive behavior therapist? *Cogn Behav Pract*. 2003;10(2):112-119. https://doi.org/10.1016/S1077-7229(03)80019-6.
9. Kalarchian MA, Marcus MD. Psychosocial concerns following bariatric surgery: current status. *Curr Obes Rep*. 2019;8(1):1-9. https://doi.org/10.1007/s13679-019-0325-3.
10. David LA, Sijercic I, Cassin SE. Preoperative and post-operative psychosocial interventions for bariatric surgery patients: a systematic review. *Obes Rev*. 2020;21(4):e12926. https://doi.org/10.1111/obr.12926.
11. Cassin SE, Sockalingam S, Wnuk S, et al. Cognitive behavioral therapy for bariatric surgery patients: preliminary evidence for feasibility, acceptability, and effectiveness. *Cogn Behav Pract*. 2013;20(4):529-543. https://doi.org/10.1016/j.cbpra.2012.10.002.
12. Cassin SE, Sockalingam S, Du C, Wnuk S, Hawa R, Parikh SV. A pilot randomized controlled trial of telephone-based cognitive behavioural therapy for preoperative bariatric surgery patients. *Behav Res Ther*. 2016;80:17-22. https://doi.org/10.1016/j.brat.2016.03.001.
13. Delparte CA, Power HA, Gelinas BL, Oliver AM, Hart RD, Wright KD. Examination of the effectiveness of a brief, adapted dialectical behavior therapy-skills training group for bariatric surgical candidates. *Obes Surg*. 2019;29(1):252-261. https://doi.org/10.1007/s11695-018-3515-2.
14. Robinson AH, Adler S, Darcy AM, Osipov L, Safer DL. Early adherence targeted therapy (EATT) for postbariatric maladaptive eating behaviors. *Cogn Behav Pract*. 2016;23(4):548-560. https://doi.org/10.1016/j.cbpra.2015.12.003.
15. Sockalingam S, Cassin SE, Wnuk S, et al. A pilot study on telephone cognitive behavioral therapy for patients six-months post-bariatric surgery. *Obes Surg*. 2017;27(3):670-675. https://doi.org/10.1007/s11695-016-2322-x.

16. Weineland S, Arvidsson D, Kakoulidis TP, Dahl J. Acceptance and commitment therapy for bariatric surgery patients, a pilot RCT. *Obes Res Clin Pract*. 2012;6(1):e21-e30. https://doi.org/10.1016/j.orcp.2011.04.004.
17. Weineland S, Hayes SC, Dahl J. Psychological flexibility and the gains of acceptance-based treatment for post-bariatric surgery: six-month follow-up and a test of the underlying model. *Clin Obes*. 2012;2(1–2):15-24. https://doi.org/10.1111/j.1758-8111.2012.00041.x.
18. Wild B, Hünnemeyer K, Sauer H, et al. A 1-year videoconferencing-based psychoeducational group intervention following bariatric surgery: results of a randomized controlled study. *Surg Obes Relat Dis*. 2015;11(6):1349-1360. https://doi.org/10.1016/j.soard.2015.05.018.
19. Wild B, Hünnemeyer K, Sauer H, et al. Sustained effects of a psychoeducational group intervention following bariatric surgery: follow-up of the randomized controlled BaSE study. *Surg Obes Relat Dis*. 2017;13(9):1612-1618. https://doi.org/10.1016/j.soard.2017.03.034.
20. Sockalingam S, Leung SE, Hawa R, et al. Telephone-based cognitive behavioural therapy for female patients 1-year post-bariatric surgery: a pilot study. *Obes Res Clin Pract*. 2019;13(5):499-504. https://doi.org/10.1016/j.orcp.2019.07.003.
21. Castro A, Gili M, Ricci-Cabello I, et al. Effectiveness and adherence of telephone-administered psychotherapy for depression: a systematic review and meta-analysis. *J Affect Disord*. 2020;260:514-526. https://doi.org/10.1016/j.jad.2019.09.023.
22. Coughtrey AE, Pistrang N. The effectiveness of telephone-delivered psychological therapies for depression and anxiety: a systematic review. *J Telemed Telecare*. 2018;24(2):65-74. https://doi.org/10.1177/1357633x16686547.
23. Mohr DC, Ho J, Duffecy J, et al. Effect of telephone-administered vs face-to-face cognitive behavioral therapy on adherence to therapy and depression outcomes among primary care patients: a randomized trial. *JAMA*. 2012;307(21):2278-2285. https://doi.org/10.1001/jama.2012.5588.
24. Irvine A, Drew P, Bower P, et al. Are there interactional differences between telephone and face-to-face psychological therapy? A systematic review of comparative studies. *J Affect Disord*. 2020;265:120-131. https://doi.org/10.1016/j.jad.2020.01.057.
25. Sockalingam S, Leung SE, Cassin SE. The impact of coronavirus disease 2019 on bariatric surgery: redefining psychosocial care. *Obesity*. 2020;28(6):1010-1012. https://doi.org/10.1002/oby.22836.
26. Rodgers B, Elliott R. Qualitative methods in psychotherapy outcome research. In: Gelo O, Pritz A, Rieken B, eds. *Psychotherapy Research: Foundations, Process, and Outcome*. Vienna: Springer; 2015:559-578. https://doi.org/10.1007/978-3-7091-1382-0_27.
27. Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *Int J Qual Health Care*. 2007;19(6):349-357. https://doi.org/10.1093/intqhc/mzm042.
28. Frambach JM, van der Vleuten CP, Durning SJ. Quality criteria in qualitative and quantitative research. *Acad Med*. 2013;88(4):552. https://doi.org/10.1097/acm.0b013e31828abf7f.
29. Starks H, Trinidad S. Choose your method: a comparison of phenomenology, discourse analysis, and grounded theory. *Qual Health Res*. 2007;17(10):1372-1380. https://doi.org/10.1177/1049732307307031.
30. Côté L, Turgeon J. Appraising qualitative research articles in medicine and medical education. *Med Teach*. 2005;27(1):71-75. https://doi.org/10.1080/01421590400016308.
31. O'Brien BC, Harris IB, Beckman TJ, Reed DA, Cook DA. Standards for reporting qualitative research: a synthesis of recommendations. *Acad Med*. 2014;89(9):1245-1251. https://doi.org/10.1097/ACM.0000000000000388.
32. Glaser BG, Strauss AL. *The Discovery of Grounded Theory: Strategies for Qualitative Research*. Chicago, IL: Aldine; 1967.
33. Strauss A, Corbin J. *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory*. 2nd ed. Thousand Oaks, CA: Sage Publications; 1998.
34. Charmaz K. *Constructing Grounded Theory: A Practical Guide through Qualitative Analysis*. Thousand Oaks, CA: Sage Publications; 2006.
35. Costa-Dookhan KA, Leung SE, Cassin SE, Sockalingam S. Psychosocial predictors of response to telephone-based cognitive behavioural therapy in bariatric surgery patients. *Can J Diabetes*. 2019;44(3):236-240. https://doi.org/10.1016/j.jcjd.2019.06.008.
36. Sockalingam S, Kantarovich K, Hawa R, et al. Effectiveness of telephone-cognitive behavioural therapy for patients one year after bariatric surgery. *Surg Obes Relat Dis*. 2017;13(10):S39-S40. https://doi.org/10.1016/j.soard.2017.09.083.
37. Kalarchian MA, Marcus MD. The case for stepped care for weight management after bariatric surgery. *Surg Obes Relat Dis*. 2018;14(1):112-116. https://doi.org/10.1016/j.soard.2017.07.023.
38. Sjöström L, Lindroos AK, Peltonen M, et al. Lifestyle, diabetes, and cardiovascular risk factors 10 years after bariatric surgery. *N Engl J Med*. 2004;351(26):2683-2693. https://doi.org/10.1056/NEJMoa035622.
39. Youssef A, Chaudhary ZK, Wiljer D, Mylopoulos M, Sockalingam S. Mapping evidence of patients' experiences in integrated care: a scoping review. *Gen Hosp Psychiatry*. 2019;61:1-9. https://doi.org/10.1016/j.genhosppsych.2019.08.004.
40. Ardito RB, Rabellino D. Therapeutic alliance and outcome of psychotherapy: historical excursus, measurements, and prospects for research. *Front Psych*. 2011;2:270. https://doi.org/10.3389/fpsyg.2011.00270.
41. Phelan SM, Burgess DJ, Yeazel MW, Hellerstedt WL, Griffin JM, Ryn M. Impact of weight bias and stigma on quality of care and outcomes for patients with obesity. *Obes Rev*. 2015;16(4):319-326. https://doi.org/10.1111/obr.12266.
42. DiCicco-Bloom B, Crabtree BF. The qualitative research interview. *Med Educ*. 2006;40(4):314-321. https://doi.org/10.1111/j.1365-2929.2006.02418.x.
43. Farinholt GN, Carr AD, Chang EJ, Ali MR. A call to arms: obese men with more severe comorbid disease and underutilization of bariatric operations. *Surg Endosc*. 2013;27(12):4556-4563. https://doi.org/10.1007/s00464-013-3122-1.
44. Mitchell JE, King WC, Chen JY. Course of depressive symptoms and treatment in the longitudinal assessment of bariatric surgery (LABS-2) study. *Obesity*. 2014;22(8):1799-1806. https://doi.org/10.1002/oby.20738.

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