

“BANDING TOGETHER:”
BIOSOCIALITY, WEIGHT LOSS SURGERY,
AND NEOLIBERAL DISCOURSES AROUND OBESITY

By

ZOË C. MELEO-ERWIN

A dissertation submitted to the Graduate Faculty in Sociology in partial fulfillment of the requirements for the degree of Doctor of Philosophy, the City University of New York

2013

© 2013
ZOË C. MELEO-ERWIN
All Rights Reserved.

This manuscript has been read and accepted for the Graduate Faculty in Sociology in satisfaction of the dissertation requirements for the degree of Doctor of Philosophy.

Professor Victoria Pitts-Taylor

Date

Chair of the Examining Committee

Professor John Torpey

Date

Executive Officer

Professor Barbara Katz Rothman

Professor Jessie Daniels

Professor Setha Low

THE CITY UNIVERSITY OF NEW YORK

Abstract:

**“BANDING TOGETHER:”BIOSOCIALITY, WEIGHT LOSS SURGERY,
AND NEOLIBERAL DISCOURSES AROUND OBESITY**

By

ZOË C. MELEO-ERWIN

Advisor: Victoria Pitts-Taylor

Drawing on post-structuralist and feminist theories about the relationship between knowledge, power, bodies, health, and subjectification, in this dissertation I critically analyze the experience of individuals who were medically diagnosed as obese or morbidly obese and underwent bariatric (weight loss) surgery. During the late 20th and early 21st century, the United States saw an explosion of discourse and anxiety about rising population body weights. In national public health addresses, obesity was commonly referred to as a threat to the nation state. During this same time period, anti-fat stigma significantly increased and the number of bariatric surgeries performed skyrocketed. I argue that these concurrent phenomena must be understood within a neoliberal political-economic and healthist context in which ‘proper’ citizenship is held to involve ‘proper’ health (and by extension ‘proper’ weight). Fat bodies, within this framing, suggest ‘failed’ citizenship and moral laxity. Through the use of qualitative interviews with bariatric patients and surgeons, as well as brief participation at peer-led weight loss surgery conferences, I explore the ways in which bariatric patients take up or refute medicalized notions of fatness. I do so by examining why formerly fat individuals underwent bariatric surgery as a means of weight loss, and the physical, physiological, psychological, and social transformations involved in this process. I show that participants experienced pervasive anti-fat stigma and that this stigma operated in ways that were simultaneously discursive, emotional, and material. I argue that choosing weight loss surgery was not just a means of achieving a visually more

normal appearance, but a means by which these individuals took responsibility for their current and moreover, their future states of health. I document how, following surgery, bariatric patients reported substantial improvements in physical health as well as emotional well being. However, they also experienced significant physiological and physical side effects from both rapidly losing a tremendous amount of weight and also living with a dramatically altered digestive system. Because of this, bariatric patients effectively trade one set of embodied health concerns for another. I demonstrate that bariatric surgery not only shifts the relationship to the body but to others as well: patients must learn to both socially manage the impact of their new eating rituals and navigate the complexities of new attentions, envy from others, and criticisms for having taken the ‘easy way out.’ I argue that these new embodied and social concerns are helping produce the formation of online and in-person communities around bariatric surgery. I conclude this dissertation by documenting both the forces that help push bariatric patients together, as well as those factors that pull them apart, creating divisions within bariatric communities in the process.

Acknowledgments

In 2001 I entered a PhD program in sociology driven by questions about the ways in which leftist social movements create and recreate hierarchies and exclusions, even as they seek to challenge these very phenomena. In the end, this program did not end up being a good fit and thus, after receiving my Master of Arts, I left and began working in a public health agency. My work there involved designing a public health outreach and education campaign aimed the queer community about the dangers of smoking and secondhand smoke. It was during this time that I began to think about the disjuncture between how marginalized communities understand and experience health and how public health agencies design and wage interventions. As well, I began to think about the ways in which public health campaigns inadvertently extend stigma, rather than challenging it, by taking up normative notions of bodies and health practices. Frustrated with the limitations of what I could do in this field, I applied to the CUNY Graduate Center and in 2006 I moved to New York City to begin a new graduate career.

Without question, some of the courses I took early on, such as sociology of the body, the social construction of illness, and medical sociology helped me to channel a broad interest in social movements and public health into a more concrete research project. The professors who taught these courses, Victoria Pitts-Taylor (who would become my advisor and dissertation committee chair) and Barbara Katz Rothman not only exposed me to fascinating scholarship on the body, health, illness, and medicine but also encouraged my interest in a critical exploration of fatness. Their support helped me to find the courage to study a topic that is still, in large part, considered to be a self-evident pathological condition of the body. I am thus deeply grateful to the both of them for their guidance and encouragement to think about fatness sociologically.

This dissertation would not have happened if it were not for the unwavering support and mentorship of Victoria Pitts-Taylor. Over the years, Victoria has spent countless hours reading drafts of my work and offering advice, suggestions, and revisions. As well, she has steadfastly advocated for me during my graduate school career. I am perhaps most grateful to Victoria for her encouragement to think complexly about fatness – to neither accept fat as a pathological condition of the body nor to straightforwardly reclaim and celebrate it as a mere matter of bodily difference. Her support and advice have guided this project from beginning to end.

I am grateful to Barbara Katz Rothman for many things, but especially for giving me some of the best advice I have ever received in graduate school, which was “It’s not doing anyone any good sitting in a drawer.” By this she meant that I should not be afraid to send the papers I had written for courses out to academic journals. I took her advice and the very first paper I sent to the journal *Health* was accepted with minor revisions. Thanks to Barbara’s advice, I will be leaving graduate school with seven publications under my belt.

During my graduate career I met and took courses with Setha Low in the anthropology department. Without question I can say that my interest in the interface between flesh and environment stemmed from my experience in her class on the ethnography of space and place, something I am thankful for. I am also indebted to her for approving my registration into her highly popular anthropology mini courses on interviewing and on fieldnotes. In these classes I received key training on the nuts and bolts of qualitative research, and perhaps more importantly, I was exposed to critical discussions on the ethical issues entailed in such work.

My sincere thanks also go to Jessie Daniels. Over the years, she has provided guidance on research projects we both worked on, has helped me secure employment, has read drafts of my work and offered suggestions for revision, and has offered endless advice on every possible

facet of academic life. In all these ways and more, Jessie has helped to guide me through graduate school. She has been a tireless supporter over the years, a mentor, and a friend.

My thanks also go to the CUNY Graduate Center, the Sue Rosenberg Zalk Travel and Research Fund, the Mellon Foundation, the Interdisciplinary Committee on Science Studies, and the Institute for Research on the African Diaspora in the Americas and the Caribbean (IRADAC) for the travel, research, and doctoral support which made this dissertation possible. I am especially grateful to Juan Battle of IRADAC for helping me to keep on track throughout the dissertation writing process.

I cannot thank my family and my community for their love and support enough. I lack the words to fully express my gratitude toward my parents. All I can say is that everything I have accomplished is because of your unconditional love and faith in my abilities. A big thank you to my siblings, Carrie and Michael, for their love and support as well. My friends also helped make this dissertation possible in a myriad of ways. I am deeply appreciative of the conversations spent over brunches, coffees, dinners, and drinks about the ups and downs of graduate school. As well, I am deeply grateful to my friends outside of academia for conversations about anything but graduate school. Truly you are all my family as well.

My deepest gratitude goes to my partner, Arun Bryson. Whether it was talking me through various graduate school related anxieties, making sure I had clean clothes to wear and food to eat, or encouraging me to take breaks to get outside for some fresh air and exercise, Arun has been a tireless supporter, a wonderful friend, and a caring partner. I am also in his debt for the many hours he spent reading my dissertation and offering suggestions on how to improve it. But most especially I am thankful to him for his deep love and endless belief that I could do this.

Table of Contents

	<u>Page</u>
Abstract.....	iv
Acknowledgement.....	vi
List of Tables & Figures.....	x
Glossary.....	xi
Chapter 1: Introduction, Epistemological Framework, Methods.....	1
Chapter 2: The Terror Within.....	25
Chapter 3: “Shape Carries Story:” Navigating the World as Fat.....	50
Chapter 4: Navigating the Bariatric Body.....	89
Chapter 5: “I just couldn’t keep it in control anymore:” Bariatric surgery, food addiction, & anti-fat stigma.....	135
Chapter 6: Banding Together: The Biosociality of Weight Loss Surgery.....	165
Conclusion & Implications.....	221
References.....	230

List of Figures

Figure 1: Clinical Pearls for the Emergency Care of the Bariatric Surgery Patient.” 179

Glossary

AHRQ	Agency for Healthcare Research and Quality
ASMBS	American Society for Metabolic and Bariatric Surgery
DS	Duodenal Switch
LAP-BAND	Laparoscopic Adjustable Gastric Banding procedure
OH	Obesity Help
RnY	Roux-en-Y Gastric Bypass
Sleeve	Vertical Sleeve Gastrectomy,
WLS	Weight Loss Surgery

Chapter 1:

Introduction, Epistemological Framework, Methods

"What is the impact [of obesity], not only today, in the short term, what's [sic] the workforce implications in the future? Where will our soldiers and sailors and airmen come from? Where will our policemen and firemen come from if the youngsters today are on a trajectory that says they will be obese, laden with cardiovascular disease, increased cancers and a host of other comorbidities when they are your age and a little bit older?...Obesity is the terror within. It is destroying us and destroying our society from within and unless we do something about it, the magnitude of the dilemma will dwarf 9-11 or any other terrorist attempt..." - Former Surgeon General Richard Carmona (2006).

During the end of the 20th and beginning of the 21st centuries, the United States witnessed a significant increase in both population level average body weight and the popular, public health and medical discourse surrounding it. In 1999, Mokdad et al published findings in the *Journal of the American Medical Association* (JAMA) showing obesity had increased from 12% to 18% between 1991 and 1998. In reporting their findings, the authors referred to obesity¹ as an 'epidemic,' both in the title of their article and throughout the text.² Following this publication, articles began appearing in medical and scientific journals also utilizing the term 'epidemic' to refer to obesity (Oliver 2006).³ In 2001, the Surgeon General of the United States reported that the amount of American adults considered obese had risen to 20%. Three years later, in 2004, the World Health Organization declared obesity to be an epidemic of 'global proportions.' That same year the Centers for Medicare & Medicaid Services officially classified obesity as a disease, opening the door for reimbursement for certain weight loss interventions. And by 2010, over 35% of Americans were obese, according to the Centers for Disease Control (CDC) (CDC, 2010).

Alongside this increase in average population level body weight was an explosion of media attention devoted to covering the topic. Between 1990-2005, the *New York Times*

1 Whereas "obesity" was once a term used by nineteenth century doctors in qualitative terms (Austin, 1999), today it

2 For a critique of the Mokdad et al (1999) study design, see Oliver (2006).

3 For instance, commenting on the Mokdad et al (1999) publication, the editors of the *Journal of the National Medical Association* (JANA), stated "The growing rate of obesity across all age and racial groups in the United States has led health officials to declare the problem an epidemic" (JANA 1999: 645).

published over 750 articles on obesity, most of which occurred after 1998 (Boero, 2007). A review of Lexus-Nexus US News Sources for articles with ‘obesity’ in the headline showed a similarly rapid acceleration, with 62 such articles published in 1980 and over 6,500 published in 2004 (Saguy & Almeling 2008). Halse (2008) reports a concurrent rise in internet searches for “obesity” - within a six month period of 2008 alone, the number of Google hits increased by a million, from 32,600,000 to 33,600,000.

During this same timeframe, the language used to discuss obesity shifted within both media coverage and government public health addresses. Obesity was increasingly described in media coverage in terms of crisis, urgency, and alarm with a significant proportion of news articles using war metaphors to describe the vital need to take action (Saguy & Riley 2005). In the early 2000’s, government officials began to speak of obesity as a direct health and economic threat to the nation. In December of 2001, then Surgeon General David Satcher announced America’s “War on Obesity” to the press. Satcher stated that overweight and obesity were amongst the most pressing health issues facing the nation and cost the United States \$117 billion in 2000 alone. In encouraging Americans to take action, Satcher and former Health and Human Services Secretary Tommy G. Thompson suggested that as their patriotic duty, all Americans should lose ten pounds (Herndon 2005). In 2003, former Surgeon General Richard Carmona testified before the House of Representatives Committee on Education and the Workforce that obesity would ‘condemn’ American children to a lifetime of “serious, costly, and potentially fatal medical complications” (Carmona 2003). Linking obesity with diabetes, he noted that diabetes cost the United States \$132 billion annually. Three years later years later, Carmona referred to obesity as “the terror within” that would destroy the United States. He stated, "Unless we do something about it, the magnitude of the dilemma will dwarf 9-11 or any other terrorist

attempt” (Carmona 2006). And in 2010, over 150 United States Admirals, Generals, and other senior leaders (Mission: Readiness) issued a report entitled “Too Fat to Fight: Retired Military Leaders Want Junk Food Out of America’s Schools.” Linking obesity to a military crisis, the authors concluded, “If we don’t take steps now to build a strong, healthy foundation for our young people, then it won’t just be our military that pays the price – our nation as a whole will suffer also” (Christeson et al 2010: 1).

While discursive representations of obesity as an escalating epidemic are commonplace, in fact a great deal of debate surrounds obesity research. For example, leading CDC obesity researcher Katherine Flegal contests the use of the term ‘epidemic’ to describe changes in population level weight over time (Bartoshuk 2010). Flegal disputes the notion that the United States saw a relatively recent sharp spike in mean body weight and argues instead that this has been a gradual increase over a longer period of time. She states: “Data dating back to the Civil War, though limited, suggests that weight has been increasing fairly steadily ever since and increasing at a slower rate now than it did in the last half of the 19th century. A broader perspective then would suggest that the current trends in obesity are a further manifestation of this longer-term trend and not a sudden outbreak of a disease” (Bartoshuk 2010: 2). More recent research by Flegal et al (2012) suggests that there has been no significant increase in population level weight since 1999, and that rates of obesity have actually leveled off. Wilson & McAlpine (2006) suggest that obesity research can be characterized by a lack of agreement and have documented debate around: definitions and measures of obesity; the effects of obesity on morbidity and mortality; the effects and effectiveness of treatment; whether or not weight loss improves health outcomes; whether or not weight loss can be maintained over time, and the health consequences of failing to maintain weight loss. Despite this lack of agreement, medical

and public health professionals steadfastly hold that obesity is a public health crisis and have struggled to uncover not only its causes but also the reasons why efforts at curbing it have proven unsuccessful.

In the context of both obesity-epidemic anxieties and the contested terrain of obesity research, weight loss surgeons made a bold claim: weight loss surgery (WLS), also known as bariatric surgery or obesity surgery, is the only proven method to achieve durable weight loss and also serves as an effective treatment for weight-related metabolic diseases, such as Type 2 Diabetes, hypertension, and obstructive sleep apnea (AMSBS 2005). Although the first procedures were initially developed in the 1950s (AMSBS 2005), weight loss surgery is a relatively new phenomenon. In 1996, there were fewer than 10,000 bariatric procedures performed in the U.S. (Hutter, 2006). Yet between 1998 and 2004, this number increased by 726% for individuals between the ages of 18 – 54, and nearly 2000% for patients age 55 - 64 (AHRQ 2007).⁴ Weight loss surgery is now considered to be one of the fastest growing hospital procedures (Encinosa et al 2009) and with an estimated 300 million Americans considered to be either overweight or obese, there are potentially up to 12 million people who would qualify as candidates for surgery (Hutter 2006). Moreover, in 2011, a FDA advisory panel voted to lower the BMI threshold that potential weight loss surgery candidates must meet by 5 points, potentially doubling the number of Americans who qualify for weight-loss surgery to 24 million (Pollack 2011).

Reflective of gender-based differences in dieting behavior (Davy et al 2006), women make up 84% of bariatric patients (Santry et al 2005). This is despite the fact that only 60% of individuals considered to be morbidly obese are female (Smoot et al 2006). Rates of bariatric

⁴ The dramatic increase in the 55+ age range is explained, in part, by the fact that in February of 2006, The Center for Medicare and Medicaid Services (CMS) developed guidelines, accreditation, and coverage standards for bariatric surgery.

surgery procedures per 100,000 morbidly obese individuals are highest in women aged 40-49 in the Northeastern U.S., yet this region shows the lowest national morbid obesity rates for women in every age group except 40-49 year olds, second only to the West (Poulose et al 2005).

National estimates of bariatric surgery patients by race are not well documented. The Bariatric Outcomes Longitudinal Database (BOLD), a registry of information from 57,918 self-reported bariatric surgery patients, suggests that approximately 78% of weight loss surgery patients are Caucasian, 10.5% are African American, 6% are Hispanic, .20% are Asian, and .46% are Native American (DeMaria et al 2010). Given the small sample size relative to the number of individuals who undergo surgery each year, this may not be reflective of the overall population of bariatric patients.⁵ For example, one Michigan-based study found that Black women have the highest rates of bariatric surgery, followed by white women (Birkmeyer & Gu 2012).

Bariatric procedures result in significant weight loss by virtue of their restrictive effects, in other words, they reduce the amount of food that can be consumed in a given sitting to a few ounces. Some procedures are additionally malabsorptive and reduce the amount of nutrients and fat the body can absorb. The field of weight loss surgery has a mixed history and was, until recently, considered to be on the periphery of what was considered acceptable in surgery (Hutter 2006). More than a dozen procedures have been utilized in the past with highly mixed results, including failure (weight regain), severe health complications, and death (ASMBS 2005; Hutter 2006). Today, the most commonly performed bariatric surgeries in the United States are the Roux-en-Y Gastric Bypass and the Laparoscopic Adjustable Gastric Banding procedure (popularly known by the Allergan brand name “LAP-BAND”). Less commonly performed are procedures such as the Vertical Sleeve Gastrectomy, and the Duodenal Switch. The Vertical Sleeve Gastrectomy, a somewhat newer surgery, is however gaining in popularity amongst

⁵ Estimates of annual prevalence vary, however media reports on bariatric surgery typically report 200,000-250,000.

patients who seek an alternative to the LAP-BAND procedure. The Duodenal Switch is not a commonly performed procedure because of the risks associated with it. Nevertheless, it is considered to provide the most durable weight loss results. While surgical techniques seem to be improving and complications from weight loss surgeries have decreased over time (AHQR 2009), perhaps due to the increased volume of procedures performed (Snow et al 2005), bariatric patients require lifelong medical follow-up and those who undergo malabsorptive procedures require significant vitamin and mineral supplements in order to avoid malnutrition (Chauhan et al 2010).

Given the rapidly increasing numbers of individuals undergoing this procedure and the great number of potential surgical candidates, weight loss surgery has generated great public interest and attention. The commercialization of bariatric surgery is highly visible. The Internet, in particular, has become a site of information for individuals who desire weight loss (Thompson & Heinberg 1999). In their survey of 813 weight loss surgeons, Salant and Santry (2006) found that 58% used the Internet to advertise their services. On such sites, bariatric surgery centers use surgeons' and patients' testimonials, imagery of metamorphosis, and triumph, and before and after photos to promote the idea that surgery is the only successful means of attaining weight loss for fat people.⁶ Weight loss surgery centers particularly entice potential candidates with both these narratives and images of transformation and by describing the serious health consequences of obesity, Salant & Santry argue. Moreover, these websites help prospective patients place their experiences of fatness, undergoing an invasive surgery, and a dramatic transformation, in a social context of shared experiences (Salant and Santry 2006).

⁶ Following the tradition of Fat Studies, in this text I move back and forth between the term "obesity" which I use to refer the framing of fatness as disease state (on the medicalization of fatness see Chang & Christakis 2002; Jutel 2006; Rasmussen, 2012) and the term "fat" which I use to describe an embodied state of being fat, in the same way one might use "tall" as a descriptor.

Peer-based Internet forums also attract a large number of individuals interested in pursuing weight loss. The Obesity Help website, for example, has over 600,000 members and provides information, forums based on methods of weight loss, medical conditions, and types of weight loss surgery; galleries of before and after photos; peer-based reviews of bariatric surgeons; topic-based support groups; a chat room; and a full social networking platform. Similarly, the members-only Yahoo Group "Bandsters," with nearly 13,000 members, describes itself as "the primary Adjustable Gastric Banding online support group since 1998."

In this dissertation, I argue that this increase in obesity and the discourse and anxieties surrounding it have had productive effects: Firstly, they have helped to tie notions of selfhood and citizenship to fatness, and have helped to further tie notions of citizenship to health. Secondly, they have helped to bring into being the weight loss surgery patient, with rapidly increasing numbers of individuals, particularly women, undergoing a highly transformative surgical operation in an attempt to lose weight. Finally, they have helped to form community, what Rabinow (1996) calls 'biosociality,' around the desire for both weight loss and for normativity.

Theoretical Approach and Research Context

Under what Foucault (1990) described as a biopolitical mode of governance, great focus is placed on health and vitality of the population and systems of measurement, classification, ordering, and identification allow for intervention at the mass level. These systems and interventions effectively produce some bodies as normal and others as pathological. Population-level statistics can, in this sense, be seen to constitute a technology of risk, or a "way of managing the individualization of people in aggregate classes, through the calculation of the

probabilities of certain events and the application of such calculations to individual people,” (Kirkland 2003: 46). Discourse around health and obesity can thus be seen as creating some as proper selves, bodies and citizens while simultaneously producing others as failed and pathological in the context of a free market (Crawford 1977; Crawford 1980; Johnson 2008; Metzl 2010; Pitts-Taylor 2010). Under a system of neoliberalism, defined broadly as the rolling back of government services, privatization, and a focus on individual responsibility (Petersen 2003; Pitts-Taylor 2010; Rose 2006; Smith 1998), all people are compelled to take up practices to avoid or reduce the risk associated with obesity. While some may take up these practices and techniques more fully than others, there is no “outside” of them; we are all implicated.

As Rabinow (1996) and others have argued, the increasing proliferation of biomedical truths about the body has had the productive effect of inspiring the formation of identity-based organizations and communities. These organizations and communities form around shared biomedical experiences and offer members social and emotional support, as well as a vehicle for individuals to “transform personal experiences of illness into a social problem and a political issue” (Novas 2006). The Internet can be seen as increasingly facilitating the production of such “biosociality” (Novas & Rose, 2000; Novas 2006; Rabinow 1996). Novas & Rose (2000) have argued that such participation in e-health forums constitutes a form of “digital bio-citizenship,” as individuals not only associate around biomedical categories but also actively participate in the creation of knowledge about their health conditions. Rather than the body becoming irrelevant in cyberspace, the physical body has become “*the* focus or cause of travels in virtual worlds for many individuals” (Parr 2002b, emphasis in the original). There is no clear division between online and offline biosociality, however, and “in real life” interactions both inform and are informed by those that take place online (Heath et al 1999).

Foucault's (1991) concept of "governmentality," or the "conduct of conduct," provides a useful lens through which to explore weight loss surgery. Specifically this concept can help to illuminate how bariatric patients simultaneously critique and take up biomedical labels and practices as well as provide insight the means by which they shape themselves into normative subjects (Petersen 2003). Foucault's early work focused on discipline and regulation, however, it was an interest in the processes by which individuals actively take up practices to shape themselves into normative subjects that guided his later work on governmentality. Individuals engage in those technologies of the self that are held out as means by which to attain a socially desired version of selfhood. While there is agentic choice involved in such practices, these practices still exist within larger relations of power that help to shape the subjectification process to reflect normative ideals. The subject's mode of operation is in effect "malleable through the application of proper techniques that are expertly validated and supervised" (Frank & Jones 2002).

Rose (2007b) reminds us that medicine has long been involved in the production of certain epistemologies and the governance and shaping of populations and selves. However, within a neoliberal climate of reduced government spending, medical self-evaluation and improvement as strategies to preemptively avoid risk increasingly become an obligation (Rose 2009). Further, disciplinary techniques proliferate throughout macro, mezzo, and micro levels of society and are no longer concentrated within the state. Overt forms of discipline do not entirely disappear, however, and those who "fail to comply" may become subject to increased practice of surveillance, intervention, and isolation (Petersen 2003). Moreover, even as individuals take up and incorporate self-surveillance and improvement techniques in the care of the self, they often do so according to ambivalent frameworks of interpretation and meaning

(Petersen 2003). Given that weight loss surgery involves both great physical and physiological transformation, and given that any social rewards for weight loss are necessarily entwined with the physiological side effects that are common in all forms of bariatric surgery (Sheipe 2006), weight loss surgery provides a means by which to examine this process.

Despite some significant contributions to a sociology of this phenomenon (cf Boero 2012; Chang & Christakis 2002; Jutel 2006; Saguy & Riley 2005; Salant & Santry 2006; Throsby 2007; Throsby 2008a), fat as anything other than a pathological disease state remains relatively unexplored in Sociology. For a discipline that is dedicated, in large part, to the examination of the social construction and social production of the taken-for-granted and of stratification, fatness remains something of a “black box” (Latour 1987) and well-documented anti-fat bias and discrimination (cf Puhl & Brownell 2003) has not generated much sociological attention. With a minimum of 24 million eligible patients, with bariatric surgery fast becoming one of the most commonly preformed surgical procedures in the United States (Encinosa et al 2009), and finally with women having this highly transformative surgery at rates that exceed current medical thresholds and guidelines (Poulose et al 2005), sociological explorations of the lived experience of these procedures is imperative.

Of the sociological research on fatness, only a handful of studies (Boero 2012; Fox & Ward 2006; Salant & Santry 2006; Throsby 2007; Throsby 2008a) explore how the practice of weight loss shapes identity and community. Throsby (2007) explores the entanglement of dieting regimes and subjectivity in her interview-based study of weight loss surgery patients. She notes that these individuals tended to account for their size in ways that refuted any notion of moral failure while simultaneously representing their decision to undergo surgery as a means by which to ‘take control’ of an otherwise ‘out-of-control’ body. Looking at online weight loss

groups, Fox & Ward (2006) found that the interactions between forum participants largely centered on sharing exercise tips, diets, progress reports, and the unpleasant side effects of weight loss medication. Through their participation, the weight loss seekers constructed health identities that were based in large part on the desire to act as ‘model patients,’ in line with official medical instruction about healthy bodies and lifestyles. Coleman (2010) also explores the ways in which engagement with dieting websites and is generative – however her focus is not so much on the production of identity, but rather on temporalities. Coleman argues that because dieting is not a successful one-off linear event, but rather involves repetitions of the cycle of gaining/losing/[re]gaining weight, dieting websites “attend to and at the same time [create] new kinds of dieting temporalities” (265). Finally, Boero (2012) traces key moments in the medicalization of fatness. She argues that because obesity is not actually contagious, rising concern about obesity are fueled, to a large degree, by a media and public health expert driven moral panic (Boero 2012).

Throsby’s (2008a) and Boero’s (2012) research comes closest to exploring the biosociality of weight loss. Throsby (2008a) explores the work required by former weight loss surgery patients to support the identity of the post-surgical ‘new me.’ Her interview-based research demonstrated that those who undergo weight loss surgery experienced a great deal of anxiety in attempting to hide the fact of their surgeries from others. The disciplinary work necessary to “pass” was often based on information and tips collectively shared in support group meetings. She argues that the communal declaration of a rebirth through weight loss surgery “signals a new form of belonging (to the bariatric community) that stands in stark contrast to the exclusion and denigration that many of those who are visibly larger experience routinely” (Throsby 2008a: 130).

In tracing the contradictions between public health framings of obesity as epidemic and individual lived experiences, Boero (2012) interviewed individuals who pursued weight loss through Weight Watchers, Overeaters Anonymous, and bariatric surgery. She found that the desire for weight-loss could not be separated from normative ideas of gender, race, class, and sexuality. In addition, she found that the hope for bodily normativity, rather than seeking improved health outcomes, drove the desire for and pursuit of weight loss. Looking specifically at weight loss surgery patients, Boero argued that weight loss surgery community is built on the stigmatizing experience of having lived as a very fat person, the desire for or experience of having had weight loss surgery, and the process of learning to live in thinner and externally more normal body that is also highly surgically altered. Further, weight loss surgery communities are places in which women in particular learn to “negotiate a world of normative gender and sexual expectations that they had previously been outside of by virtue of their fatness” (Boero 2012: 104).

Heyes (2006) argues that feminists have tended to view dieting through the lens of Foucault’s earlier work on “docile bodies.” She contends that the practice of weight loss must also be examined in light of Foucault’s later work on practices of the self – or the ways in which individuals constitute and reconstitute themselves according to preexisting modes of intelligibility and identification. Such a focus, she continues, allows us to see weight loss practices as not only disciplinary but also enabling, or productive. That is, instead of seeing weight loss practices in terms of ‘false consciousness,’ we might instead understand that these practices help to create certain kinds of selves. Walkerdine (2008: 203) has called for scholarship on fatness that explores the question “how is the pathologized body lived?” Finally, Doyle & Roen (2008) suggest that a gap remains in the sociological literature on “how surgery,

as a set of discourses, has become central to the mediation between body and psyche in cultural understandings and individual experiences of embodied subjectivity.” This dissertation seeks to address these gaps by exploring the ways in which weight loss surgery patients discuss their experiences.

In this work I examine the ways in which the experience of having both been medically classified as obese and then undergoing bariatric surgery may be seen as an axis around which some individuals interact, create identity, and form community. The exploration of this phenomenon is specifically guided by the following questions: Why individuals would seek community around the very stigmatized and pathologized bodily state they desire to leave behind? Why do some who have had weight loss surgery form identities around what would seem to be a transitional bodily state? In what ways do such identities and groups affirm and/or unsettle dominant discourses around obesity and weight loss? And finally, what does weight loss surgery, during a period when fatness is considered to be an epidemic and a crisis to health care, national security and life itself, tell us about the production of bodies, selves and identities in the United States under neoliberal capitalism? These questions, pertaining to broad themes of responsibility, authority, social acceptance, subjectivity, health and disability, aesthetics and body image, and built environment, guide my dissertation research.

Methodological Approach

Because different research methods rely on and impose different views of the social world, qualitative research is often best produced through triangulation, or the integration of different methods (cf Alford 1998; Berg 2009). My dissertation work thus integrated semi-structured interviews, brief participant observation, and a close reading of official public health

documents on obesity. I also rely on a Post-Structuralist and feminist framework. I do not claim to offer a complete account of weight loss surgery. Rather I use a critical, interpretative framework to trace the shift that takes place for bariatric patients from a highly stigmatized bodily state to what I see as a passing, normative one. By examining how bariatric patients discuss this shift, I explore how notions of selfhood and community become tied to not only durable bodily conditions but also liminal, transitional, and surgically transformed states as well. As well, I explore how relationships between transforming the fat body, subjectification, and community are fully embedded in neoliberal relations of power.

Semi-structured interviews

As my primary research method, I conducted 32 semi-structured face-to-face and telephone interviews, primarily in the greater New York City area between June and December of 2011. Twenty-one interviews were conducted face-to-face in locations chosen by participants, and eleven were held by telephone. Interviews averaged 60 minutes in length, were digitally recorded with permission of the participants, and were professionally transcribed. In this work pseudonyms are used to protect the confidentiality of the participants. An initial call for research subjects was sent to weight loss surgery online patient forums and, from there, the recruitment proceeded by means of a non-probability, snowball sample design.⁷ Bariatric surgeons were approached by contacting their home bariatric surgical centers directly with a formal request for an interview. I approached four bariatric surgical centers in this manner and was granted interviews at two of them with the lead surgeons at those facilities.

⁷ Within social science research, snowball samples are considered to be limited because of low validity and the fact that they are not generalizable. However, this methodological design is useful in observing shared cultural codes within communities of interest (Pitts 2003: 19). Given that this dissertation specifically seeks to examine community, this sampling strategy proved to be very useful.

Of the thirty weight loss surgery patient research participants, all were post-operative: six had had the Roux-en-Y Gastric Bypass; nine had the LAP-BAND procedure; nine had the Duodenal Switch, and two had Vertical Sleeve Gastrectomy. Three patients had revision surgeries: first had a revision from LAP-BAND to the Vertical Sleeve Gastrectomy, the second had a revision from the Roux-en-Y to the Duodenal Switch, and the third revised her LAP-BAND to a Duodenal Switch. Finally, one patient had her LAP-BAND removed entirely. At the time of the interview, individuals were between six months and twelve years out from surgery. Of the patient participants, twenty-seven were female and three were male. Twenty-two identified their race as Caucasian; five as Hispanic; two as African-American, and one as a multi-racial Alaska Native. The average age for these participants was 40, with ages ranging from 19 to 71. The age group with the largest number of participants was 30-39. Three participants had a high school education, eleven had attended some college courses, nine had graduated from college, and seven had post-graduate degrees. Twenty-six patient participants identified their sexual orientations as heterosexual, two as lesbian, one as gay, and one as bisexual. Nineteen individuals lived in the New York City and Greater New York City Metropolitan Area, one lived in the Mid Atlantic, three lived in the Southeast, three lived in the Central South, two in the Upper Midwest, one in the Central West Coast area, and one in Alaska. The two bariatric surgeons that were interviewed practiced in the Greater New York City Metropolitan Area at Bariatric Centers of Excellence, one on Western Long Island and one in central Manhattan.

Based on my theoretical literature review, I identified seven domains around which I structured interview questions: responsibility, authority, social acceptance, subjectivity, health and disability, aesthetics and body image, and the built environment. In the interviews, I

attempted to assess the embodied lived experience of both fatness and weight loss surgery with particular attention to the use of and importance of online and in-person bariatric support groups, forums and events. Examples of questions from the interview protocol for bariatric patients include:

1. How did you decide to have weight loss surgery?
2. How are you physically adjusting to the procedure now?
3. How are you psychologically adjusting to the procedure now?
4. How did the people in your life respond to your weight loss?
5. Before you had your surgery, did you consult any online sources of information?
6. Did you ever participate in weight loss surgery community groups?
7. What changes, if any, do you see in yourself since you had your WLS?
8. What changes, if any, have occurred in your social life since you had WLS, if any?

Examples from the interview protocol for bariatric surgeons include:

1. What lead you to become a bariatric surgeon?
2. What are the differences between bariatric surgery and traditional weight loss programs?
3. Beyond physical changes, do you think patients change following surgery? If so, how?
4. How important do you think support groups are before surgery? Afterward?
5. What do you think the cause of regain following surgery is? How common is regain?
6. What are the rewards of doing this work? What are the challenges?

The protocol served as a guide but did not limit emergent themes and discussion during the interviews.

Participant-observation

Obesity Help (OH) is a self described 600,000+ member strong organization devoted to “the education, empowerment and support of all individuals affected by obesity, along with their families, friends, employers, surgeons and physicians” (www.obesityhelp.com). In addition to hosting a website that provides information, chat forums and a social-networking platform, OH holds several weekend-long events throughout the year at which members, almost exclusively made up of individuals who have had or who are planning on having weight loss surgery, may

spend a concentrated period of face-to-face time with similarly-situated others. Obesity Help describes these conferences as places where members can attend workshops, lectures, network at social functions, and become more involved with the organization (www.obesityhelp.com).

I attended two such conferences as a participant. At both conferences I attended panels, workshops, as well as evening dances and fashion shows. At one of the events I also attended a pre-conference continuing education training entitled “Understanding the Obese Patient.” The first conference was in early September of 2011 in New Orleans, Louisiana and the second was in late October of 2011 in Long Island, New York. By spending time at one of these events with other attendees, I sought to better understand how individuals at both conferences position themselves in relation to bariatric surgery. As well, I sought to trace how medicalized discourse and anxieties over obesity travel, are reaching, and are taken up by fat individuals in different ways. In taking fieldnotes, I paid particular attention to noting expert and patient discussions of health, the body, selfhood, and community.

Document Analysis

Discussions of obesity, health, and weight loss surgery cannot be understood outside of the larger social and political context in which obesity and weight loss surgery occur. As this dissertation explores neoliberal discursive linkages between weight, health, and citizenship, the anxieties over these linkages, and the degree to which these linkages are taken up by bariatric patients, it was key to examine how official United States public health agencies discussed obesity. To do this I analyzed key Centers for Disease Control, National Institutes of Health, and Office of the Surgeon General documents on obesity published between 2001 and 2010. Although connections between proper bodies and proper citizenship, particularly where weight is concerned, certainly

predate the early 21st century (cf Schwartz 1986), I chose 2001 as a starting point for two strategic reasons: First, this was the year the Surgeon General's report "Call to Action to Prevent and Decrease Overweight and Obesity" was released. Second, 2001 was also the year in which then Surgeon General David Satcher announced a "War on Obesity." The year 2001 can thus be seen as a key moment in framing the fight against obesity as both a national priority and a responsibility of proper citizenship.

Data Analysis

The data were analyzed by means of discourse analysis. Discourse can be seen as "sets of deep principles incorporating specific grids of meaning which underpin, generate and establish relations between all that can be seen, thought and said" (Shilling 2003: 66). For this work I follow Gill's (2000: 188) definition of discourse analysis as a "careful, close reading that moves between text and context to examine the content, organization and functions of discourse." As Gill argues, language is not just descriptive, but evaluative – it contains assessments about the social world that are highly ideological. Further, language can be seen as a productive social practice – it shapes both the social world and subjectivity, helping to bring things into being. In exploring discourse around a given phenomenon, a researcher thus asks what 'work' is being accomplished. Because language is "always occasioned" (Gill 2000), discourse analysis does not seek to identify universal processes. Rather, the examination of language used to discuss a given topic must be situated within a discussion of the social context in which discourse occurs. Finally, discourse analysis sees the social world as characterized by conflict. In using this method, therefore, the researcher examines how language is often designed to be persuasive and to serve as a potential solution to a problem. However, as I argue in this dissertation, ideas about

fatness and experiences of living in fat bodies are not merely shaped by the discursive. Rather, they operate through the circulation of emotions and at the interface between the material body and the built environment. Thus, in analyzing the data, I also paid particular attention to references to emotion, the physical and the physiological body, and the material world.

In conducting an analysis of the data, I used the cloud-based internet software Dedoose (www.dedoose.com). Data were first examined inductively, looking for emergent themes (Charmaz 2006; Gill 2000; Glaser & Strauss 2009). I then revisited the data in accordance with my initial theoretical and empirical domains of responsibility, authority, social acceptance, subjectivity, health and disability, aesthetics and body image, and the built environment, paying attention to how these topics were discussed vis-à-vis obesity and weight loss. Following Gill (2000) I not only looked for patterns but for variability, paying particular attention to exceptions and differences. As well, I looked for both what was said and what was not said. As Gill (2000) notes, silences are as informative as that which is articulated; they can be a clue into the discursive limits of what can be said. Finally, following Weis & Fine (2000) and Walkerdine (2009) I was cognizant of the tendency to over focus on themes victimhood and/or resistance and agency, and attempted to pay attention to complexity, contradiction, multiplicity and unexpected emergences.

Structure of Dissertation

This dissertation is structured into seven chapters. In chapter two, I elaborate the discussion begun in this chapter on the theoretical and conceptual framework for this work. I situate my work within a Poststructuralist tradition that explores the relationships between knowledge, power, bodies, health, and subjectification. In this chapter I review the rising

national public health concern over obesity, critically analyzing the rhetorical and affective impact of the framing of obesity as a threat to the nation state. I argue that within a neoliberal economic and healthist context wherein citizens are held to be responsible for maintaining good health, fat bodies are seen as markers of moral laxity and failed citizenship. Fatness, in effect, is framed as a deliberate choice to disregard the rules (Guthman 2009). But as I show in this chapter, discourses and anxieties around fatness and risk get attached to particular bodies. Moreover, discourses and anxieties around obesity are expressed through older sedimented discourses and anxieties around race, class, gender, and disability. Thus, while anti-fat stigma is often justified as concern over health and well being, it also works to further marginalize already oppressed populations.

In chapter three, I examine the rise of anti-fat stigma that has occurred in the United States alongside concurrent rises in population level body weights and in bariatric surgery procedures. I provide an overview of how anti-fat discrimination operates interpersonally, structurally, and environmentally. I then discuss the impact of anti-fat stigma on fat individuals with reference to my semi-structured interview data. As I show, participants reported pervasive anti-fat stigma, which shaped their interactions and relationships with friends, family, employers, medical providers, strangers, and the built environment. Although participants did internalize the fat hating messages they received to some degree, as I detail in chapter three, they also adopted creative ways to avoid and sometimes confront anti-fat stigma in their lives. Following Ahmed (2004) I suggest that anti-fat stigma operates not just discursively, but through the circulation of emotion. Specifically, I argue that the fear and hatred of fat expressed in anti-fat stigma works to form borders and boundaries between subjects and collectivities along the lines of health and responsibility. In chapter three I also discuss the ways in which anti-fat stigma is

also a strongly material process. Participants often reported the strongest feelings of shame around their bodies when they experienced a ‘misfit,’ in Garland Thomson’s (2011) term, between their bodies and the material world. I discuss the strategies participants used to navigate environment exclusions and to avoid stigma, anxiety, and physical pain. I also describe the ways in which this misfitting between body and world lead to isolation. I conclude chapter three with a discussion of how both anti-fat stigma and health concerns shape participants’ decisions to have weight loss surgery. I highlight the ways in which concerns over health were expressed with reference to a future temporality – weight loss surgery became a means by which to act now to avoid future morbidity and early mortality.

Chapter four traces the psychological, emotional, social, physical, and physiological shifts participants undergo in having bariatric surgery. As I discuss, all participants reported improvements in health and well being following their surgeries. In addition, they expressed great relief and joy at becoming ‘normal’ and no longer experiencing the widespread anti-fat stigma and built environment exclusions. Most described weight loss surgery as the ‘best decision’ they had ever made and many expressed a wish to have had surgery sooner. Yet, as I detail in this chapter, because of the physiological and physical side effects of weight loss surgery, participants can at best be seen as passing for normal. This is because daily life with bariatric surgery involves contending with very particular relationships with a surgically altered digestive system and very particular relationships to food. As well, the rapid weight loss caused by bariatric surgery results in a significant amount of loose skin – something that most bariatric patients cannot afford to address with reconstructive plastic surgery. Chapter four thus explores the ways in which the anxieties and calculations about navigating the world as fat do not disappear after bariatric surgery, but rather shift. Participants must now navigate the

particularities of their new digestive systems (something made all the more challenging in social meals) and new body image concerns. As well, as these participants come to realize, having weight loss surgery shifts more than the individual body – it shifts relationships with others as well. Participants must therefore learn to navigate the complexities of new attentions, the envy of others, and finally criticisms for having had weight loss surgery rather than losing weight through dieting and exercise. All of these processes lead bariatric patients to question whether or not they are the same people as they were before surgery.

In chapter five I address the problem of regain that is increasingly becoming understood as common with bariatric surgery. I review recent neuroscientific research which suggests that both obesity per se as well as regain following weight loss surgery can be understood as due to ‘food addiction’ that stems from neurochemical and neuroanatomical anomalies. Bariatric surgeries thus fail, according to this new research, because they take as their target the digestive system rather than the brain. While it would seem that the development of (currently experimental) anti-obesity treatments, such as deep brain stimulation, as well as new pharmaceutical treatments, might serve as a challenge to the bariatric profession, as I argue in this chapter, this is currently not the case. Bariatric surgeons frame bariatric procedures as tools that patients must work with in order to effectively maintain weight loss. Because of this, when patients regain weight, the bariatric profession generally holds that it is not that the surgery that fails the patient but rather, the patient that fails the surgery. Moreover, as I detail, there is evidence to suggest that the bariatric profession is looking to neuroscientific research on food addiction to develop better screening tools to sort and potentially weed out patients likely to ‘fail’ these procedures. The bulk of this chapter explores how participants took up the notion of food addiction when discussing their decisions to have surgery. As I discuss, while patients did not

take up the concept of food addiction in a fully neuroscientific sense, they did discuss their pre-surgical fat bodies with recourse to an uncontrolled eating that bariatric surgery helped them to reign in. Having bariatric surgery, for these participants, was not only an act of medical necessity but one of taking responsibility. However, participants state that after having bariatric surgery they are not freed up from struggles with compulsive and uncontrolled eating. Echoing the bariatric profession, they describe their surgeries as tools they must work with in order to avoid complications and regain. As I argue, when participants describe the daily hard work that was part and parcel of living with weight loss surgery, they do more than accurately describe the realities of living with these procedures. Rather, they refute the notion that bariatric surgery was the ‘easy way out.’ In this sense, I suggest, referencing the hard work involved in weight loss surgery becomes a means by which bariatric patients demonstrate proper subjectivities as they work toward proper bodies.

In chapter six I discuss the new sites of kinship and community that have formed around bariatric surgery. I detail how the common experiences of having been medically diagnosed as morbidly obese, having had weight loss surgery, having lost a significant amount of weight, contending with the social shifts that follow such weight loss, and living with the embodied particularities that are endemic to these surgeries leads to the desire to connect with similarly situated others. I further discuss how three very particular issues that help to form these new sites of kinship. First, peer-led bariatric communities become necessary because weight loss surgery patients lack ongoing, professional medical care and information that is particular to their bodies. In effect, patients must create this for themselves. Second, online and in person bariatric communities become sites in which patients collectively work to avoid regain by trading tips and advice and by reaffirming the need to make the ‘right choices.’ Third, bariatric

communities serve as sites in which patients learn to collectively negotiate anti-weight loss surgery stigma – specifically the notion that by having surgery, patients have taken the ‘easy way out.’ However, just as these factors push bariatric patients, other factors pull them apart, creating divisions within bariatric communities in the process. Chapter six thus details the reasons behind the formation of surgery-specific subgroups, tensions around access to reconstructive plastic surgery, and frictions around original starting weight. I conclude this dissertation in chapter seven with a discussion of what this work contributes to the sociology, feminist, disability studies, and biosociality literatures.

Chapter 2:
The Terror Within

Questions about what constitutes health and healthy living are intrinsically political questions that call for new forms of analysis appropriate to the times. (Petersen et al 2010: 397)

Whenever citizenship comes to look like a question of the body, a number of processes are being hidden. (Berlant 1997: 36)

There is general agreement amongst scholars who critically examine fatness that obesity discourse changed during the late 20th century. More specifically, in the 1990s the United States saw an explosion of public health, medical, and media reports about fatness as an epidemic disease that, if left unchecked, would cause great harm to the physical, economic, and military health of the nation (Biltekoff 2007; Boero 2012; Greenhalgh 2012; Lawrence 2004; Oliver 2005; Rail et al 2010; Wright 2009). In this dissertation I explore the way in which weight loss surgery patients take up or refute such anti-fat discourses and anxieties. However, these narratives and experiences must first be understood in the larger historical and socio-political context in which they occur. Thus, in this chapter I review this rising concern over obesity in the United States.⁸ Following the work of Foucaultian scholars who have argued that obesity epidemic discourse should be seen as “productive” (Guthman 2009; Greenhalgh 2012), I argue that such discourse can be seen as mode of neoliberal governance that helps to tie subjectification, community, and notions of citizenship to ‘proper health’ and ‘proper bodies.’

A brief genealogy of obesity as an epidemic threat

Concerns about obesity greatly increased during the late 20th and early 21st centuries, in part in response to the release of two reports which claimed that there had been a substantive and continued rise in population level body weight since the 1970s (Biltekoff 2007; Wright 2009).⁹

8 The medicalization of obesity has been well covered elsewhere (cf Austin 1999; Boero 2012; Chang & Christakis 2002; Jutel 2006; Oliver 2006) and thus is not a focus of this chapter.

9 National concerns with the weight of the population can be traced back to World War I. For instance, Schwartz (1986) holds that during World War I, fat people were portrayed as putting the United States at risk for alleged

In 1994 when former U.S. Surgeon General C. Everett Koop launched his “Shape Up America” campaign, he reported that obesity had become the second leading cause of death in the United States, following smoking, and resulted in the death of 300,000 Americans annually. Urging the nation to pay heed to the threat obesity posed to America’s future he stated, “An intensified focus on achieving and maintaining a healthy weight is essential to reducing the risks that threaten the lives and future health of many Americans. Elevating the issue of healthy weight must become a new imperative to which we devote the intelligence and resources of our communities and our nation” (Office of the Surgeon General 1994). Following Koop’s statement, an explosion of media stories then repeated this statistic and reported that obesity that was costing the nation millions in both unnecessary health care expenses and lost labor due to employee sick time (Biltekoff 2007; Gaesser 2002; Oliver 2005).

In 2004, CDC researchers Mokdad et al (2004) published an article in the *Journal of the American Medical Association* in which they increased Koop’s estimate. They reported that obesity related deaths had climbed to 400,000 per year (cited in Guthman 2011). Interestingly, one year later different CDC researchers, Flegal et al (2005), challenged the Mokdad et al (2004) study, provoking great controversy within the agency in the process. After reanalyzing the data by using age adjusted mortality rates, Flegal et al reduced this number to a mere 26,000. They further demonstrated that the risk of death for those in the ‘overweight’ BMI category was actually lower than the risk for those in the ‘normal’ category (Guthman 2011). In commenting on the Flegal et al (2005) findings, chief CDC scientist Dixie Snider is reported to have said,

overconsumption of scarce food resources. President Hoover headed a campaign for domestic food conservation that equated individual excess with treason (Chang & Christakis 2002). McPhail (2009) demonstrates a growing panic over fat men’s bodies during the Cold War in Canada. She argues that during this period of high immigration rates and a shift toward white collar work, fat men were discursively portrayed as symptomatic of Canada’s vulnerability to nuclear annihilation and the demise of the white, middle class, heterosexual nuclear family. Although such concerns extend back to at least the early 20th century, they dramatically intensified during the late 20th and early 21st centuries (Boero, 2007; Jutel 2006; Greenhalgh 2012).

“We cannot and should not let this discussion of scientific methodology detract from the real issue” (Guthman 2011; Washington Times 2005). And although the CDC controversy was picked up by the media, news articles continued to report that obesity resulted in somewhere in the range of 300,000 - 400,000 excess deaths annually (Biltekoff 2007).

In the early 2000’s, public health leaders and other government officials began to explicitly link notions of civic duty to weight control, fitness, and personal responsibility for health in public addresses.¹⁰ In 2001, former Surgeon General David Satcher declared America’s “War on Obesity.” That same year, then Secretary of Health and Human Services Tommy Thompson suggested that as a patriotic gesture, all Americans should lose ten pounds (Herndon, 2005; Biltekoff 2007). In 2003 speech, President Bush emphasized the national importance of Americans making individual healthy choices. He stated that while the federal government would take care of reforming national healthcare, including Medicare, “...one of the best reforms in America for health care is a strong, preventative health care program that starts with each American being responsible for what he or she eats . . . drinks . . . whether or not they get out and exercise. . .” (Quoted in Biltekoff 2007: 43). By 2005, two states had implemented “BMI report cards” for school children, and legislators in twelve additional states had proposed similar measures (Biltekoff 2007). In 2006, then Surgeon General Richard Carmona made explicit links between the September 11th attacks on the World Trade Center, terrorism and obesity. Carmona referred to obesity as the “terror within.” He stated: “It is destroying us and destroying our society from within and unless we do something about it, the magnitude of the

¹⁰ It is important to add that obesity as a public health crisis was not taken up evenly amongst official public health agencies. For instance Boero (2012) argues that it was not until the third, 2010, edition of the *Healthy People* series that the Department of Health and Human Services included obesity as a Leading Health Indicator (LHI). She notes that the inclusion of obesity as a LHI was highly influenced by the American Obesity Association (AOA) and the North American Association for the Study of Obesity (NAASO). Both organizations have been highly effective in lobbying for a disease model of obesity. While *Healthy People* may have been slower to adopt obesity as a problem for public health, the groundwork was nevertheless laid in the first, 1979 edition which had a strong emphasis on ‘unhealthy behaviors’ and ‘lifestyle choices’ as major contributors to U.S. mortality (Galvin 2002).

dilemma will dwarf 9-11 or any other terrorist attempt...” (Carmona 2006). Despite the dangers that it posed, Carmona also argued that fight against obesity could be winnable through the combined efforts of America’s citizenry (Biltekoff 2007). Finally, in 2010, over 150 United States Admirals, Generals and other senior leaders (Mission: Readiness) issued a report entitled “Too Fat to Fight: Retired Military Leaders Want Junk Food Out of America’s Schools.” The authors of the report warned, “If we don’t take steps now to build a strong, healthy foundation for our young people, then it won’t just be our military that pays the price – our nation as a whole will suffer also,” (Christeson et al 2010: 1).¹¹

During this same period of time, official public health agencies also increasingly identified the built and food environments as contributing to the obesity epidemic. In official publications and on websites, the Office of the Surgeon General, the CDC, and the NIH all indicated that some of root causes for the obesity epidemic could be found in the corporate food environment – which makes inexpensive, high caloric but nutritionally poor food readily available – as well as an improperly maintained, unsafe built environment that discourages physical activity. Addressing obesity at the national level was therefore seen to involve addressing these external causes through policy. For example, in a 2009 report the CDC summarized this strategy thusly: “healthy policies → healthy environments → healthy behaviors → healthy people” (Keener et al 2009: 1). These agencies further suggested that this health-harming external environment shapes human biology in such a way that obesity is the pathological result. Therefore, in addition to health policy, advances in epigenetics,

¹¹ While fatness is seen in public health addresses and in popular media reports as a threat *to* the nation, ironically in leftist rhetoric, fatness is portrayed as symbolic of the threat *from* both the nation state and capitalism. This can be witnessed in any leftist political cartoon in which Uncle Sam, state troopers or Wall Street executives are portrayed as very fat white men, usually in contradistinction to very thin brown people portrayed as oppressed immigrants and laborers. Thus fatness serves as a fluid political metaphor for decline and danger in contemporary American discourse.

neuroscience, cell biology, metabolism, and other areas were called for. As the NIH argued in its 2011 *Strategic Plan for NIH Obesity Research*, new scientific research will help to “improve our understanding of fundamental biologic pathways involved in weight regulation – and what goes awry in obesity” (NIH 2011: V).

Despite this environmental focus, however, the language of personal responsibility remained. In some official reports by these agencies, particularly the Office of the Surgeon General, officials continued to make explicit linkages between personal responsibility for weight, health, and civic duty. For instance, the 2001 *Surgeon General’s Call to Action to Prevent and Decrease Overweight and Obesity* states “...each one of us as an individual must understand that we are called upon to act...” (XI). In her 2010 *Surgeon General’s Vision for a Healthy and Fit Nation*, Surgeon General Regina M. Benjamin stated “I am calling on all Americans to join me in a national grassroots effort to reduce this trend [increasing rates of obesity].” A healthy nation, in this sense, relies on the health of each of its citizens (Galvin 2002).

Gard & Wright (2005) make clear that there is nothing incommensurate in simultaneously emphasizing environmental causes of obesity and individual responsibility for combatting it. They argue that obesity epidemic rhetoric in the public health, media, and private sectors which takes up discussions of the food and built environments repeats a long-standing tale about Modernism – namely that of Western decline and decadence. In effect, advances in technology and increased overall affluence have led to effortless modern lifestyles that encourage excess consumption and discourage physical activity. This notion is most present, they suggest, in discussions of childhood obesity wherein contemporary children are portrayed as ‘couch potatoes,’ mindlessly consuming junk food while watching television. In this sense, Gard & Wright argue, an environmental focus on obesity does not delink notions of personal

responsibility and health. Rather, it further ties notions of civic responsibility to the avoidance of risk. They suggest that, because the problem is modern life per se, we are all implicated. We are all either already obese or at risk of becoming so. And, in a climate of pervasive risk, expert knowledge providing advice on how to control that which has ‘gone awry’ becomes key. To not follow expert advice, they argue, is therefore to invite blame for not taking responsibility. As I discuss later in this chapter, the focus on individual responsibility for health in the face of pervasive risk is a hallmark of neoliberal economic policy.

Risky fat bodies

Greenhalgh (2012) suggests that during the late 20th and early 21st centuries, the United States underwent a major cultural shift in discursive representations of fatness— moving from a representation of larger bodies as indications of moral abjectness to fat bodies as risky and biologically pathological. Importantly, she argues, these newer notions of fatness did not replace older moral conceptualizations. Rather, they built upon them. In this sense, as Rich and Evans (2005) argue, discourse around population level risk simultaneously suggests the need for intervention and classifies behaviors as either good/right/normal or bad/wrong/risky.¹²

Importantly, because of the etiological and epidemiological uncertainty that surrounds obesity, because excess caloric intake and lack of exercise remain the prime culprits for rising population body weights, and because we are all potentially at risk, threats to American health and waistlines seem to be everywhere and nowhere. Obesity epidemic discourse thus produces a pervasive sense of threat¹³ and suggests that the danger of becoming obese may lurk “within the

12 Such a construction of fat individuals as not only pathological but as social irresponsible is, at least in popular discourses, thoroughly entangled with notions of fatness as disgusting and repellant.

13 The mid-late 2000s also saw the publication of a series studies linking obesity with the decline of the planet itself. In their 2006 article Blair & Sobal calculated what they believed to be the impact of excess weight on the

most mundane aspects of daily life in the U.S.” (Biltekoff 2007: 34). For instance, in 2007 Christakis & Fowler argued that obesity spreads via social networks. Because people are connected, they argued, their health outcomes are connected. Researchers have since challenged the results of this study by pointing to a number of methodological and inferential flaws (cf Lyons 2011; Noel & Nyhan 2011). Nevertheless, media stories, YouTube videos, and Ted talks which took up this notion of obesity as ‘contagion’ affectively and effectively helped to drive home the point that risk factors for obesity lurk everywhere. Each one of us, therefore, has a responsibility to be ever vigilant.

While adult obesity remains a top concern for national public health agencies, Gard & Wright (2005) argue that childhood obesity has become a particular source of anxiety about the future. Public health initiatives have shifted much of their focus to childhood obesity (Evans et al 2004; Kohn et al 2006) for two primary reasons: 1) As with the adult population, obesity rates were held to be on the rise for children (Thorpe et al 2004); and 2) Some look to targeting children as a way to prevent high rates of future adulthood obesity (Gable & Lutz 2000). Anxieties about both pervasive risk and the future impact of childhood obesity are perhaps best exemplified in the Mission: Readiness report, *Too Fat to Fight*. The authors state: “...the U.S. Department of Agriculture’s (USDA) recent school nutrition study showed that high-calorie, low-nutrition foods and beverages that are obtained and consumed at school contributed 89 calories to the daily energy intake of school children. That may not seem like many calories, but as David Wallings noted in a *Health Affairs* article, ‘Over ten years, an extra 130 calories per day

planet based on then current rates of U.S. obesity (Cited in Guthman 2011). They argued that obesity was linked with both excess CO₂ admissions (released upon death) and agricultural burden (over-framing necessary to produce the excess calories fat people were assumed to consume). Also in 2006, Cafaro et al argued that moderated eating behaviors would lead to environmental protection (cited in Guthman 2011). Finally, a May 2008 study published in the *Lancet*, held that fat individuals are associated directly with global warming by increasing transportation fuel costs and by consuming more food (see Edward & Roberts 2008). Following this publication, the British tabloids featured headlines such as “Fatties Cause Global Warming” (see Jackson 2009).

(less than what is in a twelve-ounce can of sugared soda) can spell the difference between a young child on her way to obesity and one who is not” (Christeson et al 2010: 5).

While this dissertation does not focus on the impact of obesity epidemic discourse on youth, I include the discussion above to make the following point - public health interventions targeting children are legitimized not simply by *current* fears and concerns, but rather by calculations of risk and by expert knowledges that warn of undesirable outcomes in the *future*, lest action be taken (Petersen & Lupton 1996). In this sense, public health initiatives around obesity promote a generalize climate of risk and suggest that interventions should be waged in a largely preemptive manner.¹⁴

As an intervention, researchers and government bodies have linked together broad-based surveillance and education programs as well as calls for personal responsibility. For example, The Office of the Surgeon General (2001) states that individuals, families, communities, schools, worksites, health care, media, industry, organizations and government all have a role to play in curbing obesity. Government and public health initiatives do not promote a shame-based approach to obesity reduction in these programs, and in fact often at least parenthetically warn against anti-fat stigma. Nevertheless, the responsible citizen in such initiatives is framed as the “citizen in good health, the metaphorically ‘fit’ citizen, who does not inflict (self-created) problems on health care” (Elliot 2007: 140) and the economic and physical health of the nation state. As I describe below, within a system of neoliberalism the notion proper citizenship has become increasingly linked to a notion of proper health.

Importantly, these initiatives are not particular to the United States. Government officials in the U.S, U.K., Canada, Australia, New Zealand, Hong Kong, and Singapore have instituted

¹⁴ Beck (2006) argues modern society should be seen as a ‘risk society’ and is characterized by living in a constant state of potential, future catastrophes that must be addressed preemptively.

interventions that similarly combine broad based surveillance, public health interventions, and public health education campaigns that emphasize personal responsibility as part of a larger national duty (Elliot 2007; LeBesco 2004; Wright 2009). The World Health Organization (WHO) also recommends a combination of instruction, surveillance and evaluation to “promote lifestyles that include a healthy diet and physical activity and foster energy balance” (quoted in Groskopf 2005: 42). Moreover, scholars have demonstrated a similarly dramatic increase in obesity discourse in Australia (Gard & Wright, 2005), England (Evans et al 2004; Evans et al 2008), and Canada (Rail 2009; Rail et al 2010). How might we understand this global trend?

In her work on the WHO’s response to obesity, Groskopf (2005) argues that interrogating the ways in which obesity is portrayed can tell us something about conditions under contemporary capitalist society. Her argument follows the Foucaultian tradition of examining seemingly self-evident notions and beliefs about society and placing them in a social, political, and historical context (Galvin 2002). Thus in the section that follows, I review how an understanding of the economic philosophy of neoliberalism and Foucault’s notions of biopolitics and governmentality provide a needed framework for understanding late 20th and early 21st century obesity discourse.

Contracting the state, expanding responsibility

Neoliberalism is a term used to describe a set of economic policies designed to serve as a fix for the economic crises¹⁵ of global capitalism in the 1970s (Guthman & DuPris 2006).

Although it is often associated with the policies put in place under former President Regan and,

15 “In the United States, the confluence of falling rates of profit under Fordist manufacture, high inflation, and the debt created by the Vietnam war, among other things, gave rise to an accumulation crisis of high magnitude, which provided fodder for the newly emerging new right and its desire to dismantle what existed of the Keynesian welfare regulatory state” (Guthman & DuPuis 2006: 440).

in the U.K., former Prime Minister Thatcher, neoliberalism's antecedents can be found in both social democratic regimes and the 'Chicago Boys' influenced economic policies of Chilean dictator General Pinochet (Bondi & Laurie 2005). Chicago school U.S. neoliberalism is generally seen to entail the expansion of free markets through economic policies such as the privatizing of government resources, deregulating interest rates, further opening up of domestic market to capital investment, minimizing labor costs, reducing taxes, and the further eliminating of regulations perceived as unfriendly to business (e.g. health, labor, and environmental protections) (Guthman 2011; Melamed 2006). A key goal of neoliberal political projects is rolling back the state by shifting public services to private, for profit, markets (Richardson 2005). The efforts of international organizations such as the World Bank, World Trade Center, and International Monetary Fund, (organizations in which the United States and United Kingdom hold great influence) were crucial in the global expansion of neoliberal policies during the late 20th and early 21st centuries. This occurred particularly through the global promotion of economic reform packages (Bondi & Laurie 2005).

Neoliberal policies are often described by supporters in terms of individual rights and freedom –the portrayal of individuals as autonomous, self-directed, and freed from the burdens of state control (Bondi & Laurie 2005). According to this political and economic philosophy, by expanding markets and providing information and advice, governments enable citizens, as active consumers, to make their own best decisions in the marketplace. However critics of neoliberal economics argue that this political practice actually combines highly authoritarian social policies with the expansion of market control over greater and greater spheres of social and political life (Bondi 2005; Bondi & Laurie 2005). By removing social safety nets and promoting market-based solutions, neoliberal policies expand notions of personal responsibility for making proper

decisions in the marketplace and avoiding risk increasingly becomes an obligation (Petersen et al 2010). Those individuals and populations who seem unable to make proper decisions are often held by neoliberal supporters to be the products of the ‘dependency culture’ of the welfare state. Neoliberal governance therefore seeks to implement interventions which, rather than providing marginalized populations with economic and social supports to alleviate suffering, encourages “their engagement with a whole array of programs for their ethical reconstruction of active citizens” (Rose 1996: 60).¹⁶ As Larner (2000), Bondi (2005) and others have argued, this form of governance is best understood in light of the Foucaultian concepts of biopolitics and governmentality.

You have only yourself to blame

Central to Foucault’s later body of work was his tracing of the eighteenth century shift from sovereign forms of power, which were openly coercive, bodily, and public, to contemporary biopolitical techniques of governance, which involve an increase in surveilling, categorizing, and interceding into the vitality of the population as a whole. Whereas sovereign power took as its focus the ability to take life, the political goal of biopower is life’s fortification. Rabinow & Rose (2006) argue that Foucault’s concept of biopower has remained conceptually underdeveloped and thus offer their clarification on the term. Biopower, they posit, “entails one or more truth discourses about the ‘vital’ character of living human beings: an array of authorities considered competent to speak that truth; strategies for intervention upon collective

¹⁶ This can be seen in Clinton’s 1996 “Personal Responsibility and Work Opportunity Reconciliation Act” which mandated that those receiving welfare assistance must work for it by participating in workfare programs (Galvin 2002). Similar policies were undertaken in Australia and England during this same period. Former British Prime Minister Tony Blair was said to have inaugurated the shift to workfare-like policies by declaring the end of the “something for nothing welfare state” (Galvin 2002).

existence in the name of life and health; and modes of subjectification in which individuals work on themselves in the name of individual or collective life and health” (195).

Foucault notes that the “phenomena addressed by biopolitics are, essentially, aleatory events that occur within a population over a period of time” (Foucault 2003, quoted in Harwood 2009: 22). Importantly, therefore, biopolitical governance creates and implements interventions designed to not only promote population level health but also to eliminate risks. Population-level statistics can, in this sense, be seen to constitute a technology of risk, or a “way of managing the individualization of people in aggregate classes, through the calculation of the probabilities of certain events and the application of such calculations to individual people” (Kirkland: 2003: 46).

Foucault’s later work on governmentality examined “strategies of rule that come into play at different times and places that encourage subjects to think and act in particular ways” (Guthman 2011: 18). An examination of neoliberal governmentality thus explores how biopolitical techniques of governance regulate the vitality of populations through active citizen engagement with recommended practices, rather than overt forms of coercion. Citizens are encouraged to seek care in personal and market spheres rather than public ones (Guthman 2011) and regulatory practices are largely organized around categories of risk. Dean (1999) identifies risk as a set of techniques used to order reality and render it calculable and amenable to certain forms of governance for particular goals. Techniques of risk management include those designed to target “epidemiological risk” and “clinical risk.” The former includes those practices, which take up as their concern the health outcomes of the population and enact public health interventions designed to reduce and eliminate future mortality and morbidity. Clinical risk, though similar to epidemiological risk, comprises techniques of clinical risk management that

combine screening with diagnostics and therapeutics. These forms of risk are key in transmitting 'healthy living' guidelines to individuals and populations that encourage the belief that health is a personal responsibility and not a social one (Guthman 2011; Petersen et al 2010).

However, techniques of risk are “not simply about the growing appreciation of risks among certain populations but also how groups of various kinds have come to understand themselves, their future, and their needs in terms of risks with the assistance of a range of specialists and tutors in the identification and management of risk” (Dean 1999:150). Key here, is the notion that neoliberal modes of governance seek to align political goals with active individual choices made in consort with the adoption of expert advice. Because these choices are actively made, individuals experience them as self-actualizing and self-fulfilling (Rose 1996). Empowerment, Rose (1996) argues, can therefore be understood as a “technology of subjectivity that recruits people into active self-management and fosters neoliberal forms of (individual) freedom” (quoted in Bondi 2005: 504).¹⁷ Rose & Miller (2008) state:

Empowerment, then, is a matter of experts teaching, coaxing, and requiring their clients to conduct themselves within particular cultural communities of ethics and lifestyle, according to certain specified arts of active personal responsibility. Empowerment, with all its emphasis on strengthening the capacity of the individual to play the role of actor in his or her own life, has come to encompass a range of interventions to transmit, under tutelage, certain professionally ratified mental, ethical and practical techniques for active self-management (106-107).

Rose (1996) terms this form of governance one that occurs “at a distance.”

Petersen et al (2010) argue that contemporary public health discourses in particular have been key in proliferating a neoliberal agenda around empowerment and choice. Within these discourses, everyone is called upon to play her part in advancing public health through the

¹⁷ Bondi (2005: 499) further argues that neoliberal subjectivity is seductive not only for the political right, but the left as leftist activism “depends, at least to some extent, on belief in the existence of forms of subjectivity that enable people to make choices about their lives.” Importantly, Katz (2005) argues neoliberalism is not fully hegemonic and Lerner (2000) suggests that neoliberal subject formation is “messy.” Nevertheless, ironically leftist activism often buys into the “very model of subjectivity that critics of neoliberal governmentality seek to contest” (Bondi 2005: 499).

adoption of what are held to be health-facilitating lifestyle choices and the avoidance of health-harming ones.¹⁸ As noted above, the taking up of such practices is portrayed as a path to physical, emotional, and psychological well being. Such discourses, as Petersen et al (2010) argue, are rarely ever questioned. This is because they are framed as “‘common sense,’ in some sense, rendering rule invisible” (Guthman 2009: 1115). The belief that our choices are our own and are freely made in turn suggests that the ills that befall us are also of our own making. Neoliberal policies effectively shift responsibility for social issues such as sickness (as well as poverty, unemployment, homelessness, and more) from the state to the individual (Galvin 2002).

The rational and proper citizen of neoliberalism, thus, acts prudently, responsibly, and preventatively in the present to avoid future risk by “undertaking diet, lifestyle and exercise regimes recommended by private health and fitness professionals or publicly funded health promotion” (Dean 1999: 1460). Those individuals, specifically the chronically ill, that ‘fail’ to regulate their own behavior by making ‘responsible choices,’ however, become the targets of increased surveillance and intervention (Dean 1999; Galvin 2002; Petersen 2003). “Neoliberal governmentality thus creates divisions between active citizens, those who can manage their own risks, and ‘targeted populations,’ those who require intervention in management of risks” (Guthman & DuPuis 2006: 443). Returning then to the subject of obesity, how then do neoliberal discourses around obesity shape both bodies and subjectivities?

Fat bodies, neoliberal times

Greenhalgh (2012: 473) argues that in order to understand how fat subjects are created, one must explore both discourses around fatness and how individuals take them up and interact

¹⁸ Petersen et al (2010: 391) argue that while an emphasis on healthy living can be traced as far back as the 5th century and reached a “fevered pitch” during Nazi Germany, during the late 20th and early 20th centuries, this focus as “reached a new, consistently high level.”

with them. “Fat discourse,” she argues is a “complex, internally structured, historically specific body of knowledge that structures how weight and weight-related behavior can be talked about and that does things, that produces effects.” Key here is the argument that discourse does more than specify what can be done or said in a given time or place. Rather discourses are ‘productive,’ meaning they “systematically form the objects about which they speak” and shape “grids and hierarchies for the institutional categorization and treatment of people” (Luke 1995, quoted in Rich & Evans 2005: 356). Discourses thus help construct, define, categorize, and position human subjects (Rich & Evans 2005).

Greenhalgh (2012) argues that fat discourse targets both the bodies of individuals (by biomedicine, through individual interventions) and populations (by public health community education interventions and policies designed to address the ‘obesogenic’ environment). However, fat discourse does not, she states, actually seem to reduce rates of obesity. There is no safe and reliable weight to achieve durable weight loss, Greenhalgh notes. Not only do the vast majority of weight loss practices fail in the long term, many can do harm in the process – for example, the recalled diet pill Fen-Phen which was linked to harmful cardiovascular effects. What fat discourse produces, she suggests, is the “irresponsible fat subject” whose stands in contradistinction to a thin, responsible one. Fatness demonstrates a failure of character, visible on the body. In Guthman’s (2009: 1126) words, it appears “as a choice to disregard the rules.”

Again, under a neoliberal mode of governance, we are all compelled to take up certain practices and avoid others in the name of health. In this sense, obesity discourse, as a mode of neoliberal governmentality, targets not only fat people, but all people. As Guthman & DuPuis (2006: 444) state, public health interventions are not primarily directed to the population considered to be at risk but rather seeks to intervene at the level of the population as a whole:

The interventions are really about warning, even about disciplining, the 'normal' by using the at-risk as examples. So, in the case of obesity, we get the shocking statistics about inexorable roads toward fatness if current eating patterns continue. We are shown how these statistics correlate with race, class, and gender. We are hounded with intense calculations of the nutritional constituents of all our favorite processed foods. Basically, we are told that obesity cannot be cured only prevented, in light of diet failure (Germov and Williams 1999; Sobal 1999). The war on obesity – including the epidemic talk, that is – is directed toward the relatively thin and in that way is most centrally about disciplining the center.

Fat discourse thus operates on the population as a whole through the circulation of generalized anxiety and fear of becoming fat or fatter. Through the consumption of an endless array of market-based products and services, each promising weight loss and improved health and well-being, individuals can alleviate this anxiety. However, because risk is ever-shifting, the fix is only temporary.

Despite the fact that we are all targeted by obesity discourse, we are differently impacted by it based on whether our bodies are seen as potentially at risk or already in need of intervention. Galvin (2002) argues that those who are not sick exist in a constant state of worry about becoming so, but are also rewarded for their ongoing efforts to maintain good health. Those who are not well, she continues, are seen as failing in their quests for health. Yet they too, Galvin continues, are offered a number of market-based solutions for improvement, so long as they are 'responsible enough' to take them up. In line with neoliberal modes of governance that work through expertise to promote responsibility, government interventions thus typically focus on educating the fat to make better choices.¹⁹

The remainder of this dissertation explores Greenhalgh's (2012) argument that in order to understand how fat subjects are created we must examine both fat discourse itself as well as

19 While not typical of official government public health discourses, the remarks of certain policymakers in attempting to pass obesity intervention bills in their home states reveal the victim-blaming underside of neoliberal educational and empowerment discourses. For example, Puhl and Heuer (2010: 1024) report that: "In arguing in favor of the 'Personal Responsibility in Food Consumption Act,' one Congressman stated, 'This bill is about self-responsibility. If you eat too much, you get fat. It is your fault. Don't try to blame somebody else.' In 2008, a Mississippi State House Bill was proposed to prohibit restaurants from serving food to any person who is obese."

how individuals engage with this discourse. However first, it is worth returning to Guthman & DuPuis' (2006) comment that statistics about obesity are discussed in terms of race, class, and gender. Wright (2009) argues that discourse about obesity not only works to govern bodies, but provides the social meanings by which individuals come to know themselves as well as others. As Rail et al (2010: 263) argue, post-structuralist theory suggests that subjectivity is made possible "through the already gendered, heterosexualized, and racialized discourses that deeply inform Western life and values." Thus, this next section will briefly explore the notion that obesity discourses are articulated through larger discourses of race, class, gender, and disability.

Sedimented discourses

In reports on obesity, it is often noted that obesity rates have been rising across all demographic categories. However, obesity statistics also commonly report that the highest prevalence of obesity is found amongst women, African Americans and Latinos, and amongst those of lower socio-economic status. It is the case, as Kirkland (2011) and Guthman (2011) argue, that food environments have changed; that health disparities do exist along the lines of race and class; that population level body weights have increased; that there are weight differences by race, class, and gender;²⁰ and that there are correlations between weight and some chronic diseases. The problem, as both authors argue, is twofold. First, obesity epidemic

20 Interestingly, certain forms of obesity measurement predispose certain bodies to be considered pathological. For instance, the standard use of the Body Mass Index (BMI) to measure obesity actually prompts women, particularly African-American women, to be classified as overweight or obese as compared to men and non-black populations. As Guthman (2011: 28) states, "BMI doesn't account for recognizable and accepted variation across populations according to sex and 'race.'" Women are biologically predisposed to store more adipose tissue for pregnancy and nursing, she notes. And there is some empirical evidence to suggest that higher BMIs amongst black women, as compared to white women, is related to increased muscle mass, not increased adipose tissue. The BMI, however, cannot tell the difference. Guthman also notes that the World Health Organization recommended lowering BMI cut off points for people of Asian ancestry. While this proposal was not adopted, this would have created a race-specific BMI chart, predisposing people who are fat and Asian to be classified at higher levels of overweight or obesity than they would have using a standard BMI chart, and marking them as twice exceptional in the process.

discourses and interventions simplify and exaggerate the relationship between weight and health. Second, obesity discourses and targeted obesity interventions²¹ – even when created with benign intentions – are always already entangled with neoliberal notions of proper bodies, proper behavior, and proper citizenship. Therefore, they end up resolidifying race, class, and gender-based inequalities. It is this second issue that I take up here.

Obesity epidemic discourse has become both a coded form of racism, classism, and sexism and a highly powerful vehicle for further stigmatizing already marginalized groups in the United States (Herndon 2005). As Rich and Evans (2005) argue, the media in particular serve as one of the most powerful sources of information about health and illness, providing not only medical information and but shaping how ‘at-risk’ groups are viewed as well. Biltekoff (2007: 40) notes that “A steady stream of headlines such as ‘Poor and Fat: A Special Problem in America’ and ‘Youth Obesity Called Highest Among Latinos’ have reinforced the already prevalent perception that thinness (dietary health) is an attribute of the white middle classes, while the danger of obesity emanates from racial, cultural and socio-economic ‘others.’” This may be seen particularly in public health and media reports that suggest that cultural food traditions of Blacks and Latinos, cooked and served by women and mothers, are themselves health-harming and in need of retooling through public health education. As Biltekoff (2007) suggests, these reports serve as proof-positive that gendered Black and Latino cultures, not structural inequities, leads to obesity-related health disparities, such as type 2 diabetes. Stories about ‘ethnic food’ thus work to reaffirm social boundaries between good citizens and bad, between those who are responsible and those who need expert interventions (Biltekoff 2007).

21 For example, federal programs such as “Sisters Together” or the “Latino Childhood Obesity Prevention Initiative” which target women and children of color (Biltekoff 2007).

Similarly, Saguy and Almeling (2008) have documented that media reports on obesity in minority and low-income groups disproportionately discuss notions of behavior and choice compared to general reports on obesity. And Rich (2011) comments that many of the individuals and families selected to appear on weight intervention reality television shows are from working class backgrounds. Such shows echo and perpetuate notions of working class people, especially mothers, as pathological and in need of interventions, she suggests. Biltekoff (2007: 40) argues that public health discourses and interventions have always been a mode by which minority populations are targeted, surveilled, and intervened upon, transforming “existing class, race, and ethnic prejudice into public health scares.” However unlike 18th and 19th century public health and child-saving campaigns and crusades, the focus of contemporary public health discourses and interventions is not on saving, or containing but rather on educating – in getting working minorities to adopt (elite) expert advice and regulate themselves (Rich 2011). In the case of obesity, as Kirkland (2011) notes, if those individuals considered most likely to be obese and most at risk for obesity – namely low income, urban, women of color – fail to take up recommended norms and practices, public health policies may end up being ineffective at best and punitive at worst.

Even environmental and accounts of obesity, Kirkland (2011) continues, which are often considered to be progressive approaches, do not free minority populations from responsibility. For instance, she states, constructing more bike paths (or instituting more farmers markets) in urban areas depends on personal responsibility because people in these neighborhoods must utilize them. Kirkland suggests that what looks like a ‘benign collective intervention’ in the environmental approach to obesity is ultimately a “micropolitics of food choice dominated by

elite norms of consumption and movement”²² (477; See also Assarito 2008; Guthman 2009). The terms of the environmental account, Kirkland suggest, may ultimately be a more palatable way for elites to express disdain toward the food choices (or alleged food choices) of low income people and minorities, while feeling virtuous about their own.

Similarly, Guthman (2011) states that because environmental and food justice accounts of obesity define the problem of injustice as being about food, they tend to focus on increasing food access and on food education. This approach, she continues, appears to have many of the trappings of healthism and of ‘civilizing missions.’ That is, although the left tends to portray the fatness of low income, people of color communities as being indicative of their victim status under a corporate food system (see Berlant 2007; Probyn 2008; Yancey et al 2006), these communities are nevertheless still portrayed as ignorant and needing interventions. Moreover, she continues, the interventions proposed by environmental and food justice accounts are entirely compatible with neoliberal economic policies because they focus on education and consumption. In this way, they ignore the very political-economic and social conditions that create a need for cheap food and health disparities in the first place. Thus even those interventions that are designed to address disparities are thoroughly entangled with norms and expectations around proper behavior and proper bodies and may end up affirming rather than challenging race, gender, and class based inequalities.

22 Both Kirkland (2011) and Guthman (2011) challenge the assumption that low-income people and racial minorities are fat because they eat more. Kirkland points to a recent U.S Department of Agriculture study which showed no significant difference in caloric consumption by race or by income. Guthman discusses a recent USDA study that found similar results. Kirkland also notes that the most recent survey of American’s fast food habits shows that the highest frequency customers were men below middle age with incomes averaging \$67,575. “I have yet,” Kirkland remarked, “to see upper-middle-class men discussed as a subpopulation of concern for obesity research” (473).

Deeper anxieties

Wilkerson (1998:67) maintains that diseases and epidemics unsettle otherwise invisible social boundaries that provide “a sense of security” and transgressions indicate a fear of “border ambiguity.” In this sense, discourse around obesity is about more than just fat. In the current US political and economic climate, which can be characterized partially by fear, uncertainty, and securitization, it may be that national rhetoric on obesity partially reflects social anxieties about permeable and fluid borders and both internal and external social and political threats.

In her work, Biltekoff (2007) draws explicit links between the war on fat and the war on terror.²³ Both wars, she states, contributed to an increased sense of fear and anxiety by suggesting that danger is everywhere, the enemy is elusive, and that Americans, as good citizens, must always be on guard. Martin (2007) describes neoliberal tactics of threat management as a “war without end” wherein enemies are continually being anticipated and preempted, blurring distinctions between the “not-yet” and the now. In this way, future uncertainty is translated into present risk. Preemptive warfare is extended broadly “as if permanent war were simply a fact of life (Cooper 2006: 129).” In both the war on obesity and the war on terror, danger and risk – and moreover anxieties about them – are central features of everyday life (Biltekoff 2007). As citizens, Americans have been asked to do their part by accepting increasing surveillance and data gathering as part of the natural order of things, reporting suspicious activity, and making healthy choices about food and exercise.

23 Biltekoff does not take up the war on drugs in her discussion. The war against drugs too seems to be a ‘war without end’ where children, in particular, are continually at risk. However, it does not seem to be the case that, in the war on drugs, citizens are asked to play the same role in securing America’s future as they are in the wars on terrorism (“If you see something, say something” as the New York City Metropolitan Transit Authority slogan goes) and on obesity. It may also be the case that the war on drugs does not elicit the same sense of generalized anxiety that the wars on terror and obesity do. This is a topic worthy of future exploration that cannot be addressed in this dissertation.

Most ironically, the very groups discursively and affectively held to be jeopardizing America's future through a lack of personal responsibility are simultaneously the most imperative for America's continuance (Biltekoff 2007). After all, the future soldiers that may be "too fat to fight" that Mission: Readiness speaks of are low income, black, and brown. Thus, "the campaign against obesity enlists the nation's most underserved populations in simulated battle for national security that obscures the toll that the actual war on terror is taking on the lives of the nation's underclass, both on foreign battle fields and at home" (Biltekoff 2007: 44).

What the war on obesity does, Biltekoff (2007) argues, is provide U.S. citizens with the winnable war that the war on terror lacks. Through 'simple acts of will' American citizens are held to have in their power, the ability to secure the health and future vitality of the nation, she continues. And yet, minority populations – women, African Americans, and Latinos as well as those of low socio-economic status – are seen to place this future in jeopardy. They are said to do so through the meals they make and eat, their pathological acceptance of larger bodies,²⁴ their refusal to self-discipline, their demands on over-strained public services, and through their decreased capacity to labor for the nation, including as soldiers. Thus, whereas older public health discourses linked female, brown, and poor bodies to external risk – the spreading of filth and contagion – contemporary public health discourses locate risk internally in the 'poor choices' made by these same populations (Galvin 2002; Petersen & Lupton 1997).

24 On this point, Herndon (2005: 134) suggests: 'If there ever was any truth to the generalization that black women remain unconcerned about their weight and are not discriminated against because of it, the war against obesity has certainly changed the situation.' And in fact, recent meta analyses of ethnicity and body dissatisfaction find that while white women are the most dissatisfied, the difference is small (see Grabe & Hyde 2006). Wilson (2011) suggests that just as piety, purity and domesticity were held to be those virtues that defined 'true womanhood' in the 19th century – a form of womanhood that was, by definition white and propertied – today discourses around weight may do similar cultural work. The hiring prominent of African-American women, such as Jennifer Hudson, by diet industries thus serves to not only recruit black women into the war on obesity as a specifically Black issue, but also into a notion of beauty and acceptance (and perhaps we might add health and citizenship) that is always already defined against them (Wilson 2011).

Melamed (2006) argues that ‘neoliberal multiculturalism’ – or the form of racism typical of the neoliberal era – moves beyond phenotype to innovate new ways of naturalizing inequality. “The new racism deploys economic, ideological, cultural, and religious distinctions to produce lesser personhoods, laying these new categories of privilege and stigma across conventional racial categories, fracturing them into differential status groups” (Melamed 2006: 14). In essence, Melamed argues, new categorizations and dividing practices that do not appear, on the surface, to be about race are in fact ways in which a more insidious forms of racism are expressed and perpetuated. Similarly, Davis (2007) argues that neoliberal racism operates by denying the ongoing realities of structural racism. Impediments to success (a success defined by white, middle class values and behavior), she states, are attributed personal or cultural flaws but in ways that allegedly are not about biological notions of race. These impediments, she continued, are expressed through coded racism, like ‘Welfare Queen’ or ‘Quota Queen.’

Melamed’s and Davis’ insights are key to understanding how inequality operates under neoliberalism. I would suggest that in addition to discourses around work, coded neoliberal racism is especially salient in discourses around health and obesity. Notably, the ‘Welfare Queen’ was discursively represented not only as female, low income, and African American, but also fat – her fat being symbolic of her (race and class based) sloth and gluttony. As Guthman (2009) notes, neoliberal discourses on health obscure the structural inequalities that shape health disparities and thus work to “legitimate class and racial privilege and constitute others as beyond repair” (1116). The ‘good subject’ of neoliberal governance becomes not only fit and thin, but often white, male, and class privileged.

Neoliberal forms of citizenship also privilege the able-bodied and the well. Given that these models of citizenship are based on ideals of autonomy, control, self-determination, as well

as good health, they are, by their nature, abelist.²⁵ Crawford (2006: 402) argues that in contemporary society, health has become the “sine qua non of individual autonomy and good citizenship.” Conversely, chronic illness and disability, as Galvin (2002: 108) suggests, are “increasingly viewed as culpability in the face of known risks, an instance of moral failure that requires the intervention of a range of political technologies.” Consider the following language from the 2004 British House of Commons Health Committee report on Obesity:

Should the gloomier scenarios relating to obesity turn out to be true, the sight of amputees will become much more familiar. There will be more blind people. There will be huge demand for kidney dialysis. The positive trends of recent decades in combating heart disease, partly the consequence of the decline in smoking, will be reversed.” (Quoted in Rich & Evans 2005: 352-3).

As this quote makes clear, discursive representations of obesity as threat to the nation are fundamentally entangled with the specter of disability and chronic illness. In effect, discourse around obesity and risk reflects the ways in which notions of proper citizenship are linked to notions of proper health under neoliberalism. In their circulation they take up older, sedimented discourses and anxieties around race, class, gender, disability, and citizenship in new ways (McPhail 2009).

Fat subjects

Rose (2007a: 13) argues that in addition to heaping negative judgments upon targeted populations, 20th century biopolitics and biomedicine (which he refers to as “advanced liberal” rather than neoliberal) have helped shape “the kinds of human beings we take ourselves to be.” He argues “we are increasingly coming to relate to ourselves as ‘somatic’ individuals, that is to say, as beings whose individuality is, in part at least, grounded within our fleshly, corporeal

25 As with low-income people in general, disabled people (who are also disproportionately low income) are particularly impacted by neoliberal service cuts.

existence, and who experience, articulate, judge and act upon ourselves in part in the language of biomedicine” (Rose 2007a: 13). However, given a neoliberal context in which pursuing health and avoiding risk have become obligatory, subjects do not regard their biology as inevitable. He states, “at least in part, fears and anxieties about morbidity and mortality are being reframed within an ethos of hope, anticipation and expectation” (Rose 2007a: 14). In the following chapters I explore Rose’s argument as well as Greenhalgh’s (2012) claim that in order to understand fat subjects we must understand how they take up obesity discourse. I do so through an examination of the psychosocial experiences of having been diagnosed as morbidly obese and then having had weight loss surgery.

Chapter 3:

“Shape Carries Story:” Navigating the World as Fat

Story spreads out through time the behaviors or bodies – the shapes – a self has been or will be, each replacing the one before. Hence a story has before and after, gain and loss. It goes somewhere...Moreover, shape or body is crucial, not incidental, to story. It carries story; it makes story visible; in a sense it is story. Shape (or visible body) is in space what story is in time...Identity is finally shape carrying story (Bynum 1999, quoted in Garland Thomson 2007: 113-114).

Feminist scholars have well explored the imperative to thinness in contemporary Western societies, particularly as it relates to gender and body image (Bordo 1993 serves as a classic example). The dominant trend within feminist theory on body size, as Heyes (2006) and Coleman (2010) argue, has been to frame weight loss practices in terms of either Foucault's earlier work on 'docile bodies' or the Marxian notion of 'false consciousness.' Such conceptualizations foreground the repressive nature of weight loss practices, but cannot conceive of the ways in which they are generative. Given this, both authors suggest that Foucauldian work on "practices of the self" – or the ways in which individuals constitute and reconstitute themselves according to preexisting modes of intelligibility and identification – allows for a better examination of dieting as simultaneously regulatory and productive. Coleman (2010) further argues that such an approach also illuminates the ways in which the inability to lose weight suggests an inability to adopt proper eating and exercise behaviors. This, by extension, suggests failed citizenship. Key to this argument is the notion that bodies, subjectivity, and citizenship are produced through relations of power. Importantly, such relations of power are not merely discursive but are material as well. Recent feminist scholarship on the body offers an important corrective to post-structuralist work that overly-focused on representation and language. It has done so through work that highlights the dynamic relationship between the material, the discursive, the emotional, and the social (Cf Barad 2007; Bennett 2009; Clough & Halley 2007; Grosz 1994; Pitts-Taylor forthcoming; Wilson 1998).

In this chapter, I examine how participants navigated the world as fat and explore how these experiences bore upon their decisions to have weight loss surgery. I begin a review of the literature on how anti-fat stigma shapes the lives of individuals. In light of this literature, I then examine how fat individuals negotiate experiences of anti-fat stigma. In doing so, I consider Greenhalgh's (2012) directive to explore how fat individuals take up (or reject) obesity epidemic discourses. I then elucidate the ways in which fat bodies are lived and negotiated in space and place; I argue that these experiences are dynamic and contingent but also produce structural consequences (Garland Thomson 2011: 592). Following this, I explore ways in which participants take up notions of time, specifically in regard to risk, in discussing what brought them to the decision to have bariatric surgery. I conclude this chapter by arguing that it is a dynamic interaction between the material, social, emotional, discursive, and the temporal that produces not only fat embodiment, but fat subjectivity and citizenship as "failed" and serves as an impetus for seeking bariatric surgery.

Anti-fat stigma: A review of the literature

Drawing on Goffman's (1963) classic work on stigma, research documenting the existence of discrimination and bias against individuals considered obese goes back five decades. Since Cahnman (1968) published "The Stigma of Obesity" other researchers have well documented systematic and growing discrimination against fat people (cf Puhl & Brownell 2003F; Puhl and Heuer 2009; Puhl & Heuer 2010; Fikkan and Rothblum 2012). Puhl & Heuer (2010) contend that anti-fat stigma has steadily increased during the 21st century; that prevalence rates of anti-fat stigma have become similar to prevalence rates of racial discrimination, and that anti-fat stigma is rarely acknowledged as a social problem or a problem for public health. They

further argue (2009) that anti-fat discrimination is pervasive in employment, health care, education, media, and interpersonal relationships with friends and family members. Anti-fat stigma has direct impacts on the life chances of overweight and obese people including: earning less than non-overweight people in comparable positions; receiving fewer promotions; being viewed negatively by coworkers and employers; being fired or suspended for appearance; receiving substandard care from medical providers; receiving fewer medical interventions than thin people for the same conditions; being refused treatment by medical providers, and having lesser educational achievements than thinner peers (Friedman & Puhl 2012). Friedman & Puhl (2012) suggest that anti-fat bias is so widespread that it should be considered a social justice issue requiring legal redress.

Given that obesity is considered a medical and public health issue, it is important to briefly review the health impacts of anti-fat stigma. Both Schwartz et al (2003) and Puhl & Heuer (2010) found evidence for extensive anti-fat bias amongst doctors, nurses, and medical students, including those who specialize in working with obese populations. Such bias has a direct effect on the quality of care that fat patients receive from providers (Friedman & Puhl 2012).²⁶ Notably, Schwartz et al (2003) find that anti-fat discrimination amongst medical providers varies by cohort. Specifically, while anti-fat discrimination is prevalent across all age groups, younger providers show stronger rates of anti-fat bias, even after controlling for sex and BMI. This suggests, they argue, that anti-fat stigma may be increasing. They further argue that the fact that medical professionals, who are well aware of the complex and poorly understood

²⁶ In addition to receiving a substandard quality of care and fewer interventions, fat patients also report high rates of discrimination by medical providers and particularly note a lack of appropriately sized medical equipment (gowns, examination tables, etc.) and receiving unsolicited advice about weight when seeking care for other concerns (Puhl & Heuer 2010).

etiology of obesity, still harbor such negative attitudes toward fat people, is indicative of the strength of anti-fat bias.

Anti-fat discrimination and stigma is associated with delays in seeking care amongst fat people; an increase in unhealthy eating behaviors; lower levels of physical activity; increased functional disability; lower self-related health; increased stress response; depression; low self-esteem; suicidal ideation at attempts; isolation, and increased body dissatisfaction (McHugh and Kassardo 2012; Puhl & Heuer 2010; Schafer & Ferraro 2011). Given this, Schafer & Ferraro (2011) argue that social and economic marginalization is responsible, at least in part, for the linkages between weight and morbidity. In an epidemiological sense, these might be considered unexamined intervening and confounding variables in the correlation between body weight and morbidity.

Negative outcomes on health and well-being also result from the internalization of anti-fat stigma by fat people themselves. Multiple studies suggest that individuals medically classified as obese accept, at least partially, a medicalized account of their bodies, personal responsibility for dieting ‘failures,’ and that such individuals continue to believe that a new, future weight management intervention will result in durable weight loss (Greener et al 2010; Lewis et al 2011; Throsby 2007; Schafer & Ferraro 2011; Wang et al 2004). As I illustrate later in this chapter, my research confirms this as well. In addition, fat people appear to show levels of anti-fat bias similar to their thinner counterparts (Wang et al 2004). The ways in which, following surgery, bariatric patients struggle with holding simultaneous feelings of empathy and disdain for other fat people is taken up in chapter four.

Despite strong evidence for the negative impacts of anti-fat discrimination on health and well being, debates continue to circulate in public health about whether or not anti-fat stigma can

actually serve as an effective behavior change motivator (Evans & Colls 2009; Lewis et al 2011; Puhl & Huerer 2010). These debates continue despite not only strong ethical concerns, but also a lack of any clear evidence for the effectiveness of shame-based tactics in improving health outcomes (Lewis et al 2011). What's more, there is evidence to suggest that shame-based obesity interventions achieve the opposite of the intended effect and contribute to steeper health declines (Puhl & Huerer 2010; Schafer & Ferraro 2011). Finally, anti-fat discrimination exists in the face of extensive medical evidence that challenges the belief that fatness is the result of individual behavior, that weight loss is a reasonable and feasible goal, and that dieting is linked to improved health outcomes (Puhl & Huerer 2010).²⁷

Importantly, anti-fat stigma intersects with other forms of marginalization. Fat women, Murray (2010) argues, are often represented as 'out of control' and deviating from dominant feminine aesthetics. Consequently, as Fikkan and Rothblum (2012) carefully document, women are more strongly disadvantaged by anti-fat stigma across a range of measures than are men. Nevertheless, men are still impacted in highly gendered ways: Because fat men's bodies deviate from cultural norms of masculinity, anti-fat bias disadvantages men by feminizing and thus devaluing them (Monaghan 2008; Murray 2010; Saguy 2012). Saguy (2012) holds that fat men are made to feel shame about "man boobs," pregnant looking bellies, and penises rendered invisible by large, overhanging bellies. She also notes that gay men have body image concerns at rates that equal or are higher than heterosexual women. Saguy (2012) further argues

27 On the contested terrain of weight and health, see for example: Bacon & Aphramor (2011); Brown (2012); Campos et al (2006); Flegal et al (2013) Jerant & Franks (2012); Kassirer & Angell (1998); Mann et al (2007); NIH News (2012); Powell et al (2007); Wilson & McAlpine (2006). The evidence for the extreme inefficacy of dieting, for instance, is so strong that it has "prompted agreement among a number of expert panels and scientific groups (including the Institute of Medicine, World Health Organization, Preventive Task Force, Canadian Task Force of Preventive Health Care, and National Heart, Lung, and Blood Institute) that health care providers should counsel patients to set a goal of 10% reduction in total body weight rather than struggle to attain ideal body weight" (Puhl & Heuer 2010: 1020). This means that even if fat patients are able to successfully lose 10% of their body weight, they will likely still be classified as morbidly obese, obese, or overweight even though they have been medically compliant.

that while some racial groups, notably Blacks and Latinos, are held to be more accepting of larger bodies, there are limits to this tolerance. Specifically, while ‘thick’ and curvy bodies are may be prized, very fat bodies are not. Further, social class mediates the effect of race/ethnicity in such a way that upwardly mobile racial and immigrant groups see thinness as a marker of success and are therefore less accepting of bigger bodies (Abou-Rizk & Rail 2012; Saguy 2012). Finally, while low socioeconomic status groups are said to have higher rates of obesity than higher SES groups, Fikkan & Rothblum (2012) and Ernsberger (2009) suggest that the relationship between class and weight is dynamic: it is not just that poor and working class individuals are more likely to be fat. Rather, the “obesity penalty” (Cawley 2004) of anti-fat discrimination also results in diminished economic outcomes for fat people.

While negative stereotyping of fat people has a long history (Chang & Christakis 2002; McPhail 2009, Schwartz 1986), contemporary forms of anti-fat stigma and discrimination are both pervasive and structural and should be understood within a social and economic context of neoliberal healthism. By neoliberal healthism (see Crawford 1977; Crawford 2006; Metzl 2010), I refer to the set of discourses that suggest that humans are rational, self-determining actors who independently make their own choices and are thus responsible for their life chances and health outcomes. Good health, thus, equals good citizenship and there are material and social consequences for those who either unwell or perceived to be unwell. In keeping with other neoliberal health interventions, government obesity programs have tended to focus on educating fat people to make better health choices but have not addressed any of the structural inequalities that are associated with higher body weights and health disparities (Puhl & Heuer 2010). As Puhl & Heuer (2010: 1024) put it: “Discrimination manifests in illness and disease that society and governments do not adequately address due to the very discrimination causing the

harm.” Anti-fat stigma and discrimination are perhaps better understood then, not merely as stigma or discrimination, but as a form of structural violence, defined by Farmer (2005) as a set of social arrangements that expose certain groups to harm. These arrangements are structural, he states, in that they are embedded in the political and economic fabric of society; they are violent, Farmer continues, because the result in disproportionate exposure to harm.

While discrimination based on weight and size operates structurally, the interpersonal impacts of anti-fat stigma are also significant. Because obesity is commonly represented as a matter of behavioral choices in public health, medicine, and media, to remain fat is to invite commentary from others that one is lacking in personal responsibility. Guthman (2009: 1126) suggests that this lack of empathy “also stems from the growing perception that obesity presents a social cost, made all the more tenable when the perception of health responsibility has been reversed from a welfare model.”²⁸ Her assertion is consistent with social psychology research that finds that health conditions that are rated high on personal responsibility and that are stigmatized (such as obesity) elicit little pity, low rates of helping behavior and arouses high rates of anger (Puhl & Heuer 2010). Greenhalgh (2012) argues that taken-for-granted beliefs about obesity are creating “bio-bullies” who believe that fat people must be brought into line by any and all means. These interpersonal interventions, she continues, are often framed as if they are waged out of care and concern for the fat individual in question. However, because weight

28 Consider New York State Comptroller Thomas P. DiNapoli’s October 2012 report “Soaring Health Care Costs Highlight Need to Address Childhood Obesity:” “The increased prevalence of obesity is also an important factor in burgeoning health care costs for employers, consumers, and taxpayers. Total obesity-related costs in New York State are estimated at more than \$11.8 billion annually. Medicaid funds some \$4.3 billion of such expenditures, with roughly half of that cost paid by New York State and local taxes. Another \$7.5 billion of obesity-related costs are paid by Medicare, employers’ and workers’ health-insurance premiums, and uninsured individuals” (http://www.osc.state.ny.us/reports/obesity_and_child_obesity_10_23_12.pdf). When recounted by the New York City online news blog Gothamist, which is known for its snark-filled coverage, DiNapoli’s report was presented thusly: “Those people’s problems cost the state an estimated \$118 billion in health care costs” (see Johnston 2012). In the U.K., former Prime Minister Tony Blair described the economic costs of obesity as a “collective price for the failure to take shared responsibility” (Throsby 2008a: 123).

loss is commonly held to be a reasonable and feasible goal and yet is nearly impossible to maintain in actual practice, (even through surgical means as will be discussed in later chapters), fat people are “in effect, asked to do the impossible and then socially punished for failing. (Greenhalgh 2012: 474).” In the remainder of this chapter I explore the ways in which bariatric patients experienced anti-fat stigma and how they dealt with it. As well, I examine how anti-fat stigma and discrimination informed participants’ decisions to have weight loss surgery.

Navigating anti-fat stigma

In discussing what it was like to be fat, all but one of my participants discussed experiencing size-based stigma and discrimination. As well, both bariatric surgeons I interviewed described anti-fat discrimination as “the last form of acceptable prejudice,” – a remark, interestingly, that only a few of the patient participants made. Participants described the experience of being fat or very fat as one of simultaneous hypervisibility and invisibility. Whether through overt comments, indirect remarks, dirty looks, open gawking, or being ignored and unrecognized, participants felt hurt, angry, and shamed by friends, family, coworkers, medical providers, and strangers on the street because of the size of their bodies.

Some participants stated that weight shaming from others began in childhood. Candice was taunted with nicknames such as “fatty” and “buffalo butt.” Nina stated that she was frequently bullied as a child. Other young people routinely made fun of her, including by making up songs about her that painted her in a highly unfavorable light. At times, this bullying escalated into physical abuse. She told me that on occasion, peers at school would slam her fingers in swinging doors so that she would “stop eating” and therefore lose weight. Nina described her childhood as “miserable” because of the bullying and abuse she received at the

hands of other children. Talia reflected upon the Presidential Physical Fitness Tests she endured in elementary school, noting the ways in which they served to humiliate fat children and thus actually discouraged physical activity in the long term: “OK, so you say your goal is to get the out of shape or fat kids exercising, but you’ve set up the absolute worst thing you could have set up for those kids, right? The only kids who are liking this are the kids who are already in really good shape and popular, right? The other kids are being humiliated....I fell down in less than a second and everyone laughed. And, the point of that was what?”

Mean spirited and abusive comments continued into adulthood, and while participants were better equipped to deal with them as adults, they nevertheless felt shamed and hurt. Talia and Nina described being teased on the street by strangers because of their size, taunted by comments such as “BOOM, BOOM, BOOM” (mimicking the sound of heavy footsteps) in Talia’s case, or “Damn girl, how much do you eat?!” in Nina’s. Irene recalled how customers at the Starbucks she worked at would snicker behind her back. Katrina stated that going to restaurants was challenging as she often received looks from other patrons that she interpreted as: “You shouldn’t be eating that.” Talia and Irene described being harassed at the grocery store by other customers who would openly peer into their carts and baskets, making comments about what they had purchased. Talia stated that because she was fat, “people felt like they had the right to tell me what I should do with my life.”

Katrina remarked that while she experienced negative comments about her size in the United States, these comments were far more direct in her homeland of the Dominican Republic where she was “mooed” on the street. Disputing the commonly held assertion that Latinos, like African Americans, prefer larger bodies she stated that rather it was only “J. Lo,” curvier bodies that were prized. Neither very thin nor very large women were held to be beautiful or desirable.

Her comments echo Saguy's (2012) argument that there are limits to what is commonly held to be a more permissive attitude toward larger bodies in Latino communities. Chris also argued that while the treatment of fat people in the Upper Midwest was not kind, it was far worse in the Netherlands, where he was born: "We don't really have that politically correct filter as people have here."

Some of the most difficult comments to deal with, for many participants, were those that were expressed as simultaneous compliments and insults. Reflecting the ways in which fatness is seen as marring female beauty (Murray 2010), Natalia, Kaia, and Decenia reported being repeatedly told: "You're pretty but you'd be beautiful if you lost weight" or "You have such a pretty face!" Remarks such as these were often made by family members and friends of the family, which made confronting them particularly challenging. Kaia, who was 19 at the time I interviewed her, stated that her mother's friends frequently made comments about her weight. Reaching the breaking point one day, she snapped back: "How would you like it if I told you you'd be so pretty if you didn't have such a big nose?" I said, "That's how it is. That's how it feels. I don't like it when you guys say that. It's not telling me anything."

At times, comments from family members and friends of the family were delivered in a 'tough love' fashion, designed to motivate participants to lose weight. Kaia recalled a particularly painful day when a friend of her mother's told her she was disgusting and huge: "She told me that no one would ever love me, or ever marry me, or put up with me. And, I was just the grossest she'd ever seen. She said, 'I bet you everyone thinks that when they look at you. It's just disgusting.' She's like, 'No one is ever going to want you.'" Perhaps most devastating of all, Kaia's mother – who was otherwise often supportive – flatly agreed with her friend. In this instance, Kaia responded by giving no reaction and remained nice and polite. Reflecting upon

how she was treated, she said: “As horrible as it was, I absolutely was not treated like a person...I was just like this object to people. Just this big, you know, thing. And that’s how people treated me.” Reflective of the ways in which shame-based motivation strategies not only fail to change behavior but may actually do harm (Puhl & Heuer 2010; Schafer & Ferraro 2011), the abuse that Kaia encountered only served to increase her isolation from others.

At times, participants felt humiliated by being stared and gawked at by strangers. Danielle, who had had a history of weight cycling before her surgery, described the differences in her social reception as fat smoker and then as a thin smoker, after she had lost weight on a past diet. “I would sit outside my apartment on the Upper East Side [of Manhattan] and I’d smoke cigarettes. People would walk by me and give me these like looks of disgust. I would just figure in my head at the time, ‘It’s because I’m smoking. I’m blowing smoke in the street. I’m probably littering, throwing butts on the street.’ But, then when I lost all of the weight I was still smoking, people were smiling at me, talking to me, so it wasn’t the cigarettes.” The staring and gawking of strangers was difficult not only for the participants themselves, but also their loved ones. Kaia noted that her cousin began to defensively yell, “What are you staring at?!” at gawkers. Talia described the discomfort her partner, a highly introverted person who preferred to blend into a crowd, felt when they were stared at on the street. Blending in, Talia noted, is impossible when you have a 400-pound girlfriend. Danielle’s husband would often try to convince her that people were staring at her because she was pretty, something she couldn’t believe. “I knew that’s why they were staring. There would be not another reason that they’d be staring. ...and he sort of didn’t believe that people would really be looking at me like that.” Noting the gendered nature of anti-fat stigma, she told him he didn’t know what it was like. “He’s been very big too, but he’s a 6’2” broad guy. It’s different. And even if he was a short

guy, guys are looked at differently.” Participants who were also parents had significant concerns about the effects that staring and gawking would have on their children, worried that their children would be teased. As Hanifah put it, “Being a kid is hard enough without having a fat parent.”

Although participants seemed to feel most shamed when others stared at them, not being noticed was also a source of anguish. Specifically, participants felt that they were often flatly ignored and discounted as human beings because of their size. Candice described the pain of never being asked out on dates in high school. Katrina talked about the humiliation she felt at clubs while her friends danced with men and she sat in the corner alone. Later when she was married, going out to clubs with her husband was still a challenge for her: “We would go out and women would hit on him right in front of my face. Like, they had no respect whatsoever...I was just a friend because ‘what would a tall, good-looking guy be [doing] with her,’ you know?” Naomi felt that she had fewer friends than she would have if she had been thin, stating that most people didn’t want to associate with a very fat person. Kaia remarked, “I felt invisible, I guess. Or the people that did look at you, you didn’t want to see their looks, because I guess I always felt like I was being judged negatively, like nobody would ever have given me the time of day or the chance to get know who I was, you know? It was just about how I looked.” Calvin was confident that, as a performer, he had lost countless employment opportunities because of his size.

Reflecting Kirkland’s (2008) assertion that fat individuals use the techniques of ‘positive self-presentation’ and ‘ignoring the mistreatment’ as strategies to deal with anti-fat stigma, Kaia described “killing them with kindness” so that others would like her: “They could be so mean to me, but I’d just be nice back, no matter what. And, that would surprise a lot of people. That’s

why a lot of people liked me, even besides the fact that a lot of them tormented me.” Irene discussed bending over backwards to accommodate others so that they would “look past her weight” and see her for who she was. Danielle described her efforts to win others in the following way: “If I can be really smart, and really funny, and really forward, and like the best friend, and the best sister, and the best wedding planner, and the best writer, and the best everything in the whole world then you’re not going to see my size, you know?... My goal was to have people leaving conversations with me thinking, ‘Wow, she is awesome,’ not, ‘Wow, she is really heavy.’ You know because I knew that it was one of the two, so I had five seconds to totally win someone over.” She described working overtime at getting others to like her, even “to the point of exhaustion.” Danielle’s actions suggest that some fat individuals do more than develop a positive self-presentation to avoid anti-fat stigma. Rather, they overcompensate for perceived lower worth by engaging in practices that serve others and by developing attributes that they feel will be appealing to them.

As discussed in chapter two, a hallmark of neoliberalism is the notion that one is responsible for maintaining good health. In the case of obesity, neoliberal healthiest discourses suggest that weight loss is a matter of hard work and commitment. In discussing their formerly fat bodies, participants expressed frustration that others had regarded them as lacking self-discipline because they had been unable to lose weight through dieting and exercise. Nina remarked on the differences between how fat and sick individuals are treated:

From my experience society seems to believe that obesity is self-inflicted...They think it’s as simple as eat less, move more. It really isn’t...You could smoke 20 years of your life and get cancer and people still feel pity for you. People are still like, “Oh, poor person.” They want them [to get well] -- “Go to chemo, save your life.” But when it comes to obesity, “Oh, they just eat too much. They need to put the fork down.” Like, I’ve experienced all of the prejudice, people just don’t understand.

The individuals I interviewed found comments like these to be particularly hurtful because, in fact, they had spent years and decades in some cases trying to lose weight, only to gain it back plus more. Kaia expressed confusion at the actions of the adults in her life who tried to motivate her to lose weight through veiled insults or direct abuse when she strongly believed that her weight was not due to overeating: “The thing, is people always made me feel guilty for eating and I’m like, ‘How am I supposed to live if I can’t eat?’” Talia stated, “I think my whole life the hardest, worst part of being fat, [was] this assumption from everyone that I could change it.” Despite having a strong sense that something outside of personal behavior explained their escalating body weights, participants still deeply internalized messages about responsibility and self-control. Danielle, for instance, remarked that she had felt like a failure because she could not maintain her weight loss: “Why could the one thing I want the most be so impossible for me to maintain?”

Medical providers were often equally unsupportive. The prominent Long Island bariatric surgeon I interviewed identified physician bias as a barrier to care for fat patients, stating it was “definitely a problem” and that providers “think that it’s because they just need to close their mouths and they’ll get healthier, they’ll do better. It’s just because they’re lazy.” At 14, Kaia went to the doctor seeking help for what she believed to be a medical cause of her rapidly increasing weight gain. Her doctor refused to consider approving her for bariatric surgery and instead focused on her behavior, telling her that if she continued on her present course, she would kill herself. Kaia’s response was to avoid medical care for years: “I had a fear of going to the doctors because every time I met with a new one they made me feel so horrible about myself. And, you know, just really blamed me. So, I kind of hid from doctors for a couple of years.” Importantly, Kaia’s doctor may have had very sound reasons for refusing to approval an

adolescent for a high risk and life changing surgery. As Inge et al (2004) note, medical providers must critically assess a number of factors in approving adolescents for bariatric surgery, such as the decisional capacity of the patient, family structure, barriers to adherence, and adolescent growth and development. Warman (2005) states that approving young people for weight loss surgery remains controversial in the field and that there are few bariatric surgical programs designed for adolescents. Nevertheless, Kaia's experience is illustrative of the ways in which stigmatizing encounters with medical professionals can lead to delays in seeking care amongst fat individuals (McHugh & Kassardo 2012; Puhl & Heuer 2010; Schafer & Ferraro 2011).

At times, participant resisted medical providers' arguments that weight gain was the result of overeating and lack of exercise. Shoshana, who was a psychoanalyst, repeatedly confronted professional peers about their ongoing belief that in order to lose weight, fat clients just needed to "work through their shit," telling them: "That is such a crock of shit. It has nothing to do with willpower. It has nothing to do with psychological issues." After avoiding medical care for years and at the behest of her husband, Danielle went to an orthopedist for help with hip pain but instead of receiving care, she was castigated for her weight:

He's like, "So, how long have you been this size?" I said, "A long time. I've been significantly overweight since high school."...He's like, "So what do you do, just eat a lot?" So, I said, "Well, I mean, yes, but I guess it's not that simple. It's a little bit more complicated than that." He was like, "I mean, listen, I can understand. I mean I know how sometimes you have the desire to [chewing noises] but you just have to stop at some point." I was stunned. Then I was like, "I'm going to make it a teaching moment." So, I like summoned all of my self control and I said, "You know, actually it's a disorder. It's not as widely recognized as other eating disorders, but I've been doing a lot of reading." He just cuts me off and he's like, "OK, it was good to see you. Let me know when the anti-inflammatory runs out and we'll take another X-ray if we need to." I was just like, "Fuck you."

Similarly, after Ursulina's doctor refused to approve her for weight loss surgery telling her insurance company that she could lose weight on her own, she "called him every name in the book," yelling at him in front of his staff: "If I could have done it I would not be at this weight. You know me by now. How could you possibly have told them that? You are a complete fool." After that, she no longer went to him for care.

These encounters are notable for several reasons. First, they confirm Kirkland's (2008) assertion that amongst the strategies that fat individuals use to deal with anti-fat discrimination are 'moral instruction' – in which fat people attempt to educate others – and 'redirecting shame,' wherein fat people move "shame and social disapproval "back onto the person who initiated the situation" (410). Second, they suggest that bariatric patients not only accept but demand medicalized accounts of obesity. What's more, patients utilize medicalization as a means by which to resist both providers' neoliberal choice arguments and their stigmatizing beliefs. Third, these encounters illustrate the ways in which the antagonistic relationships between general providers and fat patients mask the influence of the bariatric profession. Most participants stated that their surgeons were the first providers to both assert that obesity was a medical condition outside of their control and offer them a solution.²⁹ Within a climate of uncertainty surrounding obesity, escalating obesity rates, and increasing anti-fat stigma, the bariatric profession thus positions itself as unique by offering both understanding and a durable treatment. Finally, encounters such as Ursulina's highlight the ways in which institutional forces such as third party payers shape patient experiences. While Ursulina was eventually approved for surgery, other participants like Irene and Danielle ended up being self-pay patients. And

²⁹ As I discuss in chapter five, while bariatric professionals frequently discuss obesity as something outside of a patients' control, regain following surgery is generally attributed to patient noncompliance.

while Danielle's parents funded her procedure so she was able to have it without delay, it took Irene six years to save up for her surgery.

Pastoral experts, such as gym trainers, also echoed the assumption that weight loss was simply a matter of the will. Talia, Ursulina, and Natalia all noted that gyms were ill equipped to deal with very fat bodies. Not only were many of the exercise machines unable to accommodate them, gym trainers lacked an understanding of how to work with obese people, often pushing them beyond their physical capabilities with "just do it" messages. Natalia stated, "These trainers have never been overweight in their lives and they're trying to tell me to do certain things, 'You can do it!' It's like, 'No, I can't do it.' There are certain things you can't do." Talia wished that gyms would both divorce exercise goals from weight loss and make movement activities more accessible to different kinds of bodies. Because of the ways in which gyms felt hostile, many participants ended up avoiding exercise and turned to crash dieting – a practice, as Natalia noted, that ultimately resulted in long-term weight gain, not weight loss.

Collectively the experiences of these participants reflects Puhl & Heuer's (2009) argument that anti-fat stigma is pervasive. Participants gave extensive accounts of being discriminated against by providers, friends, family members, loved ones, employers, and strangers because of their weight. Danielle remarked upon the particularly gendered nature of anti-fat stigma. Katrina's comments suggest that, as Saguy (2012) found, Latino cultures are not necessarily more welcoming of bigger bodies per se, but rather curvier bodies. Some providers and family members seemed to take up the idea that shame could be a motivating force in weight loss, acting as 'bio bullies,' in Greenhalgh's (2012) term, toward these individuals. However, as research by Lewis et al (2011), Puhl & Huerer (2010), and Schafer & Ferraro (2011) has demonstrated, the effect this had was the opposite of what was intended. Specifically, a number

of these individuals delayed care and avoided health-facilitating behaviors, like exercising, because of the discrimination they had experienced. Instead, they turned to health-harming practices, like crash dieting. Moreover, the internalization of shame and blame served to lower a sense of self-worth for many participants. Nevertheless, these individuals did not always passively accept the anti-fat stigma they received. Rather, as Kirkland (2008) found in her interviews with fat individuals, they used moral instruction, redirecting shame, positive self-presentation, and ignoring the mistreatment as tactics to diffuse and preemptively avoid anti-fat stigma. In addition, as I have demonstrated, participants also took up medicalized accounts of obesity to refute neoliberal notions that obesity was a matter of choice and to confront anti-fat stigma.

Importantly, the medicalization of obesity that occurred during the 20th and early 21st centuries (cf Austin 1999; Boero 2012; Chang & Christakis 2002; Jutel 2006; Oliver 2006) has not served to destigmatize the experience of being fat for these participants. Rather, the fact that obesity is still commonly held to be a pathological state that results almost entirely from behavioral choices has served to intensify anti-fat stigma and discrimination (Puhl & Huerer 2010). Although many participants had internalized the belief that their ‘failure’ to lose weight was related to behavioral choices, they also deeply desired for others, including medical providers, to understand their fatness as a medical condition outside of their control and for which they needed help. In some cases they demanded a medicalized account of their fat bodies and were angry when they did not receive one from providers. These findings thus support Conrad’s (2007) argument that patients (or consumers in his term) are helping to drive contemporary medicalization.

But moreover, these findings support the work by Clarke et al (2003) on ‘biomedicalization’ – or the multi-sited, multidirectional process of contemporary medicalization. These authors argue that in an economic context of increased privatization, cutbacks in medical coverage, and devolution (or the shifting the responsibility for care from government to families and individuals), health and illness are becoming moral responsibilities and bodies come to be seen as inherently transformable and improvable. Biomedicalization thus involves a steady shift in general cultural expectations about health and wellbeing in such a way that “self-disciplining and other public disciplining” become commonplace (172). Health, they continue, thus becomes a site of stratification and diving practices; although responsibilities for health are broadly extended to all, some populations are defined by risky behaviors and need of disciplinary interventions, while others are defined by their compliance and risk-reduction.

The participants I spoke with were caught between a desire to have fatness understood as a medical condition needing intervention; the anti-fat attitudes of others, including providers, which framed fatness as a failure of the will and nothing more; their own internalization of these messages of personal responsibility for proper behavioral choices, and, the biologically intractable nature of fatness wherein dieting not only fails to reduce weight in the vast majority of cases but results, in the long term, in increased weight gain (Kassirer & Angell 1998; Mann et al 2007; Puhl & Heuer 2010). As I discuss in detail later in this chapter, increasing concerns about further and future risks of weight and health, and the belief that bariatric surgery might finally provide durable answer to obesity, served as a strong motivating factor for these participants in choosing bariatric surgery. By doing so, they were able to contest stigmatizing beliefs that their fat bodies reflected a pathological interior by seeking out, and even demanding, a medical solution to obesity.

It is important to highlight the work that emotion does in both waging and navigating anti-fat stigma. As Fraser et al (2010: 203) have argued in their discussion on fat and emotion, the social, the emotional, and the corporeal cannot be separated: “Emotions emerge and move between bodies, affecting those who carry the weight and those who do not in different but related ways, and constituting the boundaries between the two in the process.” Drawing on Ahmed (2004), they argue that emotions do not move between groups but rather constitute and differentiate the social boundaries between subjects and collectivities. The emotion of hatred is particularly powerful in this regard. “The idea proposed here is that strong negative emotions constitute categories of persons by which some are included and some are excluded, some valued and some denigrated, and thereby establish stabilities of belonging and legitimacy” (Fraser et al 2010: 205). In the case of the obesity epidemic, they suggest hatred constitutes these categories along the lines of health and responsibility in ways that are always already raced, classed, and gendered.

Guthman’s (2009) discussion of undergraduate students’ responses to a class designed to challenge mainstream ideas about fatness, morality, and health animates the arguments made by Fraser et al (2010). Throughout the semester, Guthman asked her students to keep a regular journal in which they responded to the course lectures and materials. Reflecting on the contents of the journals, Guthman stated that students became “unmoored” during the course:

Students seemed to feel that the class was undermining a lot of work they had done at self-improvement and, hence, identity creation. In other words, it appeared that I was disrupting their grids of right and wrong, for I was suggesting that what students do to make their bodies and identities (eat “right”, exercise, eat organic, moderate excess, and so forth) does not necessarily map onto body shape, guarantee health, or make people good/righteous” (2009: 1127).

Similarly in her examination of the anti-fat attitudes of her college students, Greenhalgh (2012) argued that national campaigns designed to banish obesity and promote health were not

producing weight loss but instead were producing subjectivities colonized by a fear of fat. By “colonized,” Greenhalgh suggests that weight consciousness was not only something that her students took up, but that it had become a significant component of their identities and that they deeply felt it was key to their social acceptability. Thus following Fraser et al (2010), Greenhalgh (2012), and Guthman (2009), it is possible to see that anti-fat hatred did more than reduce life chances for the participants I spoke with. Rather, it worked to produce and differentiate subjects and collectivities –the fat and the “bio bullies,” in Greenhalgh’s (2012) term – along lines of risk, responsibility, and worth.

Lewis et al (2011) contend that, like other forms of discrimination, anti-fat bias is not only direct and insidious, but also environmental. This section has provided evidence for both the direct and insidious nature of anti-fat stigma. In the section that follows, I examine the ways in which anti-fat discrimination works at the interface of the discursive, the emotive, and the material. I demonstrate how anti-fat stigma operates through what Garland Thomson (2011) calls “misfitting,” or when body and world, shape and substance come together to produce discrepancies and consequences for some bodies but not others. I elaborate how, in response, participants used a final technique discussed by Kirkland (2008) of ‘scanning,’ or preemptive ascertaining the built and social environment, as a means by which to avoid stigma, anxiety and physical pain.

Big bodies, small spaces

When they discussed their previous lives as very fat people, all of the participants made reference to social and built environment ‘misfitting.’ For Garland Thomson (2011), a misfit occurs when two things come together in disjunction, like a square peg in a round hole. In the

case of bodies, she states, a misfit occurs “when the environment does not sustain the shape and function of the body that enters it” (594). Whereas the built environment offers a fit for the majority of those bodies, Garland Thomson continues, it also creates misfits for minority forms of embodiment. While Garland Thomson’s analysis is particular to disability, I argue that it extends to fat embodiment as well.³⁰

In discussing what it was like to navigate the world as fat, participants frequently discussed the ways in which leaving the house was always a potential, anxiety-filled problem and required them to anticipate how their bodies would or wouldn’t fit in chairs, desks, restaurant booths, bathrooms, public transportation, aisles, work uniforms, and more. In describing the misfit between the social and built environments and their bodies, participants talked at length about both the physical and emotional pain entailed in living in bodies that did not fit. Participants would then contrast these stories to their current experiences of being thin/thinner and the tremendous relief and excitement they felt at navigating the world as ‘normal’ (this is explored in detail in chapter four).

Air travel in particular presented a major challenge for participants. Some were told by ticketing agents in less than kind terms that they would be required to purchase an additional seat. Many felt humiliated at having to ask for a seat-belt extender. As well, participants felt shame when fellow passengers expressed disgust and annoyance at having to sit next to them. Some described the physical pain of trying to squeeze into too small seats as nearly unbearable. For example, Sarah spent ten hours out of a thirteen-hour flight home from Israel in the

30 The relationship between fatness and disability has not been well taken up by either fat studies or disability studies (cf Aphramor 2009; Cooper 1997; Garland Thomson 2005; Herndon 2003). Garland Thomson has addressed this relationship and suggests that that fatness is always an appearance impairment, such as *nervus flammeus* (port-wine stain birthmarks), and at times is a physical impairment as well. (To this I would add that there is a correlation between fatness and chronic illnesses such as type 2 Diabetes.) She argues that fatness is therefore a disability issue. Her argument does not appear, however, to be common in disability studies. For a full discussion on the linkages and convergences between fatness and disability, see Meleo-Erwin (forthcoming).

bathroom because the man next to her insisted on putting the arms between their seats down, which meant that she could not fit: “I just went in there, locked myself in, and fell asleep because I fit and I didn’t have to worry about anybody else.”

Whereas all of the participants I interviewed discussed the shame and humiliation involved in misfitting, it was notable that participants in the Greater New York City area (21 individuals, 70% of the sample) spoke about this topic at length. Specifically, they made frequent and explicit mentions of the particular interface between their fat bodies and the MTA, or Metropolitan Transit Authority, and the tightly packed spaces of the city itself.³¹ I thus focus the majority of the following discussion on participants in the Greater New York City Metropolitan Area. With an annual ridership of over 1.5 billion, 468 stations, and 26 subway lines, the subway system of New York is the largest transport system in the world and has the fifth largest ridership globally (MTA Website 2009). Only 23% of subway & commuter rail stations, however, meet the accessibility specifications of the 1990 Americans With Disabilities Act. Walking up several flights of stairs to get out of some stations can be a challenge for even for the most able-bodied of New Yorkers. Additionally, social norms in Manhattan dictate that individuals should move through public spaces, including MTA exchanges, very quickly. However, for others who require more time, and for those would be aided by the use of elevators and escalators, these norms in combination with the lack of accessible stations unquestionably excludes individuals with mobility impairments from equal use and participation, forcing them to

31 While participants didn’t reference the New York City Department of Health and Mental Hygiene anti-obesity campaigns, it is notable that they are advertised heavily within the MTA. Moreover, these ad campaigns rely on highly stigmatizing, fat phobic messages and images. One recent ad features the outline of a very fat man literally pouring excessive amounts of junk food into his mouth. Other ads suggest New Yorkers use the city as their gym. And others still show fat individuals in mobility devices, struggling to make their way up subway stairs, and as amputees (In this case, the lower leg of the model was actually digitally removed to underline the notion that obesity inevitably leads to chronic illness and disability.). These campaigns well illustrate Evan & Colls’ (2009: 1012) assertion that “space and place are becoming increasingly important to the conception and deployment of obesity politics.” Moreover, they illustrate Petersen & Lupton’s (1996) argument that notions of the ‘healthy city’ are becoming increasingly prevalent within contemporary public health.

use the unreliable Access-a-Ride system and city buses (Finkelstein et al 2008).³² And thus, as disability scholars and activists have articulated, the built environment assumes a certain type of body – how it moves, what it looks like –and in doing so creates challenges and exclusions for those whose bodies look and work differently. Strategizing about how to navigate these challenges was a frequent topic of discussion for participants in the New York City and greater metropolitan area.

Many participants spoke of the shame and physical discomfort in having to stand on public transportation for fear that they would be openly disparaged for “taking up too much room” on subway and bus seats. When I asked about how she navigated daily life in her formerly fatter body, Laura, noted:

When I first moved to New York, I lived almost in between two different subway stops but at one of them, you had to climb about four flights of stairs to get out of the subway, and the other one you had to climb two. I would make sure to get out at the one where I just had to climb two because if I got out at the other one my heart would be pounding out of my chest, or I would have to take a break in the middle because I couldn't climb all the way up.

Both Laura and Kathleen mentioned that the seats in certain subway and commuter lines were made of molded plastic, and thus indicated by design the amount of space an individual should take up. Deciding to sit, then, was not simply a matter of taking an open seat. Rather, because they knew they would require more space than what was allotted per individual, these participants only took seats after calculating how crowded the subway or train car was and how crowded it would likely become.

32 Participants in 2008 study by Finkelstein et al described the Access-a-Ride system as a “separate but not equal” mode of transportation: “People we spoke with described long delays in the cold; waiting for vans that never arrive; inefficient, circuitous routes; unhelpful dispatchers who send drivers to the wrong location or leave messages at home when the person is on the street waiting; and limited routes that do not pick people up close to home (particularly in public housing developments) or allow people to get where they need to go” (38).

The decision to not take a seat, to stand instead, was one that was made at a cost for larger individuals who experienced weight-related joint pain. Danielle noted that the middle seats were almost always the only available places to sit in crowded cars and “wedging herself in” would not be an option. Thus only on days that there was an available end seat that she could perch on the end of was she able to take the weight off her feet and knees. Because end seats were rare and the experience of riding the subway was both challenging and painful, she began to avoid the subway, instead having her husband drive her when possible. Talia similarly reported driving herself or catching rides with her partner to escape using public transportation when she could. The pain involved in misfitting was not just physical, however. As Ursulina described, it was emotionally devastating as well: “Not fitting on chairs when you go somewhere. Do you know how embarrassing that is, where you [sit on] a chair and you’re flopping over it? I can’t tell you. Little things like that that just hurt, they hurt. They absolutely hurt.”

Many participants noted that the densely populated nature of New York City, where space was limited, made navigating daily life in the city at large very challenging. In Talia’s words, “More people, more obstacles, less space.” Participants described daily life in the city as having to always be on guard, looking for the next obstacle. For instance, Talia stated:

In the city everything is crowded. When you go into a store, the clothes, the racks are closer together than they are in other cities because the space is at such a premium. And, there are crowds of people everywhere...I was constantly scanning the world for like, “Where will I fit?” If I went into a restaurant the first thing I did was, “Are there arms on the chairs,” and if there were I would have to go searching through the restaurant for one without arms...I was just used to doing that. I did that every minute of the day. I was just constantly scanning like, “What’s coming next? What’s the next obstacle?”

Many participants reported fearing that they wouldn’t be able to pass through tightly packed spaces in restaurants and other establishments. Candice worried she was always in people’s

way: “I would walk in some place and say, ‘Will I be able to fit? Will I be able to maneuver around these people and not bump into them?’ I was always self-conscious.” Talia learned to wait until other passengers exited the subways and climbed the stairs before she made her up. She did so to avoid the open hostility from other passengers who felt inconvenienced by her slow ascent.

Danielle discussed the ways in which, even something as quotidian as joining coworkers for lunch involved a degree of shame-filled internal strategizing:

I knew that I wouldn’t be able to keep up with them walking comfortably... There was always calculation going on in my head, you know? And so I would be like, “OK, I’m going to meet you guys there because I have to run to the bank first.” I would always be doing things like that, just sort of to shield myself from that kind of shame, or embarrassment.

Talia stated that her job required her to visit clients at their homes. Because many New Yorkers live in walk-up apartments, she struggled with climbing multiple flights of stairs and found herself arriving at their doors “huffing and puffing.” Eban, who had moved a several hours outside of the city described the challenges of driving to visit his family Manhattan: “I was living in a suburb and driving everywhere was pretty acceptable... As I got more and more disabled by weight I hated coming to the city, because it’s so hard to be a driver, to go anywhere by car. It made me more and more anxious, coming down to visit my family. It became hard...to just think about finding parking within the couple of blocks that were like a comfortable waddle.”

Although participants often found creative solutions to navigating the hostile environment of both the MTA and the city at large, they also identified an increasing sense of isolation that resulted from the physical discomfort and embarrassment of not fitting in. For instance, Talia rarely joined her partner and their friends on outings to movies or the theater because the seats were too tight. Even when she was able to find the rare locale with armless

chairs, she still encountered difficulties; She would sometimes have to explain to other annoyed patrons that the chair next to her was not free, and that she was using both of them. Weariness over having to explain herself or ask if a venue could accommodate her became too much, and thus she would often remain at home. Similarly, Decenia would make excuses to her husband in order to avoid social situations outside of the home: “I’d say to my husband, ‘I don’t feel well, you go.’ But you know what? It was because I was afraid not to fit, you know?” Katrina also avoided going out with her boyfriend (and later husband) for fear that he would be embarrassed of her. Reflecting the emotional and physical confinement that comes with being very fat (Longhurst 2011), Kathleen noted: “In New York, because [of the reliance on public] transportation, I think it is a huge problem that so many things are not more accessible. There are a lot of people really whose lives are very limited because of those things. I think that really sucks.”

The anticipatory scanning described by these participants, and the anxieties it produced, echoes Kirkland’s (2008) contention that in addition to moral instruction, redirecting shame, positive self-presentation, and ignoring the mistreatment, fat individuals use the technique of ‘scanning’ in order to anticipate, manage and navigate hostile social and built environments. Scanning, she states, “is a technique for assessing, surveilling, and planning one’s movements through the world to avoid discomfort and humiliation” (410). This technique, Kirkland suggests, involves both literally rapidly looking over situations and places to determine accessibility, as well as a learned assessment and observation technique that allows fat people to anticipate how they will be received in new situations and new places.

For these individuals, worries about not fitting were more than just internal calculation. Rather, others made all too clear that fat bodies are not welcome. Nina recalled nasty looks she

received from other subway riders when she attempted to sit down. She interpreted these looks as expressing the message: “Oh, she ain’t trying to squeeze into this little seat, right?” Decenia described an experience on a crowded commuter train in which the woman next to her openly expressed annoyance and disgust that their thighs were touching. Talia recalled being terrified when a fellow rider rushed up to her on the subway. As she braced for an attack, the individual handed her a brochure for a weight loss program, turned, and exited the subway without saying a word.

When asked to contrast their experiences living in New York City as a fat person with their experiences of having traveled or lived elsewhere, participants almost universally described the New York as a more difficult place to live. Kathleen stated that the Midwest and the South, in particular, felt “safer” and were places where she could put her guard down. Laura noted a marked difference between her experiences as a fat person in Manhattan and her home state of Texas: “Spaces are larger there than they are here. Like, the tiny little tables in the Manhattan restaurants, and then they’ll pull them out for you? You don’t have any of that in the South because there is plenty of space for everything. There was a lot less feeling that I didn’t fit, you know what I mean?” Similarly Jennifer noted that while she never fit in on Long Island, she felt more “normal” in Virginia where her father had relocated. There, she stated, people didn’t “bat an eye at you.” However, her visits to the South did not provide total relief from anti-fat stigma. She stated that her father was always critical about her weight: “So even if I was in a place where people were larger, then he would still make me feel bad, not intentionally. He was concerned about me, so that kind of made it more stressful than anything.” This illustrates that, even in places that are ostensibly more accommodating of larger bodies, one is never outside of discourses and anxieties surrounding obesity and health. Notably, Southern and Midwestern

participants also reported high levels of anti-fat stigma in their home cities and towns. However, they did comment that when they visited California or New York City, they felt hypervisible and much more uncomfortable. As Yvonne put it, “If you’re going to be big, the South is the place to be.”

However, the experiences of three Latina New Yorkers that I interviewed troubled the narrative that the Greater New York Metropolitan Area was a more difficult, unfriendly place to live as a fat person than elsewhere. As noted above, Katrina felt that the harassment she received in the Dominican Republic was far more intense than what she experienced in Northern New Jersey. Although Decenia detailed painful experiences of anti-fat stigma in her suburban town on Long Island as well as her commutes to and from Manhattan, she nevertheless described her life as relatively “easy” compared to what it was like in her home country of Brazil.³³ There, she said, one simply did not see fat people and finding plus-size clothing was nearly impossible. She often felt great anxiety at returning home to visit family after having gained additional weight. The United States, her friends and neighbors contended, was making her fat. Although she was offended, eventually she saw their comments as something of a “wake-up call.” She was fat before, she stated, but the permissiveness toward bigger bodies in the United States had unquestionably made her fatter.

Denisa’s experiences also trouble the notion that New York City is uniformly unfriendly to bigger people. She stated, “When I grew up in Spanish Harlem, I was comfortable. When I used to go downtown, it was like, ‘Oh my God! Everyone is so skinny here.’ Nobody eats. Everyone eats salad and drinks a martini. In Spanish Harlem it was different. In Harlem it’s different. Everybody is really fat or plump -- so you feel a bit more comfortable. Not everybody,

³³ Interestingly, Brazil ranks 2nd in the world for number of bariatric procedures annually (the United States/Canada together are first), and first in terms of the number of bariatric surgeons (Buchwald & Olen 2013).

but there's a mix. Downtown -- there's no mix.” Against the “tall, blond, and skinny” women of Lower Manhattan, Denisa was materialized and thrice marked as Other: fat, short, Latina. Making a joke about the different communities in Upper and Lower Manhattan, she stated that she had never seen a fat blond girl on 18th street in her life: “I don’t think they exist.”

Collectively, their stories serve as a reminder that one should be suspicious of overdetermined accounts that suggest that “Latino culture” is more accepting of larger bodies. Their comments reflect arguments made by Colls (2007), Grosz (1999), Garland Thomson (2011), and Munn (2003) who have all pointed to the contingent nature between space and bodies. Colls (2002) argues that sizing is both a material and an emotional process – What size we take ourselves to be shifts in different physical and emotional contexts. Grosz (1999) suggests that there is a “mutually constitutive relationship between bodies and cities” – one that, I would add, is always raced, classed, and gendered. Garland Thomson (2011) has described the relationship between bodies and space/place as “a dynamic encounter between world and flesh.” These encounters, she states, are always contingent and situated: “When the spatial and temporal context shifts, so does the fit, and with it meanings and consequences” (592). Similarly, Munn (2003: 101) suggests that bodily boundaries cannot be thought of outside of the body’s “spatiality, actions, and locatedness” - they change from one moment to the next as an actor moves through space and time. In this sense, fat is materialized differently at different scales – nation, state, city, neighborhood – and the materialization of fatness is always entangled with raced, classed, and gendered social and political-economic relations.

Just as bodies are materialized differently in different contexts, misfitting is also a spatially and temporally contingent phenomenon (Garland Thomson 2011). Thus, a misfit might occur on West 18th Street in Chelsea but not on East 118th Street in Spanish Harlem (Denisa). Or

what feels like a misfit on the Long Island Railroad when flesh exceeds space and encounters other flesh might feel vastly different than the misfitting that occurs in a place where one realizes “If I gain another pound, I can’t buy anything here” (Decenia). Misfitting can thus be seen as occurring within a very specific, mutually constituting relationship between discourse, culture, emotion, and materiality.

Nevertheless, it is possible to draw some structural commonalities between divergent parts of the New York City area. Specifically, a dense population, cramped physical spaces, inaccessible transportation and transportation service cuts, social norms of fast paced life, and elite, raced, classed and gendered norms of status and beauty work to materialize fatness in such a way that a ‘misfit’ is often the result for fat people who live and/or work in this area. And importantly, misfitting, as Garland Thomson (2011) argues, has consequences. It materializes certain bodies as marked and exceptional. It literally “casts out” when the “shape and function of...bodies comes into conflict with the shape and stuff of the built world” (Garland Thomson 2011: 594). This casting out produces some bodies as irrelevant to social and economic life, resulting in segregation and isolation. To misfit, she argues, is to be denied full citizenship.

Responsibilizing the present

Garland Thomson (2011: 596), discussing Bynum’s (1999) statement that “shape carries story,” argues the following: “The idea that shape carries story suggests...that material bodies are not only in the spaces of the world but that they are entwined with temporality as well.” In the last section of this chapter, I discuss how participants described their decisions to get weight loss surgery by making references to a need to act now, in the present, in order to avoid further and future morbidity and mortality. Following Adams et al (2009: 246), I look at how the fat body is lived in a state of constant anticipation – “thinking and living toward the future.”

As I have discussed in earlier sections of this chapter, all of the participants I spoke with described long histories of weight cycling. Each one described having effectively tried every diet plan on the market – meal plans, Weight Watchers, diet pills, fad diets, hypnosis, and more. While many managed to lose significant amounts of weight, none were able to maintain this weight loss – a reality consistent with the medical fact that dieting does not produce durable results (Kassirer & Angell 1998; Mann et al 2007; Puhl & Heuer 2010). They experienced this inability as not only distressing, but terrifying, as they repeatedly regained the lost weight plus more. Participants reported feelings of both helplessness and hopelessness. When they learned about bariatric surgery, they felt a renewed sense of optimism that perhaps something could be done.

Some individuals had reached a point where they were experiencing great emotional distress about their weight. Tania stated, “I was just so heavy and so uncomfortable and crying every day.” Ursulina characterized the quality of her pre-surgical life as “breathing, but that was about it.” Hanifah felt like she just couldn’t take another round of trying and ‘failing’ with dieting: “It was very frustrating to see me diet up the scale, just get bigger and bigger.” Many described a desire to escape a sense of isolation. For instance, Calvin said, “I couldn’t go to the theme park. I couldn’t enjoy going traveling on the train, going to the theatre; There were so many restrictions... And, I felt like it was a way for me to be the person [I wanted to be], because there was so many things that held [me] back, mentally and physically in my life that I dealt with.”

Others, like Eban, Talia, and Hannah became increasingly concerned about weight related comorbidities and mobility limitations. A few participants had life-threatening health concerns to contend with: Calvin had a stroke in his early 20s, had high blood pressure, sleep

apnea, and also developed diabetes-related gangrene in his toe after stubbing it. Katrina had significant heart problems from taking diet pills and had to be put on heart medication. She worried that her weight would exacerbate her heart condition. Talia had diabetes, sleep apnea, high blood pressure, high cholesterol, fatty liver, and kidney disease. Consistent then with Boero (2012), Lopez (2009), Wadden et al (2007), the participants I spoke with did not seek out surgery in hopes of finding a permanent way to become *thin*, but rather a permanent way to become *healthy* and *normal*. Concerns about health, more than concerns about appearance, motivated their decisions.

As Denisa put it, “I think a lot of people want surgery because they obviously want to look more attractive. I was always sort of a happy, fat girl...I was never really depressed. It was really the health scare. Had my doctor not told me about the PCOS [Polycystic ovary syndrome], I don't know if I would have gotten surgery at that moment. I am sure I would have later on, but I don't think I would have said – as of August – I'm now having surgery a month later.” Talia also made the decision to have surgery based on a careful consideration of her health, not appearance. But unlike other respondents, she noted the role that anti-fat stigma and discrimination played in making this something of a forced choice: “For me, I didn't think I was a bad person. I didn't think I was ugly. I didn't think it was bad to be fat...I don't think I had to do it. I think I wanted and chose to do it because of where my life was and because of what I thought the benefits might be. But, could I have lived the other way? Sure.... Some of the health stuff probably could have been improved at that size, if the world was different.”

Significantly, for these participants the decision to have bariatric surgery was based on concerns about *future* morbidity (and mortality) at least as much, if not more so, than on concerns about a current state of ill health and impairment. Some individuals I spoke with were

unquestionably suffering from multiple chronic and even life threatening illnesses, as I have described above, and feared they would prematurely die from these conditions. Nina reported, “I had sleep apnea. I had borderline diabetes. I had high cholesterol. I had high blood pressure. I was 26 years old and I was going to die.” Nina decided to have bariatric surgery, she said, to save her life. Similarly, Calvin stated “Everyday I would just feel like I would go to bed not knowing if I was going to wake up, and it was a horrible feeling to feel at 23, 22, you know, just not knowing if this was the day I was going to die. I just didn’t want to go through that anymore, you know?”

These stories complicate straightforward medicalization accounts of fatness. It is true that the morbidity and mortality risks associated with fatness are socially shaped, if for no other reason than anti-fat stigma mediates and confounds this relationship. It is also the case that the health issues that these participants were contending with might have been approached in a different manner, and that anti-fat stigma shapes the forms of treatment medical providers suggest to fat patients. Nevertheless, one should not reduce the decisions these individuals made to have bariatric surgery to ‘disease mongering’ and some form of ‘false consciousness.’ Rather, the decisions these individuals made to have bariatric surgery can be seen as faithful attempts to address very real health concerns by utilizing the medical resources available to them.³⁴ (The extent to which participants’ health concerns were resolved by weight loss surgery is taken up in chapter 4.)

34 “Health at Every Size” (HAES) approaches, which suggest that durable health improvements for fat individuals are best seen with interventions that deemphasize weight loss and instead focus on enjoyable movement, healthful eating, and self-acceptance, do appear promising (cf Bacon et al 2002; Bacon et al 2005; Bacon & Aphramor 2011). However, the HAES approach is not currently well accepted within the larger medical community, which makes it unlikely that fat patients are aware of it. As well, while the HAES approach seems well suited to overall health improvements for fat individuals, it is unclear if it can address immediate and high-risk medical conditions that some fat individuals may face.

Other participants did, however, make the decision to have bariatric surgery despite the fact that they had no comorbidities whatsoever. Motivating their decisions to have surgery was the fear that they would eventually *develop* them. Looking to familial histories, Kathleen, Shoshana, Candice, and Faith worried that they too would eventually develop diabetes, cancer, or heart disease. Faith remarked, “I just had this deadline of my 30th birthday just looming over me. That was the catalyst: I wanted to do it before I was diabetic.” Marion was motivated to have surgery based on the early death of an overweight friend: “I had a friend who, literally, dropped dead at 42 years old. He was maybe like 50 pounds overweight, not significantly overweight, and nobody ever knew what actually happened. The reality kind of set in for me like, ‘You better take care of yourself or this could be you, too.’ So, really, [the reason for having surgery was] just not having to worry anymore that I would be healthy.” Nadia and Kristin were both in relatively good health but worried about the effect yo-yo dieting was having on their states of health over time. Decenia was concerned that her plantar fasciitis would eventually lead to more significant mobility impairments: “I have to walk. I have to be mobile. I’m too young to be, God-forbid, in a wheelchair.” Shoshana, who was in her 60s and had no significant health concerns at the time she decided to have surgery, said: “My terror of becoming ill made me do research to find out about it, to find out what existed out there for me.” Worrying about the possibility of future health concerns, Karen decided she had better save herself for the sake of her children. Conversely, Hannah’s children lead an intervention and told her that they feared she would die if she didn’t take action.

Importantly, these concerns were not merely the result of internalizing commonly held societal discourses about the relationship between weight and health. Rather, medical providers also explicitly and repeatedly told these participants that lest they take drastic and immediate

action, they would die. Nina's doctor told her she would have a heart attack or a stroke by 30 if she didn't lose weight. Faith's reproductive endocrinologist said: "You're going to have diabetes by the time you're 30; You're going to have a stroke by the time you're 40. And I can only hope that you can recover enough from your stroke that you'll be able to take care of your family." Kaia's doctor told she was going to kill herself if she kept overeating. Katrina, Sarah, Danielle, and Talia were told that without losing weight, they would never have children – something they all deeply desired. Sarah was told that even if she managed to become pregnant, she could die in childbirth.

It would be a mistake to conclude that some bariatric patients (like Calvin, Eban, or Talia) needed surgery while others (like Shoshana, Faith, or Marion) choose it for the wrong reasons. Regardless of their states of health at the time they made the decision to have surgery, the concerns that drove these patients to seek out these procedures were experienced as very real. Whether or not these concerns would have materialized as actual health conditions is unknown. Furthermore, bariatric patients should not be seen as having been duped or suffering from false consciousness. Rather, they operate within a particular set of social, cultural, and political-economic conditions that suggest that good citizenship requires risk avoidance and personal health management. This set of conditions helps to produce a bariatric patient population that includes *both* those who were contending with serious health concerns and those who feared they would develop them. All bariatric patients operate within this set of conditions (as do medical providers) and make decisions regarding health (current, future, or both) by using the resources available to them.

In her work on the temporalities of dieting, Coleman (2010) argues that rather than seeing dieting as a linear and progressive event, we might think of it instead a process that brings the

future into the present. “The future is brought into the present as an idea(1) that may or may not be reached. This is to conceive the temporality of dieting concerned with the future, not as open-ended or endlessly open, but neither as pre-determined through detailed planning” (194). The future is thus brought into the present as a potential. Adams et al (2009) suggest that a concern about potential futures is a defining characteristic of our time, particularly in regard to health. “The present is governed, at almost every scale, as if the future is what matters most. Anticipatory modes enable the production of possible futures that are lived and felt as inevitable in the present, rendering hope and fear as important political vectors” (249). The ability to act in the present based on potential future risks, they argue, has become a moral imperative and a marker of proper citizenship. Importantly, however, our work to secure the ‘best possible future’ is never fully assured, as risks are constantly changing. The future “is always uncertain and yet is necessarily coming and so therefore always demanding a response” (249). Acting responsibly in the present is thus an ongoing event, one that engenders “alertness and vigilance as normative affective states” (254).

Moreover, these anticipations are not diagnostic, but productive. As Adams et al (2009) state, “the future arrives already formed in the present, as if the emergency has already happened...a ‘sense’ of the simultaneous uncertainty and inevitability of the future, usually manifest in entanglements of fear and hope” (250). It is in this light, then, that we might see the decision to have bariatric surgery. For these participants, their future weight-related morbidity and mortality had already arrived in the present and thus needed to act. The emotions of hope, fear, anxiety and I would suggest, hatred, were key in making these decisions. And, as I will argue throughout the remainder of this dissertation, these participants acted in the present not only to secure the ‘best possible health futures’ but to secure responsible subjectivities and

citizenship statuses as well. Yet, this work, as I discuss in chapter 4, is never done: Participants must *continually* work *with* their surgeries to maintain a proper body health and body weight and thus proper subjectivities and citizenship.

Conclusion

To conclude this chapter, I argue that medical, public health, and media discourses – that are always already about race, class, gender, and disability – frame obesity as an epidemic that threatens to bring untold financial disaster and escalating rates of morbidity and mortality upon the nation. As Fraser et al (2010) argue, strong emotions (such hatred, fear, anxiety, and hope), are at the center of these discourses; they construct, circulate, and proliferate them. In this sense, strong emotions about obesity are neither interior psychological states that work between individuals or societal states that impact individuals. Rather, emotions emerge between subjects and between subjects and society, (Ahmed 2004; Fraser et al 2010). Emotions are fundamentally productive, social, and are *constitutive of* subjects and collectivities. By this, Fraser et al, following Ahmed (2004), mean that strong negative emotions, such as hate and fear, produce categories of people, defining them as a common threat. In the process they also create categories of people who are deemed legitimate. In this sense emotions are productive of the borders and boundaries between subjects and between collectivities, defining some as inside collectivities and some as outside of them. In the case of fatness, Fraser et al state, “Notions of obesity provoke an ‘intensification of feeling’ that in turn materializes particular subjects (such as the healthy citizen), objects (including the object of obesity itself) and collectivities (such as the responsible healthy citizenry). In this respect, rather than engendering or expressing chaos,

the obesity phenomenon can be seen as engendering and expressing particular politically articulated forms of order” (Fraser et al 2010: 206).

As these authors have argued, the social, the emotional, and the corporeal cannot be separated. To this I would add the material world. For fat individuals, experiencing the world as a second-class citizen is more than just discursively produced. Rather, the misfit between fat bodies and the built environment also produces both stigma and exclusion. Moreover, feelings of shame over this disjuncture work in tandem with a deeply felt, pressing sense that something must be done in the present to secure a better health future. The decision to have weight loss surgery thus occurs at the interface of emotion, flesh, space, place, and time, and in ways that are fundamentally shaped by the broader social context of neoliberal healthism.

In the next chapter, I discuss the ways patients’ lives shifted after having bariatric surgery. I discuss the fact that while patients were thrilled with the remediation of health concerns and at experiencing the world as (more) normal, these experiences were counterbalanced by new concerns over the physical and physiological side effects of weight loss surgery. As well, I discuss the ways in which having bariatric surgery, and losing a significant amount of weight, had unexpected social consequences, which, in turn, opened up new questions of selfhood for the participants I interviewed.

Chapter 4:

Navigating the Bariatric Body

The intersubjective negotiation of being-in-the-world as a 'banded body' is complicated, confusing and, at times, disturbing...In my own experience post-surgery, my visibly normative (inter)corporality is continually haunted by a management of internal psychological and physical conflict, a hidden dis-abled embodiment. (Murray 2009: 158)

I was never comfortable in the old body, but find myself somehow not entirely comfortable in this new one, either. Although here and there have shifted places— here has become the place I want to be and stay, and there a nightmare to which I never wish to return—I am not convinced I am certain of their boundaries. (Glenn 2012: 9)

Despite the increasing public interest in bariatric surgeries and a dramatic rise in the number of procedures performed over the past two decades (AHRQ 2007; Encinosa et al 2009), weight loss surgery remains much maligned by both proponents of traditional dieting and by fat activists. In her content analysis of mainstream magazine articles on weight loss, Drew (2011) found that bariatric surgery is frequently portrayed as 'medically risky,' 'extravagant,' and an 'overly easy escape from obesity.' To have weight loss surgery is to have 'cheated.' By contrast, dieting and exercise are framed as involving 'real work' and are thus portrayed as more virtuous. Throsby's (2007; 2008b) research shows that bariatric patients are highly aware of these negative portrayals. Her participants felt twice chastised, she states – first for having become very fat and then for having taken 'the easy way out.' Portraying bariatric surgery as 'stomach amputation' and 'mutilation,' fat activists have also critiqued weight loss surgery. For instance, the National Association to Advance Fat Acceptance (NAAFA), which also rejects dieting, has condemned bariatric surgery "under any circumstances." NAAFA argues that social reforms, not body normalization, should be the means by which fat people address anti-fat stigma and discrimination (cited in Murray 2010). From the perspective of many leading size acceptance activists, bariatric surgery patients have – at best – been duped by the weight loss surgery industry; at worst they are complicit with anti-fat discrimination and are thus 'traitors' (Throsby 2008b; Throsby 2012a).

Following Throsby (2012a: 109), a critical approach to weight loss surgery need not portray bariatric patients as cheaters, victims of a monolithic bariatric profession, or “lost in a fog of false consciousness.” To see bariatric patients in this way, she argues, is to miss “a valuable opportunity to appreciate more fully the contradictory nature of these experiences, their problems and constraints, and, simultaneously, their pleasures” (Throsby 2012a: 121). Engaging weight loss surgery critically, she suggests, involves looking for the contradictions, ambivalences, and complexities of everyday bariatric lived experience. Drawing on Haraway (1991[2004]), Throsby (2012a: 113) advocates seeking the ‘unexpected openings’ – the “small breaks and disjunctures in the weave of anti-obesity rhetoric, where the work of unsettling certainties can gain hold.” By ‘disjunctures,’ Throsby is referring to what might be seen as inconsistencies in bariatric patients’ experiences and opinions around obesity, weight loss surgery, and health. Importantly, to look for these unexpected openings is not to romanticize or overstate the opposition of weight loss surgery patients, Throsby argues. Instead, it is to “create an analytical space that can accommodate the complex simultaneity of both resistance and compliance” (2012a: 112). For my purposes, paying attention to such unexpected findings helps illuminate the multifaceted ways in which bariatric patients are socially positioned within a neoliberal healthist climate and how they respond to this positioning. As well, such an approach makes clear not only the connections but also the conflicts and divisions within bariatric communities (discussed in chapter six).

In this chapter I examine the complex and often contradictory experiences of what it is like to move from being very fat and medically assigned a diagnosis of morbid obesity, to having had weight loss surgery, and then becoming thin or thinner. As I describe, all of the participants I interviewed described significant improvements in both physical health and overall well being.

In addition, all reported feeling significant relief and even joy at no longer experiencing anti-fat stigma and instead becoming ‘normal.’ However, bariatric patients’ also discuss their post-surgical lives with great anxiety and ambivalence, specifically around the physiological and physical side effects of surgery. In many regards, weight loss surgery patients, I suggest, can be seen as trading one set of embodied concerns for another. Because of these side effects, I suggest that, at best, bariatric patients can be seen as passing for normal but actually have highly queer bodies. In this chapter I further detail the ways in which bariatric surgery is a highly social process, transforming not just the body but the social and the self as well.

No Regrets

Without exception, the individuals I spoke with described having bariatric surgery as an overwhelmingly positive experience—this is true across gender, race, age, sexual orientation, and class. It is also true for the three individuals I interviewed who were involved in fat activism to one degree or another (something I describe in further detail later in this chapter), as well as the six individuals I spoke with who had significant, even life-threatening, complications from surgery. Like the bariatric patients Joannis (2005) interviewed, participants frequently told me that they had no regrets and wished they had had their procedures much sooner. Many interviewees gave near evangelical statements about bariatric surgery, suggesting that those considering it should not wait, that it was the best decision they could possibly make, and that it would completely change their lives. For example, when asked about his overall experience with surgery, Chris stated:

Well, bear in mind that the surgery damn near almost killed me. [But] I will say it’s still the best thing I have pretty much done in my whole life. It’s amazing, and it’s amazing to the point where if I’m out, out and about, at a mall or something, and I see somebody that is completely obese, I cannot help but think, “Why, why,

why can't this person get this epiphany of 'I should really look into this?'" Because I know how big a difference in your life it makes.

Chris would later describe his pre-surgical life as "a very, very dark place." His post-surgical life was the direct opposite, he continued: "It's like butterflies, rainbows. The difference is so immense; it's so big that it's hard to explain." In relating their positive experiences with surgery, participant discussions centered around three key topical areas: pain/disability/disease remission, becoming 'normal, and a shifting sense of self.

Disability Remission

As I detailed in the previous chapter, all of my participants highlighted concerns about further and future disability and disease as the primary motivator for pursuing bariatric surgery. In discussing their lives following surgery, participants that had weight related comorbidities, participants whose pre-surgical health problems were limited to joint pain or fatigue, and participants who had no diagnosed health problems whatsoever all reported and moreover emphasized improvements in their physical health and/or well-being. For example, Barbara, who was 58, stated that she felt "twenty-years younger." Within five weeks of surgery, she came off of two blood pressure medications. As well, she could now stand for hours without back pain, something that was impossible before. While she still had knee pain, she attributed this more to her age and the damage that having been fat had done to her joints. Barbara also felt great relief in knowing that now, if friends or family asked her to join them on outings that would require physical exertion, she could accept without hesitation. Like many of the participants I spoke with, Barbara now went to the gym multiple times per week and felt both more confident and physically stronger.

Within months of having surgery, Talia was able to come off of the medications she took for both type 2 diabetes and fatty liver. Eventually, she was also able to stop taking medication for her kidney disease, as it was considered to be in remission. As well, she no longer had sleep apnea or significant body pain. Because of her long history in fat activism, Talia felt uncomfortable being considered a “poster child for weight loss surgery.” Still, she said, she could not deny that both her mobility and her overall health had significantly improved following her LAP-BAND procedure. She commented, “I’m not in pain all the time. Life feels so much easier. I can physically do things that I could do before.”

Like Barbara and Talia, Katrina, Hannah, and Denisa also came off of or significantly reduced the number of medications they were on following surgery. Katrina considered her ability to come off heart medication within three months following surgery to be an indication that her procedure was really working. And, after many years of being infertile, she also became pregnant five months after her surgery. Following her gastric sleeve procedure, Sarah too began to menstruate again after many years of not having her period. She also reported that she no longer had sleep apnea.

Regardless of prior health status, all participants described great improvements in mobility and energy. Eban first realized the difference that surgery had made in his health and energy levels when a family member asked him to get something across the room and, without thinking, he “just got up and did it” – something that would not have been possible before. He experienced his increased mobility as “freeing and awesome.” Several of the participants reported shock that they could not only keep up with friends and partners in physical activities but could surpass them. Many of the mothers I spoke with described the joy they felt at being more active with their children.

Importantly, the efficacy of bariatric surgery for improving health outcomes in the long term is increasingly in question. For instance, recent research suggests that malabsorptive procedures can lead to severe micronutrient deficiencies (Hansen et al 2012; O'Donnell 2011). Bariatric surgery also seems to raise the risk for acute liver failure because of acetaminophen poisoning (Keller 2012). Two studies (Flum et al 2005; Omalu 2007) demonstrated that risk of early death following weight loss surgery is significantly higher than had previously been suggested in the bariatric surgery literature, particularly for high risk and elderly patients. Arterburn et al (2013) found that while bariatric surgery is associated with durable type 2 diabetes remission, one third of patients experience a relapse within five years of remission onset. Three recent studies have complicated the notion that bariatric surgery reduces health care expenditures in the long term (Maciejewski et al 2012; Neovius et al 2012; Weiner et al 2013). Maciejewski et al (2012) and Weiner et al (2013) both found that long-term health expenditures were not reduced following bariatric surgery. The Swedish Obese Subjects Study (Neovius et al 2012) suggests that bariatric patients have lower medication costs than controls but, for the first six years following surgery, have higher outpatient costs. Commenting on the Weiner et al (2013) study in *JAMA Surgery*, Livingston (2013: E1) stated: "Bariatric surgery has dramatic short-term results, but on a population level, its outcomes are far less impressive."

This dissertation does not preside on the controversial issue of the long-term impact of bariatric surgery on health. Rather, what I seek to demonstrate in this chapter and in this work overall on the topic of obesity, weight loss surgery, and health is threefold: First, the bariatric patients I interviewed, who ranged between six months and twelve years out from surgery, all reported improvements of health and well-being following surgery. Again this is true for those who had major, minor, and no weight-related morbidity concerns at the time of surgery. Second,

as I discuss later in this chapter, participants also reported significant physiological and physical side effects from surgery. Their experiences are typical of the bariatric patient population (Sabin 2004; Sheipe 2006; Wadden et al 2007). In many respects then, bariatric patients trade one set of health concerns and embodied particularities for another. Third, participants' experiences and discussions of the improvements in health and overall well-being cannot be separated from a larger social context of neoliberal healthism. Moreover, the fact that bariatric patients both emphasize that having surgery was the best choice they have ever made and also discuss their post-surgical bodies and lives in highly ambivalent ways illuminates the complex ways in which bariatric patients are socially situated. I elaborate upon these three points in the remainder of this chapter and in the chapters that follow.

Becoming 'Normal'

While the participants I interviewed were delighted by their improvements in health and mobility, they were positively astounded by the ways in which life changed when they began to experience the world as more 'normal.' As described in the previous chapter, direct, insidious and environmental anti-fat stigma (Lewis et al 2011) significantly impacted the lives of all of the participants I interviewed. As they lost weight, their social reception in the world became remarkably more positive. Interestingly, this shift was described in terms of both becoming more visible to others and become more invisible – that is, blending in with the crowd instead of standing out. Participants were surprised to find that strangers now looked them in the eyes while talking to them and behaved more courteously by opening and holding doors, pulling out chairs, and offering to carry heavy items for them. Perhaps even more startling to many of the women that I interviewed was the fact that it was not just men who became more polite and

considerate, but other women as well. Katrina described this shift as the experience of becoming a person: “Now I exist. I am a person. I am someone who’s taken seriously...I’m no longer invisible.” Similarly, Calvin remarked:

I’m in a totally different world now. The way people treat you, I mean I have random people that will come up to me and talk to me for no apparent reason. I don’t know them. [It’s] more acceptable to sit next to me on the bus. Or when you smile at them or talk with them they’re more accepting of you. Do you know what I mean? They’re not as standoffish. I get more respect, you know, when I’m looking at somebody. They pay attention to me. I feel like I’m getting my point across and like I matter, if that makes any sense.

Nina suggested that perhaps she had become more acceptable to society than she was at over 400 pounds. Like the “late identifiers” in Granberg’s (2011) research, it was only after she had surgery that Tania became cognizant of how much anti-fat stigma had affected her life. She recalled having thought to herself, “Oh my gosh, are you kidding me? There really is a difference in the way people treat you.”

At other times during the interviews, participants described the relief they felt at becoming less noticeable. Talia stated that losing weight allowed her to be like everyone else. While there were times when she wanted to feel unique, she said, ultimately it was very nice to feel like just “one of the crowd.” Nina was grateful that others no longer hurled insults at her as she walked down the street and instead she could pass by unnoticed. Similarly, Danielle was excited that she now blended in with the general populous, as she put it, and was no longer a ‘spectacle’ wherever she went. Moreover, when people did stare at her, she felt that it was likely because she was pretty and not because of her size – something she could not believe before surgery. Ursulina stated that not being stared at by others made her feel confident that she had made the right decision.

Decenia began to feel normal when her weight loss allowed her to enact gendered bodily norms differently: “Little things, every day little things like crossing my legs – I never really crossed my legs before and I think that’s such a sexy thing, when a woman crosses her leg.” Sarah described her happiness at being able to shave her own legs, something her husband had done for her before her surgery. Nina and Faith knew they had lost a significant amount of weight when men began to flirt with them. Naomi particularly relished turning the tables on the men who tried to pick her up: “I would say no to guys just because I could. Not because I didn’t want to go out with them, but just because I had been turned down so many times. [Now] I turn them down.” The experience of being newly desired was not limited to heterosexual women, however. Eban, a gay male in his late 30s, also remarked upon the changes bariatric surgery had on his sex and dating life:

I was pretty well celibate from college until like three months ago. Ninety percent of that was about body image, which I’ve got to tell you is particularly weird when you deal with sexuality and gender all the time and talk in-depth and quite comfortably about sex [but] aren’t having any.

Eban had recently begun frequenting online chubby chaser sites, or sites where gay male fat admirers and gay fat men find one another, and was surprised and delighted by the overwhelming positive reception he received. Similarly, Calvin – a heterosexual man in his mid 20s – was learning to navigate his new sexual currency instead of always being seen as the ‘goofy friend.’ Their comments echo but also expand Boero’s (2012) findings. Based on her interviews with heterosexual women who underwent weight loss surgery, Boero argues that bariatric patients undergo a second-adolescence following their procedures, allowing them to experience flirtation, dating, and sexuality in a way they hadn’t been able to as fat teenagers. In effect, she states, they learn femininity and heterosexuality – something thinner, normatively

bodied heterosexual women learn at much younger ages. As my interviews make clear, the process of relearning and gender and sexuality occurs for men, both gay and straight, as well.

In addition to the changes in how others treated them, participants knew they had become normal or more normal when the built environment no longer felt inhospitable and they literally began to fit in. Tania, Hanifah, and Calvin all described openly weeping in stores when they realized they could now fit into smaller or standard sizes. Nearly all of the participants described how different air travel had become – not only did they fit in the seats more comfortably, they also didn't require a seatbelt extender and had enough room to lower the trays. This was similarly the case for movie theaters. Tania described her first experience of realizing she could fit in theater seats as one of child-like delight: "When I sat down for the first time in the movie theatre and realized I didn't have to pick up the chair rail, I kept picking it up and lowering it. I was so excited. I was like a little kid." Laura described fitting in as "what thin felt like." She stated:

It just feels like you fit. You fit in a seat on the subway, or in the seat at the movies, or you fit in the desk in the classroom, that sort of thing. I never realized how much my weight did affect things and how I let it sort of influence the decisions I made...Having it not really be a factor was great. And, being able to go shopping with my friends and not have to just look at the earrings and the socks while they try on all the cute clothes in the stores and then feeling a little guilty when I had to drag them into the one fat girl store that there – we could go in the store together and I could shop and try on clothes. It was fun. That was what thin felt like.

Just as Laura was happy to be able to join friends for shopping adventures, Karen was delighted to be able to go out with friends for meals in restaurants that had booths. Before, she said, going out was a great source of anxiety: "I never wanted to go because I didn't know where they would choose to go and I felt embarrassed to have to explain to them that we may have to choose

different seating arrangements because I won't fit in a booth, you know? That's so humiliating.” She felt so thankful, she continued, that she would never have to feel that again.

This shift was particularly significant for participants from New York City and the surrounding area who noticed the how different navigating the city as thin or thinner felt – from being able to fit through a subway turnstile, to fitting in the allotted seating space for commuters on trains and buses, to being able to pass through the narrow pathways between tables in crowded restaurants. Candice compared her recent experience of closely passing by other patrons in a crowded restaurant to past occurrences: ““Hey, sorry, my butt is going to be in your food,’ and I liked walked by. And, I thought nothing of it, whereas before I would have been freaking out in my head.” Talia described life in New York City after losing over 200lbs as “easy.” The difference to her was so astonishing that she began to feel like thin New Yorkers had no idea of how effortless their lives were by comparison: “These people just don't know what they have, you know?” Some New York City area participants reflected upon how transforming the material body simultaneously transformed their relationships to strangers. Candice was more apt to ask others for directions when she was lost because now people were nicer to her. Denisa noted that her weight loss had shifted her relationship to different social groups and different neighborhoods. While she still felt more comfortable at home in her primarily Latino neighborhood of Spanish Harlem, losing weight changed her relationship to her “skinny white girlfriends” downtown. She said, “Before I would never go out with them. Now, I'll go out to 18th Street and I'll have a drink with them. I'm okay. I'm not so self-aware.” Her comments are again illustrative of the raced, as well as classed, and gendered aspect of the mutually constitutive relationship between bodies and spaces discussed in the previous chapter.

A Shifting Sense of Self

Experiencing the world more positively was not just a matter of increased access or the cessation of stigma. Rather, it was a reflexive process – as their bodies changed and as they felt better, participants also began interacting with others differently. Echoing Joannis's (2005) research, these individuals reported feeling far more self-confident, being more assertive, becoming increasingly vocal in expressing their opinions, and developing more positive outlooks on life. Naomi said her confidence “blossomed” once she began to feel skinny. Before surgery, she continued, she projected an air of confidence but that was more a matter of, “fake it until you make it.” Now, she said, her confidence was real. Katrina's newfound confidence brought increased opportunities at work. Surprised by her sudden promotion, she questioned her boss about it. In discussing his reply, she stated:

He says, “Because I see the confidence in you.” He says, “I'll be honest with you. I was always so worried about you because you were so sick. It never affected your job. You were amazing at what you did, but you were so scared to do things and scared to make decisions. That's what stopped you from ever moving ahead.” He says, “But, now that confidence, you could go in a room and you say ‘no’ and that's what got you your position today.”

After her surgery, Candice also had no problem saying ‘no’ to others. She stated that she no longer needed to “take people's shit” because she now felt more confident. Similarly, Danielle also felt more comfortable setting boundaries. She remarked, “Before I didn't feel like I was the master of my domain. Now, I feel like I am. I feel like I can say what's right for me and what's not, with confidence. I'm kind of like, “If you don't agree, get out of my way.””

Consistent with data from psychological assessments of bariatric patients (Wadden et al 2007), many participants also reported feeling less depression and anxiety and more happiness following surgery. This, in turn, improved their outlooks on life and their senses of self. Given that they no longer experienced a “misfit” (Garland Thomson 2011) between their bodies and the

material world, participants no longer had to scan the built environment for obstacles, planning every move. Because of this, Denisa and Talia felt both far more relaxed, easy going, and more independent. Chris felt “peaceful” and like he was “walking on water” because the things had “kept him down” and impacted his mood were now gone. From the moment he had surgery, Eban felt less depressed and less self-conscious about his body. Describing how he felt the moment he woke up from his procedure, he said: “I didn’t give a fuck who was looking, because it wasn’t really my body anymore. I mean it was like I knew it was sort of on loan and changing.”

In discussing the impact that surgery had on his patients, the prominent Long Island bariatric surgeon I spoke with stated, “They’ve come out of their shells. It’s like a caterpillar becoming a butterfly; it’s a complete change.” Similarly, patients believed they had become the people they were always meant to be. Kaia reported that her weight loss gave her not only increased confidence but also the freedom to try new things. This, in turn, allowed her to become more adventurous, she said. Hanifah stated that while her heart was the same she was a very different person than she was before. Now she considered herself to be vibrant, bright, and “more fun.” Chris also saw his pre-surgical and post-surgical selves as very different. When asked to describe them, he said: “One would be sad and tired. He would tend to shy away from people and from activities with other people, not really seeing positive things much, unless it involved food in some way, not really quick to jump on board of new things. I mean the lust for life was not really there. And it’s the direct opposite now.” Bariatric surgery allowed him to recover a younger version of himself that he had lost to his obesity, he continued. Denisa felt like an entirely different person: more spontaneous, more optimistic, kinder, and less sarcastic. Her LAP-BAND surgery allowed her to become, she said, the person she had always dreamed of

being. These findings lend support for Throsby's (2008a: 119) research. In discussing the ways in which bariatric patients discuss the linkages between their new bodies and new selves, she states: "Fundamental to these accounts, and also to those of [the bariatric industry], is the framing of the re-born 'new me', not as an entirely novel entity but as having been rediscovered and restored: the 'new me' is also the 'real me.'" It is a sense of self that, according to these accounts, has been 'rescued from obesity,' Throsby argues.

While all of the individuals I spoke with expressed strong satisfaction with having had weight loss surgery, life post-op was not necessarily an easy one. Rather, as I discuss in the next section, patients traded one set of concerns for another. While they experienced improved health along many measures, were freed from painful anti-fat stigma, felt more confident, and enjoyed increased access to the built environment, they now contended with the physiological side effects common to bariatric surgery, developed new body image issues, felt unmoored by the experience of having rapid weight loss, and faced stigma for having chosen bariatric surgery.

'Side Effects'

Murray (2009) notes that bariatric procedures are frequently described as relatively simple operations that involve minimal risk and preserve aesthetic appeal through the use of laparoscopy, which results in minimal scarring. This description, she argues, emphasizes only the minor intervention at the time of surgery but obscures the "major (and ongoing) physiological, behavioral, social, and psychic impacts" of living in a post-operative bariatric body (158). As well, she contends, the 'before and after' photos that bariatric websites use to promote these procedures suggests a relatively linear transition from poor health to better health

and a normative appearance.³⁵ What's missing from these photographs is an adequate focus on the side effects common to bariatric surgery as well as the issue of the loose skin that results from rapid weight loss. More truthfully, bariatric embodiment, can involve trading one set of concerns for another.

This is particularly the case in regard to the post-surgical digestive system, which remakes the experience of eating and digesting food dramatically. According to Wadden et al (2007), up to two thirds of patients report post-operative vomiting. While these authors suggest that vomiting is thought to be most significant in the first few postoperative months and is believed to subside within a few years, Throsby's (2008a; 2008b) participants, as well as my own, vomited regularly for many years following their surgeries. In addition to vomiting, there are a myriad of other potential side effects the come with these procedures. For example, although performing the surgery laparoscopically has reduced some of the complications associated with the surgery, side effects of Roux-en-Y procedure include but are not limited to: wound infection, pneumonia, ulcers, pulmonary embolus, nausea, vomiting, hernia, hemorrhaging, regained weight, "dumping syndrome" (flushing, sweating, nausea, vomiting and diarrhea associated resulting from eating a high sugar or high carbohydrate meal), and nutritional deficiencies (Sheipe 2006). The LAP-BAND procedure is associated with: band migration or erosion, malfunction of the subcutaneous port and tubing, infection, gastroesophageal reflux disease, and additional surgery for insufficient weight loss (Sheipe 2006). LAP-BAND patients also frequently experience "plugging," or having food become lodged in the upper digestive track (Wadden et al 2007). In order to clear it, patients must induce vomiting. While the mortality rate for bariatric procedures is less than 1% (Sabin 2004), the complication rate leading

³⁵ This is also true of patient narratives, which are commonly featured in prominent ways on bariatric websites. These narratives tend to describe a shift from an unhappy and unhealthful existence to a life completely transformed by surgery in entirely positive ways (see Salant & Santry 2006).

to removal or additional bariatric surgeries is as high as 38% (Sheipe 2006). At times, these complications can be severe such as “surgical leakage into the abdomen or malfunction of the outlet from the stomach pouch” in the Roux-en-Y procedure or when the gastric bands in LAP-BAND procedures slip, cause scar tissue to build up around the band, adhere to the stomach, or penetrate it (Sabin 2004: 3).

Throsby (2008b) notes that there is debate in the field of bariatric surgery as to what constitutes a ‘side effect.’ Some bariatric professionals see nausea, vomiting, and diarrhea not as side effects per se, but rather as evidence that the surgery is working – in essence, if you the ‘wrong foods’ or eat more than you should, the procedures work as a form of surgically enforced behavior modification. Moreover, she notes, bariatric professionals frame discussions of side effects around issues of *relative* risk – that is, whether the risks of surgery outweighs the risks of not having surgery. Nevertheless, as Sanz Porras (2006: 103) comments, “The bariatric digestive system might not necessarily fit with the set of relations with which it has to deal on leaving the hospital” – specifically in regard to eating and drinking.

All forms of bariatric surgery work through restriction, or the dramatic reduction in the capacity of the stomach. In addition, malabsorptive procedures limit what the digestive system can take in. Because of this, all bariatric patients must follow very strict and very particular regimens of eating and drinking both immediately following surgery and for the rest of their lives thereafter. For the first few weeks following a bariatric procedure (as well as two weeks prior), patients are restricted to liquids. Within two weeks they can begin to eat puréed foods. Patients are advised to use small plates and teaspoons to get used to consuming very small portions (Murray 2009). Following this initial period, they are advised to keep meals to no more than 1 cup of food; to prioritize eating protein and then vegetables/fruits; to avoid sugar and

severely limit if not avoid carbohydrates; to stop eating the minute a sensation of fullness is reached; to eat three small meals and three snacks per day; to avoid drinking liquids for 30 minutes before a meal and 60 minutes afterward; to nevertheless consume adequate water throughout the day, taking slow sips; and take a multi-vitamin/mineral each day (Sanz Porras 2006). If patients are unable to follow these guidelines, serious complications can result, including hair loss, cracked nails, lessened immunity and healing (from lack of protein); dumping syndrome or plugging (depending on the procedure) from consuming sugar, starchy foods, and simple carbohydrates; vitamin and mineral deficiencies from failure to take supplements (which can lead to serious health complications such as osteoporosis and scurvy), and stretching or bursting digestive pouches because of over-eating (Sanz Porras 2006).

LAP-BAND patients are also required to get frequent ‘adjustments’ in which the band around the upper portion of the stomachs is tightened by injecting saline into a port just under the skin. When bands are tightened, patients often experience increased discomfort and pain. Foods that are too hard, doughy, or fibrous – including vegetables and some fruits – cannot pass without causing intense pressure on the chest and the need for regurgitation (Murray 2009). Ironically, for band patients, what does pass through easily are the very foods that bariatric patients are supposed to avoid and which have little nutritional value – such as ice cream and puddings. And yet, this practice, as Murray (2009: 162) notes, “is often perceived, in bariatric medical literature, as representing ‘non-compliance’ with the band, and thus a failure by patients.”

The initial period of surgery is often referred to as the ‘honeymoon’ period in which, regardless of what patients eat or don’t eat, they rapidly lose weight. However, following this period – which can last up to two years but is typically shorter – losing further weight and

maintaining weight loss is dependent following these guidelines exactly. Patients must take up the very forms of dieting practices they believed that weight loss surgeries had freed them from, such as carefully monitoring intake and counting calories. This is, as Murray (2009) frames it, the “greatest irony” of having a bariatric procedure, and was unquestionably something many of the participants I interviewed struggled with. Talia, for example, stated that she was far more obsessed with calories, measuring, and food intake following surgery than she was before. Several participants were either frustrated by a slow down in weight loss or were distraught by weight regain and were struggling with next steps. And, as I discuss in chapters five and six, participants frequently emphasized the ongoing ‘hard work’ involved in living with weight loss surgery. Notably, these exacting eating practices that bariatric patients must continue to follow (such as eating no more than 1 cup of food and heavily restricting what types of foods one eats) would likely be considered, for any other population, as indicative of disordered eating. For weight loss surgery patients, however, these same behaviors are seen as healthy, normal, and indicating compliance by the bariatric profession. As I elaborate in a later section of this chapter, because bariatric practices of eating and drinking are so precise but so atypical for non-surgical populations, sharing meals with others becomes extremely difficult for weight loss surgery patients.

Written on the body

In addition to physiological differences, bariatric patients’ bodies look very different compared to individuals that are the same size but have not had surgery. Specifically, rapidly losing a large amount of weight results in significant residual loose skin. Some tightening of this excess skin can occur over time and through exercise, especially for younger patients whose skin

is more elastic. However older patients and those individuals who have lost a substantial amount of weight are left with a great deal of excess skin, something that makes them appear larger than the actually are. Because this loose skin hangs, it can create a “bell” like physique, something that was the case for some of the participants I interviewed who had lost a very large amount of weight.

Whereas bariatric surgery is typically covered by insurance, reconstructive plastic surgery is not.³⁶ Only in cases where excess belly skin causes infections is surgery typically covered – and, as one plastic surgeon noted at the October 2011, Long Island Obesity Help event I attended – the plastic surgery procedure that is covered by insurance to remedy skin infections is designed for function, not form; It is not the same procedure that surgeons do when patients pay out of pocket and seek aesthetic results. Nevertheless, because reconstructive plastic surgery is out of reach for patients who cannot afford to pay on their own, as Throsby (2012) reports, some individuals who have had surgery will deliberately infect the skin under their bellies to improve their chances for qualifying for a covered procedure.

Even when patients can afford plastic surgery or have it covered, these procedures – ironically unlike bariatric surgery itself – are “maximally invasive,” in the words of the bariatric surgeon who spoke at Long Island Obesity Help event. Patients are left with long zipper-like scars which, although hidden on the inside of thighs, the under portion of upper arms, under the buttocks, and around the lower abdomen, are nevertheless very visible. As well, long incisions leave long healing wounds that have the potential to become infected. Skin infection, this plastic surgeon noted, is a common side effect from reconstructive plastic surgery following a bariatric

36 According to Wadden et al (2007), a 2005 American Society of Plastic Surgeon’s report finds that approximately 68,000 patients underwent body contouring procedures following the massive weight loss typically associated with weight loss surgeries. These authors suggest that body image dissatisfaction following surgery is a primary motivating reason for seeking plastic surgery procedures after a bariatric procedure.

procedure. Because of this and because plastic surgery is cost-prohibitive, bariatric patients (particularly women) often wear “Spanx” like body shapers under their clothes to achieve a sleeker, slimmer appearance. These garments can be found, alongside nutritional supplements and other products geared toward bariatric patients, in the vending areas of all Obesity Help events. As I detail below, for bariatric patients I spoke with, contending with the daily physiological, physical, and social realities of their surgeries was a worthwhile trade off, but a tradeoff that was nevertheless imbued with great ambivalence.

Lived Ambivalences

Trading one thing for another

To reiterate, participants viewed bariatric surgery as a life-saving intervention into inevitable further morbidity and early mortality. In addition, following their surgical procedures, they reported better health outcomes, improved mobility, and increased energy levels. However, following surgery, they also contended with the embodied particularities that result from having had a bariatric procedure. Their experiences of these side effects were complex – participants clearly disliked and felt great anxiety and ambivalence about their new physiological and physical realities, and yet they also felt these realities to be a reasonable price to pay for becoming healthier and thin.

While a small number of participants I spoke with reported no major adjustments in eating and drinking following surgery, most found they had to completely relearn these processes. In particular, they found they had to completely relearn what they could and couldn't tolerate. In most cases, the foods that participants had trouble with were the very ones that they were advised to limit or avoid, such as simple carbohydrates or sugar. Yet in other cases, foods

that they had previously enjoyed suddenly became indigestible and items they had previously detested became palatable. For example, Katrina had never liked onions but now she enjoyed them and yet other dishes, which she previously “couldn’t live without” now nauseated her. Decenia had always hated figs, and now found them delicious. Irene found that while she missed some of the foods she liked, what she missed most was the ability to gulp large glasses of water. Sipping liquids throughout the day, she noted, was not as satisfying.

In addition to having to figure out what to eat, many participants had to learn to stop eating the moment they felt full or they would experience great discomfort. Yet conversely, Danielle had to set alarms to remind her to eat because the feeling of satiety would continue past the point at which she needed to consume more calories. Relearning how to eat was a confusing process for many participants: What they couldn’t tolerate one month might be digestible the next. As Kaia put it, “It was like you never knew what was going to happen next. I had control over it with what I ate and whatnot, but it’s just up to my intestines and my stomach if it digests it fast, or slow, or if it was going to get upset at something I ate... If it makes you sick, stay away from it for a little bit. But, like you can eventually try them again.” Over time these new eating patterns became routine for participants, although this process took anywhere from six months to well over two years for the individuals I spoke with. In the end, participants considered these digestive ambiguities to be well worth it. As Nadia put it, “I’ve gone ten days straight without eating a damn thing...I could anything to be thin. I mean, it was a major motivation for me.” And Natalie said, “Nothing tastes as good as thin feels.”

Relearning what to eat and what not to eat was also particular to the type of surgery patients had. For those who had the duodenal switch (DS) procedure, consuming large amounts of fat now became a necessity because this particular surgery significantly limits the amount of

fat that can be absorbed by the digestive system. While Candice enjoyed getting to eat large amounts of cheese and bacon, other people found her new eating patterns disconcerting:

“They’re like, ‘You don’t have to worry about cholesterol?’ ‘No, because my body doesn’t absorb it.’ And, that is really hard for people to wrap their brains around, really hard.”

Interestingly, because the DS procedure stands alone in regard to the malabsorption of fat, at both Obesity Help events that I attended, DS patients frequently complained that both the provided meals and the workshops on healthy bariatric eating were not appropriate for them.

Participants that had the Roux-en-Y procedure had to watch sugar consumption very carefully to avoid dumping syndrome. Though she could often tolerate a bit of chocolate, Decenia described what happened one night when she pushed her intake of sweets:

I got to the car and I was so dizzy...I said, “Shit, why did I eat that ice cream?” I was just like, “It’s going to pass.” Because people prepare you, “You’re going to feel this way. There’s really nothing you can do about it when it’s happening. You just wait, it will pass”...But, at that time I had to drive home because my husband had a few drinks. So, I said,...“How am I going to get home?” There was a storm coming. So, I just sat there in the car. He was like, “Do you want me to drive?” I said, “No, I’ll drive, just give me a few minutes.” And, then I started driving, still feeling a little queasy. So, it’s a weird feeling. I just wish I would throw up, just to get it out, but I just can’t, you know?

LAP-BAND patients, by contrast, often find soft, sweet items – like ice cream – go down the easiest. However, breads, pastas and even fruits and vegetables can get stuck and require them to vomit. Before Katrina revised her LAP-BAND to a DS – a process that nearly killed her on the operating table – the only thing she could chew was Cheese Doodles because she could liquefy them in her mouth before ingesting them. For individuals who have this procedure, getting food stuck in the esophagus is a fairly frequent occurrence. When this happens, band patients must dislodge the stuck foodstuffs by regurgitating them. Laura noted while she did not experience getting food stuck as painful and it simply meant she would have to excuse herself to

throw up, what was difficult for her was that her husband felt helpless when this occurred.

Sarah, however, did have pain with her LAP-BAND before having it removed and undergoing the gastric sleeve procedure. She stated, “Towards the end, because I had thrown up so much so often, it felt as though my stomach was turning inside out...I would pop blood vessels in my face. It was just a horrible, horrible experience. It was hard on my husband to watch me go through that.”

As Murray (2009) and Throsby (2008b) note, social dining can be a tricky affair for bariatric patients as they must make frequent excuses to explain both their eating behaviors and the side effects that often result from weight loss surgery. LAP-BAND patients in particular, Murray states, must be aware that conversation can divert attention away from the level of chewing necessary to ensure food does not become stuck above the stomach stoma. My research confirms their findings as well. For example, Talia reported that sharing a weekly Shabbat dinner with her friends and her partner had become a challenge for her after her LAP-BAND procedure. She said, “I don’t necessarily throw up every time we have Shabbat dinner, but I often need to just bend over, and when I bend over everything is fine again.” She then noted that her partner would become embarrassed when friends asked her why she was bent over. Talia’s solution to this was two-fold. First, in the moment she would explain that she was doing yoga. Second, she learned that drinking a little vodka a half hour to an hour before eating seemed to relax her esophagus and she could swallow without issue.

Dinners with friends and family opened up a number of other social concerns. Some participants reported that being invited over to diner caused stress for hosts who no longer knew what to cook for them. Others became incredibly bored during social dinners because they ate little and quickly became full. They thus spent the majority of the evening watching others eat.

Danielle found going out to dinner with friends became increasingly awkward when it came time to pay the bill. Often, she said, her friends suggested splitting the check – something she felt was highly unfair since she no longer drank and never ordered more than an appetizer. And Denisa stated that her friendships with her ‘big girl friends’ shifted after surgery because of her new eating habits. Whereas in the past they would go out and enjoy eating large meals together, now her friends were reluctant to go out with her. When they would go out, if Denisa was having a ‘tight’ day, her friends would scoff, “The LapBand girl can't even eat the meal. She can't even appreciate the food right in front of her.” Social dining thus became challenging for Denisa as her ‘skinny’ friends only wanted to go out to drink and she could no longer eat as much as her big girl friends, something they teased her for. Her best dining partners, she said, had become her fellow LAP-BAND patient friends who liked to eat but could understand what it meant to contend with restriction.

These daily experiences suggest that living bariatric surgery involves negotiating the significantly unpredictable nature of the surgically modified digestive system *while health typically improves on other measures*. This complexity, notes Murray (2009), disturbs dominant notions of health. Moreover, it is one that is “rarely, if ever, mentioned in the abundance of medical literature and clinical research that almost evangelically advocates bariatric surgery as a key treatment protocol for ‘morbid obesity’” (159). As I detail further in this chapter and again in chapter six, these experiences also demonstrate that the surgical remaking of the digestive system also shifts and reworks social relations as well.

Navigating new bodily realities

Managing surgical side effects causes other forms of anxiety for bariatric patients. As noted above, LAP-BAND patients reported being self-conscious about frequent vomiting and, at times, this post-surgical fact of life was highly distressing to their loved ones. Both Roux-en-Y and DS patients discussed the embarrassment they felt at having frequent diarrhea and flatulence. Throsby (2008a: 128) states, “while being sick is normalized within the WLS community, it still risks exposing the fact of surgery and, among those who are aware of the surgery, of undermining claims that surgically altering the body is a fundamentally ‘normal’ means of managing weight.” Because of the anxiety these bariatric particularities caused patients, and because of the discomfort and upset that these side effects often caused others, participants took pains to minimize or obscure them. This involved attempting to pass as normal even though their subjective and embodied experiences were very different than those of others.

Beyond digestive unpleasanties, patients worried about the potential for nutritional deficiencies. Candice took 6,000 mg of calcium a day but still saw osteoporosis as inevitable – she stated that although her fat hadn’t killed her, now she would live to walk around on brittle bones. This trade-off, she continued, was nevertheless worth it as, if she had not had surgery, “I would have killed myself because I was so unhappy or I have died an early death or have been miserable right up until I was dead.” Hannah knew that she would be taking a “double handful of supplements several times a day as well as a protein and fiber shake in the morning” for the rest of her life. But like Candice, she considered this to be worth it because of her substantial improvements in mobility. Before, she said, “I couldn’t have even walked five feet without having to use my walker, you know? And, now I’m going up five flights of stairs everyday.” Even though participants were well aware of the necessity of taking lifetime supplementation,

many struggled to keep up with it. Nadia was working to get back on track with her supplements and Karen was deficient in vitamins A, D, and iron and had become anemic.

In addition to contending with physiological side effects, bariatric patients must also navigate the physical changes caused by significant weight loss. Joannis (2005) reports that the bariatric patients she interviewed felt no connection to their pre-surgical bodies and regarded them as sources of anguish. While the individuals I spoke with would typically state the same, as the conversations continued, it became clear that some of the physical changes that came with rapid and substantive weight loss were not experienced positively. This was particularly the case for the women I spoke with. Decenia was thankful she had thick hair because her hair loss from protein and vitamin deficiencies was not as noticeable. She did, however, “miss her boobs.” Talia also referred to her breasts after surgery as “small and empty.” Although she was thrilled with her improved health and mobility as well as how she looked in clothes, in some ways, she said, her body image was worse after surgery than it was before: “I feel really good in clothes now, but when I weighed 400 pounds I wore sleeveless. Now, I won’t wear less than 3/4 sleeves because I’ve got all of this hanging skin.” In addition to feeling insecure about her loose skin, she was also dissatisfied with her hair loss and the ways in which her face looked older.

Nearly all of the participants I spoke with were concerned about their loose skin. This was particularly an issue in regard to dating and sexual relationships. Sarah spoke of the difficulties that she felt her loose skin presented in dating now that she was separated from her husband: “The sex thing is difficult because I now have all this hanging skin. Before, everything was firm. Now it’s a little nerve-racking, especially the first time.” In new romantic and sexual encounters, patients must decide how and when to disclose their non-normative embodiment and as they do so, they risk rejection and shame (Kelly 2008). However, anxiety about sex in their

post-bariatric bodies was not limited to new relationships for these participants. Decenia remarked that her husband had not seen her naked since shortly after she had her procedure nearly a year ago. And Talia was cognizant of the fact that her partner preferred the way her body looked and felt before surgery, even though she was also thrilled that Talia's health had improved. Now, when Talia was supine, her partner thought her upper body looked "emaciated." At both Obesity Help conferences I attended, concerns about loose skin – particularly in regard to sex and dating – and the desire to have reconstructive surgery were frequently referenced in conference workshops and panels. And as noted earlier, garments designed to minimize the appearance of loose skin were available for sale in the vending section of both conferences. These garments are highly desired by bariatric patients because they saw it as the only affordable solution, given that reconstructive surgery was financially out of reach for most.

While the dramatic transformation that weight loss surgery entails does provide patients with increased confidence about their overall appearance, these findings suggest that a strong degree of ambivalence surrounds bariatric patients' experience with weight loss. Murray (2009) describes daily life with bariatric surgery as a 'lived ambiguity.' On the one hand, she notes, her physical pain and suffering as a fat woman were real. On the other hand, following surgery, her "visibly normative (inter)corporeality" was "continually haunted by a management of internal psychological and physical conflict, a hidden dis-abled embodiment" (158). In other words, although bariatric patients achieve a visually more normal physique, they simultaneously contend with having a highly atypical and unpredictable digestive system. As Kelly (2008: 391) notes with ileostomy patients, "this major biological and anatomical difference in structure and function is invisible to the world at large." And while the fact of surgically altered embodiment

is always a background feature of life, he continues, it is only when complications or ‘side effects’ arise that this difference becomes apparent to others – “The tension between private self and public identity is therefore a central fact of life” (Kelly 2008: 391). Murray’s (2009: 159) experience of navigating the lived ambiguities of bariatric embodiment, she notes, was made particularly keen in moments when her new figure was greeted with “surprised, and positive” responses from others and was visibly coded as an improvement of health. Similarly, the participants I spoke with often discussed the complexities and, at times, disjunctures between how they experienced rapid weight loss and how others perceived this shift. These experiences are examined in the next section.

Bariatric subjectivity

In examining “stigma exits” amongst individuals who have lost weight – or the experience of moving from a highly pathologized and stigmatized bodily state to one that is considered ‘normal’ – Granberg (2011) argues that becoming normal is not always easy. For example, each time an individual who has lost a significant amount of weight is greeted with surprise or shock, their former fat embodiment is also highlighted. The effect of this, Granberg argues, is that the body shifts much more rapidly than does the self. Moreover, Throsby (2012) argues that newfound praise for their physical appearance is a complicated phenomenon for bariatric patients, as they both feel that their weight continues to dominate social relationships, and they begin to wonder how they were perceived by others before their surgeries.

While the participants I spoke with were unquestionably happy to no longer be stigmatized as fat people, navigating the world as newly thin was at times a confusing and often ambivalent experience. Talia’s coworker insisted upon calling her “slim” every time he saw her

– something that made her cringe: “It’s fine once or twice you say something, but at some point, ‘OK, enough.’” Talia and Katrina both described how awkward it was to have to reintroduce themselves to clients that no longer recognized them. While she generally enjoyed others’ expressions of surprise following her weight loss, Danielle was annoyed that some people felt compelled to make what she considered to be unhelpful and stupid remarks such as, “Keep up the good work!” Because of these sorts of reactions, Katrina avoided seeing social acquaintances for a period following her surgery as she felt uncomfortable by the attention and the “Oh my God” reactions. Faith remarked that her husband had become upset by comments that he had “gotten a new wife.” In discussing what returning to his hometown was like following surgery, Calvin stated that people he had known for years, including extended family members, did not recognize him:

I’ll say, “You don’t remember me?” And they’re like, “No, your face looks a little familiar though.” And I let them know who I am they’re like, “Oh my God!” I’ve had people cry. I was in Wal-Mart this one time, and this lady, I knew her, so I went up to her and asked her a question. And she just started having a conversation with me about it. And I was like, “You don’t remember who I am?” and [she was] like, “No.” I never will forget it; she had like four grape jellies that she had in her hand because she was about to put them in her cart, and I let her know who I was, and she just dropped them all over the floor. She [opened] her mouth like, “I cannot believe it,” you know, she just started getting so emotional.

Calvin felt ambivalent about these sorts of responses. On the one hand, he stated, the outpouring of emotion demonstrated to him that people had been concerned about him before his surgery and really loved him. On the other hand, he continued, the experience of not being recognized was upsetting. Karen’s experience with others’ shock at seeing her was more negative. She said, “I had a lot of people that were very, very freaked out when they saw me, [and] told me I was anorexic. They asked me if I was sick, you know? If I had cancer, or what happened to me. Because I was like so thin.”

Some participants felt ambivalence around the praise they got for losing weight. While they did discuss bariatric surgery as ‘hard work,’ they also didn’t think it was a particularly remarkable achievement. Naomi commented, “I kind of went through a bunch of different feelings about it. You know, people would say, ‘Oh, you’re doing great,’ and they would congratulate you. And, I would think to myself, ‘You know, I had surgery to lose weight. I wasn’t curing polo.” Similarly, Nina stated, “I lost 176 pounds. It doesn’t mean that I’m a better person now.” Others felt like the praise they got for their newfound thinness implied a simultaneous insult. Kathleen remarked, “I took it more personally when people were like, ‘Oh wow you look so fabulous!’ After a while, it does make you wonder, ‘What does that mean? What’s the hidden message there?’” Remarking upon the nervous “not that you didn’t look good before” comments that often followed enthusiastic praise for her weight loss, Candice said that these caveats made her believe the opposite of what was expressed: “They *did* think I looked like shit before.” Denisa commented with sarcasm that her favorite post-surgery compliant was, “You were always such a pretty girl. I know you lost some weight. You look so much prettier.” When I asked her if others inquired about how she felt following surgery or if they only commented on her appearance, she replied: “How I looked. Nobody ever asked me how I was feeling.”

Participants also had mixed feelings about and were confused by the new flirtatious attention they received. While he enjoyed his new dating life, Calvin wondered about the women who flirted with him: “I didn’t know if this person was with me for my looks. I didn’t know if this person was with me for my personality. [But] I knew if I was bigger we wouldn’t be having this conversation.” Irene was annoyed by the fact that she was now told she was “sexy” when eating an ice cream out in public because the same act previously would have been

seen as disgusting and as confirmation of anti-fat stereotypes. She said, “It’s so weird. I mean talk about one side of the spectrum to the other, as far as how you’re treated in society.”³⁷

Some of the participants I interviewed also felt disorientated by being treated like a thin person. Faith recalled a time at the gym wherein other women were discussing dieting and protein shakes. Because protein shakes were something she was well familiar with, she excitedly tried to join the conversation, only to be rebuffed by the other women. Faith interpreted one woman’s dirty look as: “I’m drinking them to lose weight, not to tone up like you.” When I asked how she experienced this dismissal, she said: “Well, it’s just funny because she probably has twenty pounds to lose. I don’t think she understands what it would be like to have 200 pounds to lose. So, she kind of scoffed at me and I kind of scoff at the idea that she’s [only] fighting off those twenty pounds.”

Being perceived as a thin person also became challenging for participants when strangers made anti-fat remarks about others to them. Karen stated that in becoming thin, she learned that the sorts of things that fat people imagined others thought and said about them were unfortunately true. For many participants, hearing anti-fat remarks meant being put in the position to confront them. Naomi recalled a time she was at the grocery store and a fat man who used a mobility device passed by. Upon seeing him, a young boy asked his mother why the man couldn’t walk, to which the child’s mother replied that it was because he was “too fat.” Becoming enraged, Naomi said, “Or maybe perhaps he has arthritis, or a bad heart, or a bad back, or maybe he just had his knees replaced! It doesn’t have to be because he’s fat!” When people made anti-fat remarks to her, Talia told them that human beings came in different shapes

³⁷ Commenting on the gendered nature of this very difference, Murray (2010: 3) states that whereas a fat woman is never more defined by “gluttony, addiction, indulgence, and a lack of control” than when she is eating in public, a thin woman enjoying her food in public is seen as merely having a well deserved reward for her otherwise daily restraint and rigorous regime.

and sizes and that people shouldn't be discriminated against because of their appearance.

Interestingly, Nina felt like bariatric surgery was helping her provide better support for other fat people: "I think it's easier to advocate for the obese as a thinner person than it is as an obese person. I hope that once I am at a point where I'm at a healthy weight I can advocate for the obese and actually have my words listened to." Similarly, Faith hoped she never forgot where she came from, and Irene believed that her experiences as a fat person compelled her to 'pay it forward:' "I think that's kind of why we're on this earth is to grow and learn... to make things better for people. To pay it forward, to be compassionate."

Despite the fact that nearly all of the participants I spoke with felt incredibly angry about the new levels of anti-fat stigma that they were now aware of, they also struggled with their own internalized stereotypes about fat people and their near evangelical desires to proselytize to them about weight loss surgery.³⁸ As Barbara put it, "You almost want to become an outreach person and go up and say, 'Do you realize you're killing yourself?'" Chris wished others could have the same "epiphany" that he had about his weight. However, because they understood that their pro-bariatric surgery comments would likely not be well received, participants reported that they tried to cultivate feelings of empathy instead. Danielle stated, "I now see people that are really, really big [and] like there's this germ of a thought in my mind that's like, 'Are you doing something about it?' And, I catch myself thinking that every time because it's like, 'Am I judging?'" Seeing fat people "brought back old hurts" for Irene but she had to remind herself that she didn't know their situations and that bariatric surgery was not for everyone. Nina felt disgusted by the eating behavior of fat people she saw out in restaurants but reminded herself

38 At the Long Island Obesity Help pre-conference continuing education event I attended, psychotherapist Connie Stapleton advised bariatric patients and professionals in the audience to refrain from evangelizing. She said that although it was understandable to want to "spread the good news," it was important to remember, she continued, that "you're a sinner too." The idea being that it takes time for people to come to their own realizations and that uninvited advice is often unwelcome.

that she had been the same way and still struggled: “Sometimes I go to a restaurant and I watch some people and I notice how the heavier people – they’re just shoving food in their mouth – like they’re not even tasting it. They’re just eating it so fast, you know? We all do the same thing. I still do the same thing.” However, some participants did actively promote surgery to fat people they encountered. Denisa approached people on the bus about her LAP-BAND; Decenia invited women she met to bariatric information sessions, and Hannah carried an old photograph of herself so that she could show it to other fat people and tell them about how her life had changed following surgery. She said, “What I’m hoping is that I can get through to one other person to say, “Your life can turn around, you don’t have to be that way, take a look.””

“Relearning who you are”

In her research on the temporalities of dieting, Glenn (2012) notes that individuals trying to lose weight often experience time as moving too slowly. Time, she notes, “might not keep its promises of desired change” and waiting for weight loss involves a hope-filled watching for signs (6). The very opposite is true for individuals who undergo weight loss surgery. Within the first six months to a year, weight loss is so rapid and so dramatic that bariatric patients often experience this time as something of a whirlwind. As their bodies dramatically change, which in turn leads to a vastly different social reception, their psyches struggle to keep up. Katrina became unexpectedly pregnant five months into her surgery and while she was still losing weight. She said: “I remember going to the hospital [and] I was exactly 200 pounds. I had already lost 140 pounds and I was like, ‘Wow, when I come back, when I have the baby I’ll probably only be 190. I’m only going to have to lose another 30 pounds and then I’m at a

normal weight.’ And, things just happened so fast. I mean, three weeks after I gave birth I was 165 pounds.”

Participants frequently told me they no longer knew what they looked like and couldn’t recognize themselves anymore. Barbara stated that she couldn’t quite wrap her head around how different she now looked. Every morning when she looked in the mirror, Kaia felt “shocked.” And Natalie called herself ‘change dimorphic:’ “My brain for so long is used to seeing a 400 pound girl, or a 300 pound girl, that it’s hard for me not to be hard on myself, to say, ‘You wear a size 10/12, woman.’” Chris’ rapid weight loss was both a disorienting and a positive experience. He commented, “It’s very difficult to kind of grasp this new person, but difficult in a very, very positive way. I’d say the first eight months into it and you walk like past a store and you see your reflection in the store façade you just [think] – ‘Wow, is that really me?’ And it is.”

Traversing the built environment became a highly disorienting experience as well. The lack of barriers was, at times, overwhelming. For instance, when shopping for clothes, Candice became stressed out and no longer knew what to do. Whereas before, shopping was easy given the extremely limited options for plus size women, now she had more choices than she knew what to do with. In addition, many participants still felt a trace of their previous state of fat embodiment as they moved through their cities and towns. Despite her weight loss, Kathleen continued to stand on public transportation rather than risk the embarrassment of squeezing into a seat next to or in-between other passengers. She stated that she still felt like the fat girl on the bus that no one wanted to sit next to. Hannah remarked, “That’s been a very hard transition. I had an ah-ha moment about three or four months ago. I needed to get to my mailbox in my condos and I had to walk between parked cars. And, I looked at these two cars and I go, ‘I’m not going to fit.’ And I went, ‘No, try it.’ And, I fit right through. I didn’t even have to turn

sideways. So, I mean obviously I'm still remembering what it was like to be big." Following surgery, participants contended with assessing not only how much space there was but how much space their bodies currently took up – something that could be very different from week to week. Thus, while their material bodies were smaller, participants either continued to experience their spatial fields as those of fat people or people of an indeterminate size. Size was thus relearned at the interface of flesh and the built environment.

Size was also relearned through the utilization of photography and social media. When I asked her how she dealt with the disorientation that came from rapid weight loss, Sarah said:

I take a lot of pictures -- because I don't see it when I look in the mirror. You look at yourself every day and you're not going to see two to three pounds lost or gained a week. You're just not. I take a lot of pictures. I do a lot of picture progressions. I post them all over Facebook, and the internet, and my blog, and whatever. The last one that I had taken was 4th of July. Then I took one in the dressing room at New York & Company, two weeks ago. Even those side by side, like it's not a huge change, but I saw it. It's just unbelievable. I look at my picture and I'm like, "Damn!" You know? It's just an awesome feeling. At the same time it's scary. Relearning who you are.

Similarly Nina stated that because her mind still saw a 400lb girl in the mirror, she created side-by-side photo comparisons to determine how she now looked. The use of digital imagery and social media to document these changes is common amongst bariatric patients. For instance, the profile pages on the social media component of the Obesity Help website (www.obesityhelp.com) are replete with these sorts of photographs. Patients create photomontages of their weight loss journeys and on their profiles, they report their highest, lowest and current weights, as well as the sorts of procedures they had. As I detail in chapter 7, internet forums and sites have become a key part of both the overall bariatric community and surgery-specific sub communities.

'Weighty Secrets'

The experience of rapid weight loss was not only exciting, ambivalent, disorienting, and confusing but for some it brought a new problem: 'transfer addiction.' Nina stated, "because everything changes around you so quickly and you change so quickly that your mind doesn't have enough time to catch up; it does cause a lot of emotional problems." When I asked her about this, she continued, "I still try to overeat and obviously I can't anymore. So, like I'll vomit. I've had times where I vomited every day for a month straight. So, yeah it's hard. Thankfully I haven't had to worry about transfer addictions yet, but I do know it's very common."

Transfer addiction would become a theme in my interviews, a topic that is discussed more fully in the next chapter. When I asked participants about this, none of them reported increased drinking or casual sex encounters. However, nearly all participants suggested these behaviors were common within the bariatric community. I interviewed Sarah shortly before we both attended the September 2011 Obesity Help event in New Orleans and she advised me to pay attention to how many people were drinking throughout the day: "You'll notice it because I'm going to tell you -- you wouldn't notice it otherwise, but you will see at the OH conferences at 10:00 o'clock in the morning on Saturday morning, you'll see everyone walking around with a Starbucks cup, a big one filled with Crystal Light and some sort of alcohol...Ten o'clock in the morning...There's a lot of alcoholism in our community."

Although her statement was not one that I could verify, the largest study to date (King et al 2012) on the prevalence of alcohol use disorders (AUD) in the bariatric population found alcohol use significantly increased during the second year following surgery, but only amongst individuals who have undergone either the Roux-en-Y or gastric sleeve procedures. This is

partially explained by the fact that these particular procedures “alter the pharmacokinetics of alcohol...patients reach a higher peak alcohol level after surgery compared with case-controls or their preoperative levels” (King et al 2012: E2). Notably, King et al (2012) found no significant association between postoperative AUD and preoperative mental health.³⁹ Thus, despite assertions that AUD in bariatric populations may be more of an “Oprah” phenomenon⁴⁰ than an actual one (Sogg 2007), this recent study by King et al (2012) calls that into doubt.

Participants also discussed the frequency of new sexual behaviors amongst bariatric patients following surgery. Candice stated that she was aware of individuals who were cheating on their spouses with men they met on the internet. Calling it a “mid-life crisis,” Nina commented that divorce was common in the bariatric community after surgery: “Buy a new car, change husbands, especially the ones that have plastic surgery and now have this banging body that they didn’t have before.” Interestingly, websites like “Weighty Secrets” provide forums for bariatric patients to anonymously ‘confess’ these new behaviors to others. Sarah stated, “It’s a place to tell your secrets. If you go on there, oh my God the stuff you read. It’s anonymous and people will post all the time, ‘I haven’t eaten in a week.’ ‘I am having sex with the guy next door and my husband doesn’t know.’ ‘I’m an alcoholic.’ ‘I’m a drug addict.’ ‘I’m... whatever.’ You know? We provide that non-judgmental support.”

Wadden et al (2007) state that little empirical work has been done to assesses the quality of marital relationships post surgery. However, they continue, “the effect of surgery seems to be a function of the quality of the existing relationship” (461). To whatever degree divorces and break-ups occur following bariatric surgery, the participants I spoke with seemed to think this

39 “We did not find a significant association between preoperative mental health, depressive symptoms, binge eating, or past-year treatment for psychiatric or emotional problems, and postoperative AUD” (King et al 2012: E8).
40 Oprah Winfrey dedicated an entire episode of her television show to the phenomenon of post-surgical alcoholism amongst bariatric patients. See: Sogg (2007).

was fairly common. Sarah suggested the divorce and break-up rate was as high as 80% - something that I cannot confirm and which seems unlikely. However, Boero (2012) does report that divorce following surgery is a frequent topic on the Obesity Help website message boards. And, several of the individuals I spoke with – including Sarah – had gotten separated or divorced within the first year following their surgeries. The majority of the participants that were partnered, however, reported still being very happy in their relationships.

A partial explanation for intense post-surgical shifts in patients' lives and behaviors comes from Wadden et al (2007). Citing the Swedish Obese Subjects (OSO) study (Karlsson et al 1998), they report that depression and anxiety scores fall significantly at year one following surgery. Interestingly, however, the graph that these authors provide from the OSO study shows that while these scores do dip dramatically in the first six months, following this period depression and moreover anxiety begin to *rise* again. While it is possible that this rise may not be statistically significant, it is nonetheless interesting, particularly when one considers that AUD seems to increase between years one and two following surgery (King et al 2012). The period between years one and two is also the period in which weight loss begins to slow and individuals reach their lowest weights. Regarding shifts in sexual behavior, Boero (2012) reports that nearly all of her participants had periods of intense readjustment around sex and dating following weight loss surgery, even though many of them had had successful romantic and sexual relationships as fat people. Her interviewees discussed not knowing 'how to handle it' (106). Collectively these studies alongside my own findings suggest that, while life becomes significantly easier and happier for bariatric patients in many key ways, post-surgical life is also confusing, disorienting, and ambivalent as individuals learn to navigate life in very different bodies.

“Some people are not your friends”

Although the participants I spoke with did not experience high rates of divorce, losing a substantial amount of weight did negatively impact other close relationships. As I have discussed, surgically induced weight loss resulted in the reduction or elimination of anti-fat stigma for the individuals I spoke with. However, Throsby (2007; 2008b) argues that bariatric patients can experience stigma for having undergone a surgical procedure to lose weight instead of via diet and exercise, practices that are considered more disciplined and virtuous. In effect, although bariatric patients address what is considered to be a pathological bodily state, by choosing a surgical means of doing so, they are reinscribed as ‘lazy’ and amoral. While their loved ones did, by and large, support their decision to have surgery (or came to support the decision), participants nevertheless did have to address judgments and ignorance about their bariatric procedures.

Echoing Throsby’s (2008b) and Drew’s (2011) research, many of the participants had to field concerns from others that bariatric surgery was too ‘drastic’ and too ‘risky.’ Decenia’s mother pleaded with her not to have surgery, telling her she wasn’t “that fat” and encouraged her to find a new diet plan. Other family members told her they liked her the way she was. In an effort to talk her out of having surgery, her mother and sisters told her horror stories of people they supposedly knew who had died from bariatric surgery, had regained all of their lost weight, or who could never eat meat again. When people told him stories of surgeries gone wrong, Calvin felt defensive and like he was being put in the position where he had to educate others about bariatric procedures. In an effort to avoid the concern and criticism of others, Denisa waited until after she had surgery to tell her family she had surgery, only telling her boyfriend and her sister before the procedure. While most participants I spoke with were open about their

procedures, some chose not to tell anyone other than close family members that they had had surgery at all. When asked, Gail and Karen told people they had lost weight through diet and exercise. And after moving to a new town, Irene decided not to tell anyone either that she had been fat or that she had bariatric surgery, because of the stigma attached to both.

Similarly to the bariatric patients that Drew (2011) interviewed, the individuals I spoke with did not deny that risks were involved in bariatric surgery. Rather, they often said that weight loss surgery was “not for everyone.” But, like Drew’s interviewees, they also suggested that one had a duty to inform oneself about bariatric procedures and that in doing so, one reduced the risks involved. “Potential dangers were thereby transformed into acceptable, practical choices” (Drew 2011: 1233). However, as Throsby (2008b: 96) notes, when bariatric patients feel pressured into defending their surgeries, it precludes “any discussion of fear or doubt or of the need for support when there are side effects and complications.” The need to relate to others who get the complexities of having weight loss surgery becomes a driving force for bariatric community – a topic I detail in chapter six.

For some of the participants, the decision to have surgery cost them friendships with others. Nina’s decision to have bariatric surgery led to the dissolution of the relationship with her best friend. This friend, she told me, thought she was ‘crazy’ and was taking weight loss to the extreme. Because Nina had managed to lose 10 pounds on her pre-operative diet, the friend thought that she should just continue to lose weight by dieting. Participants like Nina found these sorts of comments to be particularly frustrating as they implied that dieting was efficacious, something that they knew from long histories of weight cycling to be untrue. For these participants then, pursuing surgery was not a ‘risky’ endeavor but an act that demonstrated both self-care and responsibility (Throsby 2008b). As I detail in the next chapter, participants were

also highly distressed by accusations that they had taken the ‘easy way out,’ and instead sought to underline and affirm the hard, ongoing work involved in weight loss surgery.

For Talia, deciding to have bariatric surgery meant losing active ties with, to some extent, an entire community. Talia was a founding member of as well as the former president of a national fat activist group. Having the LAP-BAND procedure was not a decision she came to easily or readily, and her decision was hard for her fellow board members to accept. Nevertheless, the majority of them encouraged her to remain on the board but step down as president. One individual, however, felt so uncomfortable with Talia’s decision that she threatened to leave the board if Talia stayed. Talia therefore decided to step down as she believed the organization should exist, first and foremost, to support fat people who chose *not* to diet or have surgery: “I made the decision [knowing] this might not be my home anymore. You know? And that was the way it should be.”

Other participants didn’t lose friendships but nevertheless felt strain in friendships with other fat people in their lives after they decided to have surgery. Karen, who was also somewhat involved in fat activism, also had to deal with the ambivalence of her friends when she decided to have surgery. This was especially hard for her, in part, because she had mixed feelings of her own: “I had lots of ambivalence about the whole concept of weight loss. Part of me still felt like I was selling out.” Similarly, Eban found that while he got support from his foodie friends, relationships with his fat friends had been strained since he decided to have surgery – “dealing with their feelings and my feelings about betrayal, and guilt, and all of that crap was – it was weird. And still continues to be pretty odd.”

In some cases it was not having a bariatric procedure per se that caused strain in relationships with friends and family members but significant weight loss. Nina’s friend, who

was fat, began to 'jokingly' tell her that she hated her because she now became full so easily. Other friends commented on her dramatic weight loss with sarcasm – "I was saying something about how my pants were like loose and she'll be like, 'Oh, that's so hard. Your pants are loose.' You can tell in their tone of voice that they're being sarcastic. So it kind of pushes me away a little to not share." Nina found this particularly hard because, while she had lost 175 pounds, she was still fat. Referring to the other women at her university she said, "I feel like I'm in limbo. Because I'm not fat enough to fit with the fat girls, but I'm not skinny enough to fit in with the skinny girls...I feel like I can't win either way." Denisa had lost two friendships with fat friends. One claimed she had been "dishonest" in not telling her about the surgery until after it occurred. The other felt like she had made too risky of a decision.

Some participants found that the very same people who had originally supported their decisions to have bariatric surgery ended up reacting with envy to their significant weight loss. After Kaia stopped being the biggest in her family, her mother and her sisters became jealous of her. This made her sad, she said, because she just wanted them to be happy with themselves. Irene believed that some people in her life were secretly holding their breath, waiting for her to regain the weight. Tania had a friend who, after working out together, suggested the both get on the scale: "And, she's standing behind me and she gasped. I think she was so shocked that I weighed what she weighed, because I was always heavier than her... Everybody else was very supportive and OK. But she, I think, had an issue with it." Remarking on the envy of others, Hanifah said, "Sometimes I think even the people that are close to me that wanted me to lose the weight, they wanted me to lose some weight, they didn't want me to lose this much weight. They didn't want me to start looking good. They wanted me to lose just enough weight to extend my life; they didn't want me to look sexy." When I asked her to elaborate on why she

thought this was the case, she continued, “I don’t know, you’re used to a friend not getting attention, and all the sudden they’re getting attention. And although it doesn’t have anything to do with you, a lot of times it changes the way that you view yourself or you see yourself, whether you want to admit it or not.”

As detailed earlier in this chapter, upon losing weight participants began to feel increased confidence and, in turn, became more assertive. In addition, as they became more confident, they were better able to set boundaries, telling others ‘no’ when previously they had been more agreeable as a means by which make others like them and avoid anti-fat stigma. While participants experienced these changes as positive, often others had a difficult time adjusting to these shifts. Katrina was called ‘conceited’ by her former sister-in-law who stated, “[She] thinks that now because she’s skinny, she’s all that.” Katrina, by contrast felt that she was ultimately the same person but that she was no longer going to put up with “any crap from anyone” and would no longer “suffer in silence.” Eventually, she did try to moderate her behavior at the behest of her friends who told her: “Before you said nothing; now you just want to bite everybody’s head off. Calm down.” Similarly, Calvin contrasted how he interacted with others as a very fat man as compared to now, as a thin one: “You allow people to say things to you because you don’t want to get in any conflict; you don’t want to draw any attention to yourself. Now...when people say things about me or if I have an opinion about something, I say what’s on my mind.” Unfortunately, continued, many of his male friends did not know how to accept his newfound assertiveness and he ended up losing many friendships. Participants frequently told me that having weight loss surgery helped them learn who their friends truly were. For example, Faith discussed a coworker who stopped being nice to her after she lost weight: “It’s funny - I asked her why she never had a problem with me until I was thinner than her. She said that she

just never wanted to hurt my feelings. So, I'm not really sure why she's OK to hurt my feelings now. But, apparently I guess as a thin person you can handle it better." Having weight loss surgery, she said, helped her realize that "Some people don't like you [and] some people are not your friends." These findings suggest that bariatric surgery shifts more than the patients' physical appearance, physiological interior, and subjective sense of self. Rather, the dramatic weight loss entailed in bariatric surgery is a fundamentally social process that shifts a myriad of relationships.

Conclusion: Pleasures, problems, and constraints⁴¹

Weight loss is portrayed, medically and popularly, as uniformly beneficial, worthwhile, and necessary. And while traditional dieting advocates and fat activists may critique weight loss surgeries, the bariatric profession portrays them as necessary interventions into the pathological state of obesity. Every year, the number of individuals undergoing these procedures dramatically increases. And yet, the experience of weight loss and moreover, the experience of having bariatric surgery is not uniformly positive. As Sanz Porras (2006: 114) states, "The epistemological requirements of scientific medicine carry with them a commitment to the idea of [the] human body as a coherent, naturally given biological fact." This, he continues, "enacts a simple definition of treatment...bariatric surgery is defined as the tool/process in charge of curing morbid obesity as pathology" (114). And yet, paraphrasing Sanz Porras, the very same procedure that 'cures' obesity also produces the bariatric digestive system as "turbulent, and unclear, multiple and fragmented." For bariatric patients, surgery is very much an experience of pleasures but also of problems and constraints.

41 In describing the complexity of bariatric surgery, Throsby (2012a: 121) suggests researchers examine the contradictory nature of patients' experiences, looking for "their problems and constraints, and simultaneously their pleasures."

As this chapter has demonstrated, for patients, having weight loss surgery improves physical health along many measures and also enhances well-being, self-esteem, and outlook. It also leads to a reduction or cessation in anti-fat stigma, a stigma that is always already entwined with healthism and abelism. However, the physical, physiological, psychological, and social realities of bariatric surgery are also complex, disorienting, and challenging for patients. What's more, weight loss surgery does not free these individuals from anxieties and calculations about how to navigate the built environment and the social world. Rather, it shifts these anxieties and calculations into new spaces. While participants discuss the pleasures of becoming 'normal,' the biological fact and the social experiences of their rearranged digestive systems renders their bodies highly queer – a truth that they are always privately aware of, but often take pains to obscure from or minimize to others.

As I detail in the sixth chapter of this work, it was these new considerations, anxieties and calculations - whether about new routines of getting food stuck and needing to throw up, how to go about dating as a thin individual whose fat history would be revealed on the body in a sexual encounter, or how to handle weight-loss related upheavals in personal relationships –that were the issues that participants brought to bariatric support groups and conferences. These groups, as I will argue, operated as spaces in which individuals relearned who they were and collectively figured out how to navigate the physiological, physical, psychological, and social shifts involved in having bariatric surgery. In the next chapter, however, I describe the ways in which bariatric patients take up notions of 'food addiction' to explain their previously fat bodies. I discuss the ways in which, as they describe weight loss surgery as a tool that helps them manage food addiction, they simultaneously underline the hard work involved in working with this tool. I suggest that this emphasis on hard work is not only an accurate description of life with bariatric

surgery but also a means by which patients refute the notion that they took the 'easy way out' by choosing a surgical form of weight loss.

Chapter 5:

“I Just Couldn’t Keep it in Control Anymore:” Bariatric Surgery, Food Addiction, & Anti-Fat Stigma

In March of 2009, 60-year-old Carol Poe became the second person in the United States to undergo deep brain stimulation as a treatment for morbid obesity (Bashir & Sherwood, 2009). To explore the relationship between deep brain stimulation and sensations of hunger, neurosurgeons Michael Oh and Donald Whiting drilled ten centimeters into both sides of Poe's brain until they reached the hypothalamus. Once they had reached this portion of the brain, which affects feelings of hunger and fullness, Oh and Whiting altered the electricity in her brain until Poe felt a sensation of fullness but was not nauseated. Dr. Julian Bales, chairman of the West Virginia Neurology Department, explained the technique thusly: "This is a frontier of medicine, a frontier of neurosurgery, a frontier of neurological disease, to be able to generate tiny pulses of electricity in these deep nuclei of the brain, and to see what effect they may have on behavior, including in this case the behavior of eating and the issue of uncontrolled appetite" (Bashir & Sherwood 2009: para. 17). Because her previous attempts at weight loss, including weight loss surgery, had not been successful, Poe seemed unsurprised that the root of her stubborn fatness might be located in the brain. She told reporters, "I've just known in my heart that there had to be something else...I really believe that it's got something to do with the brain" (Bashir & Sherwood 2009: para. 7).

Given what has been deemed a neuroscientific turn (Rose 2003; Johnson 2008; Pitts-Taylor 2010; Williams et al 2012), it is perhaps unsurprising that the brain has become a site for apprehending obesity. Deep brain stimulation, for example, has been described as a more effective, reversible, and less invasive obesity treatment as compared to weight loss surgery, which is, as noted throughout this dissertation, currently the most prevalent medical intervention for weight loss (Halpern et al 2008; Pisapia et al 2010). However, at present, neuroscientific treatments for weight loss such as deep brain stimulation are largely experimental, and bariatric

surgeons continue to argue that weight loss surgery remains “the most effective and long lasting treatment for morbid obesity” (ASMBS 2007: para 1). Moreover, as noted in chapter one, popular demand for bariatric procedures continues to rise (AHRQ 2007).

Interestingly, both the bariatric and neuroscience professions hold that ‘uncontrolled appetite’ partially explains both obesity and weight regain following weight loss surgery. However, while the bariatric profession typically suggests that compulsive overeating can be caused by physiological, emotional, or physiological factors (see ASMBS 2004; Engel et al 2012), neuroscientists are increasingly suggesting that uncontrolled eating can be explained by a brain-based vulnerability to ‘food addiction.’ Given this, the site of intervention and what is taken as the target differs between the two professions. In this chapter, I review how the bariatric industry attempts to reign in uncontrolled appetite through surgical means and yet is beset by issues of patients regaining weight in the long-term following their procedures. I show how uncontrolled appetite as a brain-based ‘food addiction’ is offered up by neuroscientific researchers as an explanation for obesity and weight regain in ways that both challenge and support the bariatric industry. Finally, I explore how participants took up narratives of food addiction in discussing their pre-surgical states of fatness, why they chose weight loss surgery, and their post-surgical concerns about regain. I suggest that bariatric patients do not take up the notion of food addiction in a fully neuroscientific vein, but rather as a hybrid of moral, behavioral, and medical understandings (Netherland 2011b; Vrecko 2010). These narratives should be understood as occurring within a contested terrain of obesity research, the expansion of categories of addiction to include non-substance related behaviors, and a neoliberal political and economic climate.

Approaches to Obesity

As discussed throughout this dissertation, bariatric procedures surgically reduce stomach capacity or intestinal length or both. Significant weight loss results by virtue of the resulting restrictive and sometimes additionally malabsorptive effects. Weight loss surgery patients typically lose up to 80% of their ‘excess’ body weight within the first two years following a procedure, and bariatric procedures generally result in improvement or resolution of weight-related comorbidities (Omalu 2007).⁴² Although they are typically performed laparoscopically and patients spend, on average, about 2 days in the hospital (Nicholas & May 2010), bariatric procedures can be considered major surgery. This is because, with the exception of the LAP-BAND surgery, these procedures are at best revisable but are not reversible. In addition, bariatric procedures are associated with a number of complications, the most common being hemorrhage, gastrointestinal complications, operative lacerations, and respiratory complications (Nicholas & May 2010).

While both complication and mortality rates from bariatric surgery are decreasing on average (Nicholas & May 2010), more than any other complication, the issue of weight regain continues to trouble the bariatric profession. The average amount of regain tends to vary by procedure (Sjöström et al 2004); however all bariatric surgeries are vulnerable to ‘failure’ over time (Christou et al 2006; Magro et al 2008; Shah et al 2006; Sjöström et al 2004). While some patients return to commercial diet programs in an attempt to lose regained weight (Boero 2012; Murray 2010; Throsby 2012), an increasing number of patients are having surgical revisions to address weight regain (Hamza et al 2010; Chu 2011, Van Wageningen et al, 2006). Revision surgeries typically involve moving from less restrictive to more restrictive procedures that also

⁴² As discussed in chapter four, the long term health benefits of bariatric surgery as well as long term reductions in health expenditures are increasingly in question.

have a malabsorptive component, or adding an additional restriction to an already restrictive procedure, such as banding a Roux-en-Y (Chu 2011). As to the ‘why’ of regain, patient noncompliance is most typically cited in the bariatric literature. However, a new scientific literature suggests that weight regain, even following bariatric surgery, can be partially explained by a neurological vulnerability to brain-based ‘food addiction.’

Obesity as Brain-Based Addiction

In 2007, an editorial in the *American Journal of Psychiatry* suggested that obesity should be considered a mental disorder in the forthcoming fifth version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V). The authors of the editorial, Charles O’Brien and Nora Volkow, Director of the National Institute on Drug Abuse and a proponent of the brain disease model of addiction, argue that obesity is “not only a metabolic disorder but a brain disorder” (708). They go on to argue that the American Psychiatric Association (APA) should recognize obesity as a brain disorder given that it is “characterized by compulsive consumption of food and the inability to restrain from eating despite the desire to do so” (Volkow & O’Brien 2007: 708). As well, they state, both compulsive food consumption and drug use are linked to increases in dopamine activity. Thus, they continued, obesity can be attributed to a “food addiction.” Within this neuroscientific frame, the loss of control – more than the addictive properties of the substance itself – becomes the hallmark of addiction.

The ability to include certain forms of gambling and food consumption behaviors under the category of addiction involves a new expansion of the term. This phenomenon has been well documented by Netherland (2011a), who argues that recent neuroscientific research which suggests that the brain’s dopamine system is stimulated in similar ways by gambling, food, and

drugs, is helping to promote a common pathway theory. Similarly, Frascella et al (2010: 295) note that a growing literature points to neurological similarities such as “preexisting vulnerabilities in the mesolimbic dopamine reward system and its failed regulation by frontal regions.” In other words, in both substance addiction and food addiction, the brain fails to regulate its reward system, leading to uncontrolled consumption that, in turn, leads to physiological and psychological harm. The common pathway theory thus involves “carving addiction at a new joint” (Frascella et al 2010: 294) by examining the ways in which gambling, food, and drugs similarly activate the brain’s reward, motivation, and decision-making circuitry (Volkow & Wise 2005).

Advocates for the framing of some forms of obesity as food addiction, and food addiction as a brain disorder generally offer the following explanations: To address the issue of how food might be both necessary for all but addictive for some, a number of researchers suggest that addictive foods are those which are “highly palatable” (Blumenthal & Gold 2010; Frascella et al 2010; Gearhardt et al 2011a; Taylor et al 2010; Volkow & Wise 2005) or “highly processed” (Ifland et al 2009) and point to evolutionary biology to explain their addictive qualities: “From an evolutionary perspective, it would have been highly adaptive for the consumption of food to be rewarding, especially in the case of foods rich in fat and sugar, since they can be rapidly converted into energy” (Taylor et al 2010: 327). These authors suggest that given the shifts in the United States’ food environment in the past half-century, highly palatable foods having become inexpensive and extremely easy to acquire, thus increasingly population levels of food addiction and obesity. Relatedly, the “who” of food addiction is hypothesized to be genetically and neurologically vulnerable individuals who are triggered by environmental reinforcers and thus become likely to ‘misuse’ food in a manner similar to how drug addicts are believed to

'misuse' substances (Barry et al, 2009; Frascella et al 2010; Taylor et al 2010; Volkow & Wise 2005). Others have suggested that morbidly obese people (Riva et al, 2006) and individuals who have followed a behavioral pattern of restriction/binge consumption (Corwin & Grigson 2009) are most vulnerable.

In advocating for an addiction model of obesity, some proponents have pointed to not only the high rates of regain with standard dieting behavior but also to health complications and issues of regain with weight loss surgeries (Blumenthal & Gold 2010; Riva et al 2006). Others have noted the possibility of 'transfer addiction,' or the substituting of one addictive substance or behavior for another, in bariatric patients when the underlying reasons for addictive behaviors are not addressed (Taylor et al 2010). New modalities of diagnosis and treatment are thus necessary, these researchers argue, because overweight and obesity are correlated not only with adverse health outcomes but with neurocognitive and neuropsychological ones as well (Frascella et al 2010). For advocates of food addiction theory, addressing obesity as addiction may offer insights into treatment and prevention. Others still have argued for the social importance of classifying some forms of obesity as addiction because the highlighting of biological and genetic vulnerabilities to environmental triggers may reduce anti-fat stigma (cf Barry et al 2009; Taylor et al 2010). This is analogous to an argument also made by advocates of a neuroscientific framework as a means for reducing the stigma associated with substance use disorders (see for example, Dackis & O'Brien 2005).

While there is a growing literature, both scientific and popular, on the proposed neuroscientific addiction model of obesity, there is also growing debate (Corwin & Grigson 2009; Frascella et al 2010; Gold et al 2009; Wilson 2010). Wilson (2010) argues that research on food addiction over-emphasizes shared brain reward processes at the expense of distinct behavioral

and physiological differences that exist between drug addiction and obesity (see also Barry et al 2009). Others note that advocates for the addiction model of obesity have focused primarily on binge eating (Wilson 2010; Stein et al 2000).⁴³ At best, therefore, the addictions model of obesity would apply only to a subset of fat individuals who were also binge eaters. Rogers (2011) takes issue with the notion that some individuals are neurologically susceptible to developing addictions to ‘hyperpalatable’ foods, noting that there is a “lack of objective evidence for this claim” (106). Finally, several scholars raise the issue of American cultural rituals and structural reasons⁴⁴ for collective excessive consumption (Gold et al 2009; Blundell & Finlayson 2011). They suggest, in effect, that an addictions model of obesity would somehow have to tease out the clinically pathological from the social.

The bariatric industry responds: It’s the addiction, not the surgery.

Although weight loss surgery professionals promote surgery as a means to successfully reign in excessive eating and thus obesity, bariatric research suggests that weight gain after surgery is associated with a continued uncontrollable appetite (Kalarchian et al 1998; Brodin & LaMarca 2002; Powers et al 1999; Saunders 1999). Given this, the American Society for Metabolic and Bariatric Surgery (ASMBS) recommends that bariatric clinics screen potential patients for ‘addictive’ and binge behaviors to assess suitability for the weight loss surgery in general, and to determine which procedure is most suitable for their particular eating habits in specific (ASMBS 2004; see also DeMaria & Sugarman 2001; Sawyer & Dilks 2011).

43 Liu et al (2010) even provide evidence for food addiction by looking to the research on Prader-Willi Syndrome.

44 Volkow & Wise (2005) do gesture at structural factors by intimating that junk foods are designed to be addictive. They state that the availability of such foods helps to “seduce young people into obesity” (559). However, by structural causes, Blundell & Finlayson (2011), for instance, have a much broader target in mind. They argue that the overconsumption of food takes place in a larger socio-economic climate of overconsumption in which individuals are encouraged to spend beyond their means and accumulate beyond their needs.

While the neuroscientific models of obesity as addictive brain disorder might seem to threaten the bariatric profession by posing a different and more effective target of intervention, the bariatric industry may now be *looking* to these models for assistance in patient assessments. Although there is no indication that neuroscientific research on obesity is currently being used in the management of bariatric patients, Steele et al (2011: 13) recently argued in *Bariatric Times* that such work may have important implications for “the selection of patients for different surgical procedures and the prediction of long-term outcomes following bariatric surgery.” More specifically, they state that advances in dopamine research may help elucidate why some patients ‘fail’ weight loss surgery. Neuroscientific technologies, such as positron-emission computed tomography, may prove to be helpful guides in patient management in the future, Steele et al conclude.

Salant and Santry (2006) shed light on this seeming contradiction. In their analysis of 100 weight loss surgery websites, they found that while the bariatric profession generally attributes patients’ pre-surgical states of fatness to the inefficacy of non-surgical treatments, weight gain *after* surgery is discussed in terms of patients’ noncompliance with recommended diet and exercise plans. Weight loss surgery is thus simultaneously framed as an extraordinary, life-saving medical procedure and a mere surgical tool that patients must use properly in order to avoid regaining weight. Under the neuroscientific paradigm, surgical candidates believed to have neurological vulnerabilities to food addiction may be encouraged to choose some surgeries over others or are screened out altogether. Thus, whether the explanation is behavioral or neurological, it is the patient who fails the surgery; the surgery does not fail the patient.

In sum, both bariatrics and neuroscience take as their goal the moderating of ‘uncontrolled appetite,’ often framed as ‘food addiction,’ which is held to cause most forms of

obesity. Where they differ is the site of intervention and what they take as their target. The bariatric industry is dedicated to bringing eating under control through digestive restriction and malabsorption rather than exploring the causes of excessive intake per se. Bariatric procedures function, in effect, as a surgically enforced behavior modification, and thus ultimately rely on the patient to respond appropriately to the intervention by controlling her or his eating behavior. Neuroscience, by contrast, locates the root cause of uncontrolled eating in an addictive brain disorder. In doing so, it purports to explain why the supposedly most effective medical treatment for obesity, weight loss surgery, does not show durable results. Neurological treatments, such as deep brain stimulation, thus intervene directly at the level of the reward circuits of the brain and are therefore believed to promise greater success. Although the neuroscientific model might seem to threaten bariatrics, paradoxically it may become useful in screening out patients who are held to be vulnerable to ‘food addiction’ leaving the surgeries themselves untarnished.⁴⁵ As I note later in this chapter, while these are important differences between the bariatric and the neuroscientific model of food addiction, there are also important overlaps.

Psychological models: Fatness and food addiction in popular culture

Alongside the rise in neuroscientific models of obesity as brain disorder, there has been an increasing public interest in the notion of food addiction (Gearhardt et al 2009a). However, the concept of ‘food addiction’ is not new within popular culture. Haddock & Dill (2000) argue that avoiding certain foods has long been part and parcel of health regimes and dieting.⁴⁶ Based in a twelve-step model, mutual aid groups such as Fatties Anonymous, Calories Anonymous, and

45 See also Pitts-Taylor’s (2007) examination of plastic surgeons use the diagnosis of Body Dysmorphic Disorder as a means by which to separate ‘good’ plastic surgery candidates from ‘bad.’

46 Haddock & Dill (2000) state that, with reference to children, the first documented argument for drug-like components of food dates back to at least 1922 but was popularized in the 1960s and 1970s by the work of B.F. Feingold, who argued that additives and colorings increased hyperactive behavior in vulnerable children.

Overeaters Anonymous began as early as 1950 (Parr & Rasmussen 2012). These groups understood obesity to be an incurable disease and an addiction similar to alcoholism that one can at best be abstinent from (Boero 2012). The influence of groups like Overeaters Anonymous waned in the 1970s after the field of psychology took a behavioral turn and commercial diet programs began to gain popularity (Parr & Rasmussen 2012). Arguably the neuroscientific focus on addiction as a brain disorder is weakening such models as well (Netherland 2011b). Nevertheless, psychological explanations of food addiction remain salient in popular culture (Shugart 2011). For example, Shugart (2011) found that guests, experts, and hosts on television programs such as *The Oprah Winfrey Show* and *The Biggest Loser* all suggest that food addiction, and with it obesity, can be seen as a dysfunctional coping mechanism to deal with and originary psychological trauma. As well, Overeaters Anonymous still has 6,500 chapters in 75 different countries (See <http://www.oa.org/newcomers/about-oa/>).

Interestingly, Shugart (2011) notes that experts on these television programs routinely disparage weight loss surgery as a means by which to address obesity. Bariatric surgery, experts held, would at best transform the physical while leaving the psychological issue in tact, making the individual vulnerable to transfer addiction. This is a similar argument made by advocates of a neuroscientific model of food addiction, except that proponents of the brain based model see the solution in treatments that act upon the brain's reward system. Somewhat conversely, Murray (2010: para 19) argues that experts who locate the causes of fatness in deep psychological disturbances that, in turn, result in food addiction, often *recommend* bariatric surgery as system of both physiological and psychological "enforced control." That there should be multiple and contradictory scientific and professional discourses on the utility of weight loss surgery for obesity as related to food addiction is unsurprising as old models of addiction are

challenged by new ones. Importantly these challenges occur in a climate in which both the causes of and durable treatments for obesity continue to confound both experts and weight loss seekers. But what of bariatric patients themselves? Given the rise in both scientific and popular literature on food addiction (Corwin & Grigson 2009; Gearhardt et al 2009a), how do individuals who have undergone these surgeries account for pre-surgical states of fat embodiment and post-surgical regain? In what ways do they take up ‘food addiction’ as a possible explanation?

Weight gain, loss, and regain – narratives of bariatric patients

As noted in chapter one, experiences of individuals who undergo bariatric surgery have not been well examined in the sociological literature, with a few exceptions (Drew 2008; Drew 2011; Joannis 2005; Throsby 2007; Throsby 2008a; Throsby 2008b). Little work has been done on bariatric patient discourses around pre-surgical states of fatness and post-surgical regain. Drew (2011) notes in her work that bariatric patients discussed these procedures as medically necessary after long histories of failed dieting attempts and refute notions of as weight loss surgery as ‘risky’ or ‘extravagant.’ In her discussion of bariatric patient narratives, Joannis (2005) documents the suffering individuals felt before undergoing surgery, both because of issues of regain and because of anti-fat stigma. Throsby’s (2007:1567) work provides the most detailed discussion and, most notably for my purposes here, she argues that bariatric patient narratives about their pre-surgical states of fatness can be seen as “faithful attempts to make sense of their weight histories through the socially and culturally intelligible resources available to them.” Following Throsby (2007), the remainder of this chapter explores the ways in which

participants referenced the increasingly prevalent notion of food addiction in discussing both their formerly fat bodies and concerns about regain.⁴⁷

Food addiction as a reason for surgery

As discussed in chapters three and four, the decision to have weight loss surgery was not one made hastily for the individuals I interviewed. Each one spoke of turning to a surgical solution only after a long history of unsuccessful dieting attempts. Some participants described being able to lose weight through dieting rather easily but unable to maintain the weight loss over time, often regaining more than they had initially lost. (Hanifah termed this ‘dieting up the scale.’) This experience is consistent with studies showing that dieting does not work as a strategy to lose weight and typically results in weight regain plus more (Mann et al 2007; Powell et al 2007; Sarlio-Lähteenkorva 2000). Like Throsby’s (2008b) participants, the individuals I interviewed were devastated by their long histories of weight cycling and long term weight gain.

As discussed in chapter three, avoiding further or future health concerns was almost always cited as the main motivator for seeking a surgical solution to obesity. However, some participants also mentioned seeking out bariatric surgery to help control food addiction. Danielle described ‘cheating the system’ on diets such as Weight Watchers by saving up her points and

47 In examining the data for references to and discussions of food addiction, I looked for references to not only food addiction per se, but emotional eating, preoccupation or obsession with food and bingeing. While emotional eating seems to be commonly referenced as an indicator of food addiction (See Gearhardt et al 2009b: The Yale Food Addiction Scale, question #13) whether or not preoccupation and obsession with food are clinical indicators seems less clear. I include these categories here based on the following: Gold et al (2009) identify ‘preoccupation’ as being a part of the cycle of addictive behavior. Frascella et al (2010), following Potenza (2006), note that non-substance addiction behaviors are obsessive and include a feeling of craving. In a recent popular news article, Gearhardt is reported to have said: “A constant preoccupation with food may also suggest addiction” (Collier-Cool 2011: para 8). Further, popular sites such as foodaddicts.org, WebMD and Wikipedia use terms such as ‘obsession’ and ‘preoccupation’ when discussing food addiction. In this sense, while being ‘obsessed’ or ‘preoccupied’ with food might not meet the clinical criteria for Obsessive Compulsive or Impulse Control Disorders, in both the scientific and popular literature, terms such as ‘obsession’ and ‘preoccupation’ seem to be used to indicate vulnerability to food addiction. Finally, bingeing is included here as, although its use has been critiqued (Stein et al 2000; Wilson 2010), proponents of the addictions model of obesity do nonetheless provide evidence for food addiction by examining binge eating disorder.

then bingeing on dinner. Even though she would successfully lose weight on these diets, she was distraught that she could not stop bingeing: “I felt like, ‘I understand how to do this, there’s no reason I shouldn’t be able to just get control over it and do it.’ And, I’m an achiever, I’m a doer, I’m a perfectionist, so it was like, ‘Why can I do everything so well, except this?’” When Danielle later realized that she fit the clinical criteria for food addiction, she felt freed up to find an appropriate medical solution.

Gail similarly described a long history of dieting and binge eating as a main motivator for choosing weight loss surgery.

I had spent my whole life struggling with weight. Trying every diet. I tried the fasts. I tried the hypnosis. I tried the beads behind the ears. I have a stack of books that would go from floor to ceiling with every kind of diet -- Weight Watchers. I tried Overeaters Anonymous, which worked very well for a while.

Despite her temporary successes, twelve-step behavioral approaches alone did not work; Gail regained the weight and eventually turned to bariatric surgery as a ‘last resort choice.’ She reasoned that that bariatric procedure would provide assistance in avoiding bingeing. She stated: “I do consider myself to be a food addict. I just couldn’t keep it in control anymore. No matter how much I tried to stay eating normal amounts of food and not eating all the garbage foods, I just couldn’t control it anymore.” Interestingly, while she does not mention the brain, Gail’s comments about the addictive nature of ‘garbage foods’ echo the neuroscientific understanding that junk foods are not only hyperpalatable but that (neurologically) vulnerable individuals cannot control their consumption of them. Although Danielle and Gail chose different surgical procedures, both women described their procedures as one that would force a change by taking

the inability to binge away – something that was too great to resist without the assistance of weight loss surgery.⁴⁸

Emotional eating

While some participants, such as Danielle and Gail, used the term ‘food addict’ to describe themselves, others described having used food as an emotional coping mechanism. For instance, Hannah stated that she ate out of both boredom and emotional pain relief and Candice noted that she used food ‘as a crutch.’ And while these individuals noted that they could not have addressed their emotional eating without bariatric surgery, many of them continued to struggle with using food to cope. Candice stated, “I actually still use food as a crutch. I just eat less of it each time. Because our stomachs empty out pretty quickly, so if I can eat every two hours, you know? That’s a lot of times a day. I think that is absolutely an issue.” Because Candice’s surgical procedure restricts the amount she can consume in one sitting, it does partially reign in her eating behavior. But because she can also eat often, it does not fully prevent her from using food as a crutch, and therefore she still must work to control her eating behavior herself.

Although having a bariatric procedure helped individuals gain control over eating habits, the adjustment was not an easy one. Nina remarked that her initial adjustment to surgery was much more psychologically than physically challenging: “Mentally it was very, very hard, fighting my relationship with food. Because I was a big overeater; I used food to cope...I wasn’t

48 Following Keane (2002), Murray (2010) notes that it is only individuals who are trying to lose weight that both experience their eating behaviors as compulsive and are viewed by others in that way. Thin individuals who eat more than others are merely considered to be “lucky.” They are not identified as having an eating disorder. Moreover, as Wadden et al (2007) note, bariatric patients tend to over report the presence of binge eating disorder. This over reporting might be seen as, again citing Throsby (2007), a faithful attempt to explain their formerly fat bodies.

able to eat for like two weeks after surgery. So, it's a month without food. It was serious withdrawal." Similarly, Calvin described the liquid diet that is usually required of bariatric patients for up to one month before and after surgery as very difficult: "It's not like the procedure, you know, fixes any mental kind of addictions that you have." As Nina and Calvin make clear, weight loss surgery merely serves as a surgically enforced behavior modification tool. It targets the physiological ability to binge but leaves the psychological desire to do so intact, effectively subverting the mind through surgical body modification.

Interestingly, Calvin would later say he did not see himself as a food addict because he did not believe that he used food to cope:

I don't feel like I had that addiction because I generally had a good life. ...It was just when I went out I just ate large quantities because I wanted to feel full. I didn't eat every five seconds, or every, you know, every minute of the day...It wasn't like when I cried I went to the refrigerator and ate, or when I was mad I went to the refrigerator and ate.

This seemingly contradictory use of the term 'addiction' is indicative of a multivalent quality of the notion of 'food addiction,' something that can be explained by its increasing discursive representation in both medical and popular literature at the same time that its definition, relevance and clinical criteria continue to be debated. Whereas for some participants, food addiction was defined by an uncontrollable urge to eat large amounts of food, Calvin seemed to indicate that food addiction was a sign of an underlying psychological disorder. Because he believed that he had a 'good life' and simply ate large quantities of food to 'feel full,' he did not see himself as a food addict. This suggests that even when bariatric patients take up the term 'food addiction,' regardless of whether or not they identify with it, what they mean is highly variable.

Preoccupation, obsession, and transfer addiction

Some participants suggested that their bariatric surgeries were liberating in that, for the first in their lives, they could stop worrying about their weight and how much they were eating. Karen stated, “I guess I have no weight obsession whatsoever anymore. I still don’t own a scale and I don’t care. I figure if my clothes stop fitting quite right, then I’ll know I have a problem.” Other participants did not feel quite freed of their preoccupation with food or weight but were able to find new, creative or healthful ways to cope with them after surgery. Tania noted that she and her friends who had had surgery became obsessed with watching *The Food Network* and reading cookbooks: “I guess because you weren’t eating food, or you just couldn’t eat the food, at least [you] could look at it.” Hannah noted that while she was still food obsessed, she was trying to transfer her food addiction into an obsession with supplements and vitamins to ensure her good health after surgery.

But for others still, weight loss surgery helped to shape new preoccupations. Talia remarked, “You know, in a way weight loss surgery for someone like me makes you more obsessed with food and weight... I don’t think there’s ever a day where I don’t think about my eating. There are days when I stop counting [calories] and I just eat whatever, but I’m still thinking about it.” Katrina similarly stated that for a period of time after her second surgery, her obsession with food was transferred to an obsession with the scale, and she would weigh herself several times daily. Commenting on the phenomenon of ‘transfer addiction,’⁴⁹ Sarah stated: “For many of us, especially those of us who have a history of sexual abuse...our body becomes

49 As discussed in chapter four, the notion of transfer addiction is a complex and controversial one and some commentators have referred to it as more of an “Oprah phenomenon” than an actual one (Sogg 2007). While King et al (2012) found evidence for a marked increase in alcohol use between years one and two following surgery, neither these authors nor Suzuki et al (2012) found any significant relationship between binge eating disorder and alcohol use disorder.

our wall. You now don't have a choice; your wall is falling down. Now what? You can't fill that void with food anymore because your pouch is this big. So, 'What else can I do to make me forget?'" Echoing the psychological model of addiction, she suggests here that food obsession is often caused by an originary trauma that surgery alone cannot fix. Yet her statement also reflects the assumption inherent in the notion transfer addiction that the individual's lack of control is not due to the addictive qualities of any particular substance, but rather, results from an innate abnormality within the individual herself.

Sarah's fear of a transfer addiction is reflected in the ASMBS recommendation that bariatric clinics assess potential patients for both 'maladaptive eating behaviors' and substance abuse, and their highlighting the possibility of cross addiction. They state, "the risk of cross addiction is particularly relevant to the bariatric patient to the extent that food, eating, and weight are used as methods of self-regulation and self-soothing" (ASMBS 2011: 4). Sogg (2012) recommends that bariatric professionals evaluate the psychosocial factors that may affect the outcome of surgery. They state that professionals should assess patients on the following measures: general eating behaviors and patterns, (including eating pathologies); physical activity patterns; psychopathology, (including substance abuse); social support; knowledge about bariatric surgery, and outcome expectations. Patients who report substance abuse, they advise, should be asked to delay surgery. However, amongst the individuals I spoke with, there was great variation in the degree of thoroughness in pre-surgical screenings that they attended. Candice stated, "Anyone with half a brain could pass that. I thought it was ridiculous. I mean, of course I don't think I'm crazy, and I felt like I was doing it for the right reasons, so it was OK for me, but I mean looking at what other people are doing after they have this very powerful surgery, it concerns me that maybe they don't do it quite enough, screening." Similarly, Sarah

attributed the high rate of transfer addiction that she believed was prevalent amongst bariatric patients, in part, to a lack of appropriate follow-up care by bariatric professionals: “Surgeons don’t place enough care or concern on the mental health aspect of the changes that we go through.” (The lack of follow up care is taken up in chapter six.) Both Sarah and Candice expressed concern that patients were perhaps not getting the care they needed and noted that online forums for bariatric patients were replete with transfer addiction stories.⁵⁰

Weight loss surgery as tool

Regardless of whether or not they identified as ‘food addicts,’ participants saw their bariatric procedures as tools that would help them reign in uncontrolled eating and, by extension, lose weight. In addition to the success she had had in losing 157 pounds in just over one year, Danielle was grateful she could finally address her bingeing behavior.

I feel like everyday I know that I made the right choice, because every day I know that without this physical restriction, I know what I’d be doing, and it would be the same as what I was doing before. So, I always look at it how a drug addict can’t get clean while they’re still using. For me, even if I’m bingeing on vegetables, that’s using, for me. Because bingeing is the drug, it’s not the food. It’s the bingeing. So, this makes it so that I cannot binge.

Like Sarah, Danielle locates addiction not in a particular substance, but in a predisposition to uncontrolled behavior. Barbara was similarly grateful for the ways in which dumping syndrome (the rapid heartbeat, sweating, abdominal cramps, nausea and other symptoms that occur when patients who have the Roux-en-Y bariatric procedure consume simple carbohydrates) helped her to avoid bingeing by enforcing a measure of accountability:

I want there to be a consequence. I don't want to ever feel that I could go back to doing what I did before. Food is an addiction. It is an addiction just like alcohol is, just like drugs are. The only problem with food is that you can't cut it out of your life. You can never drink again and nothing will happen to you. You can

⁵⁰ In discussing this, Sarah mentioned the blog “Weighty Secrets,” referenced in chapter four.

never take drugs again and nothing will happen to you. You can't not eat. So, it is like the hardest addiction to fight because you can't give it up altogether.

Given the difficulty of addressing food addiction, for Barbara the physiological 'consequence' to bingeing would ensure that she would not go back to old behaviors and regain her lost weight.

While the bariatric patients I spoke with described bariatric surgery as a rather extraordinary procedure, they also described it as a tool that they had to work *with* to ensure weight loss and avoid regain. Even after having the LAP-BAND, Gail continued to struggle with avoiding sugar and carbohydrates:

Being that it is a food addiction, and the food is something that I use to push down my emotions, like any type of drug. If I'm feeling stressed or tired, or angry, I will go for the sweet or the alcohol, or the ice cream, or whatever...The sugars, the carbs. That doesn't go away. That emotional need doesn't go away. But, being that I did do the surgery, I'm much more aware of the need to not just let it go.

Whereas Barbara's Roux-en-Y Gastric Bypass provided a highly unpleasant physiological response to eating sugar and carbohydrates, for Gail, who chose the restrictive LAP-BAND procedure, foods like ice cream can still "go down like it's nothing" and thus require heightened attention to making 'proper' food choices.

It was partially for this reason that Katrina was happy to have made the decision to undergo a second weight loss surgery, revising the LAP-BAND to the Duodenal Switch.

LAP-BAND is great for some people...I tell people, "You need to be realistic with yourself. Is this a lifestyle you can deal with?" We tell ourselves, "Oh yeah, I'm going to change, I'm going to change," but if you haven't changed in your whole life, what makes you think you're going to change overnight? Because they operate here [pointing to her abdomen], not here [pointing to her head]. So, you're still the same person...You're still dealing with your addictions...You need to find what you can live with for the rest of your life, to be successful. That's why I think that in every surgery there's people that fail at it. It's because they choose the wrong surgery for them.

Here, Katrina echoes the rhetoric of the bariatric profession that it is not the surgery that fails, but rather the patient for having chosen the wrong procedure. And, as Katrina notes, although

bariatric procedures vary in terms of how they work and what consequences there are for overeating or eating certain foods, all surgeries require patients to be highly aware of their triggers and to work with the surgeries. Patients must remain highly aware of what they are eating and always choosing the right foods in the right order, if not avoiding sugar and carbohydrates all together. The result of not complying with this new form of eating is not only short-term physiological distress, but the possibility of continued uncontrolled eating and subsequent regain.

The hard work of taking responsibility

When participants spoke about making the right choices to ensure weight loss and to avoid both complications and weight regain, they commonly referred to the ‘hard work’ that was involved in having bariatric surgery. In doing so, participants emphasized the stigma that surrounds both fat bodies and bariatric procedures as a method of weight loss. While some participants stated that they had personal experience with being told by others that they had taken the easy way out, others noted that they were aware that this was a commonly held belief in American society.

Many participants referenced the difficulty that was involved in deciding to have bariatric surgery and living with it afterward. Karen commented: “This choice was not an easy decision. It wasn’t an easy process. And I will be living with things that are not easy for the rest of my life.” Gail described her LAP-BAND as a device that helped jump-start the process of weight loss but which also required her individual effort:

It’s a very hard decision to realize that you cannot control your weight without it. And, that it continues to be hard work to keep at it. It’s just an initial boost to getting the weight off to getting yourself to a point where you can feel good about yourself...And then while you’re feeling good about yourself you can still focus

on learning the tools that you need to keep losing and keeping it off; the chewing well, the chewing the right foods. The first eating the proteins and salads and not eating the carbs until you're almost full... You have to work at it; it's not the easy road.

Other participants similarly discussed the fact that continued weight loss and maintenance required them to count calories and effectively diet. Although the individuals I spoke with would at times describe this continued dieting with frustration, given that bariatric surgery was supposed to free them from such practices, they also pointed to post surgical dieting as a means by which to refute notions that they had 'cheated' by having surgery.

While many participants described the effort that was necessary to work with their procedures, Sarah disputed the notion that weight loss surgery was the easy way out by discussing the challenges of living in a bariatric body:

The complications -- the emotional roller coaster that so many people don't have the means to take care of. The constant anxiety when you sit down to a meal. "Is it going to go down? Is it going to stay down?"... I want people to realize, spend a week and live the lifestyle that we live. I swear to you, your whole view on surgery will change.

Despite the difficulties and challenges involved in both deciding to have surgery and living in a post-surgical body afterward, each and every participant described having a bariatric procedure as 'worth it' or 'the best decision I ever made.' As noted in chapter four, many expressed a wish to have had surgery sooner.

Other strategies for discrediting the stigma attached to weight loss surgery included referencing their histories as unique, discussing weight loss attempts prior to choosing a bariatric procedure, and describing fatness as a disease state that could only be addressed medically. Calvin stated, "They're never going to understand what it's like to be in my body. So, I would get upset about them saying it was an easy way out." Tania similarly discussed the judgment she felt she received from others:

I think about how unfairly treated obese people are. You know I always used to say I just wish, I'm probably going to cry, but I wish somebody could walk a mile in my shoes. Or just be in [my] body for a day. You know, to see what it feels like. To know what I'm going through...If it was as easy as putting the fork down we all would have.

Hannah similarly wished that others would have compassion and would see that obesity was a medical condition and not a lack of character. And, both bariatric surgeons I interviewed also dismissed the notion that weight loss surgery was the easy way out. One surgeon argued that if there were options other than surgery for treating obesity, he would be out of a job: "There is nobody who wants to have their stomach taken out, their intestines arranged, or a band put in, or whatever the procedure is, unless they're desperate... If there were successful alternatives, and the emotional costs and medical costs of obesity weren't so high, I would not exist."

Resisting the stigma of obesity also involved emphasizing the decision to seek help. Eban stated: "It is an addictive behavior and that is the first step," echoing the Twelve-Step language about the importance of admitting one has a problem. Thus, even when participants asserted that obesity was a medical issue beyond their control, they simultaneously asserted their responsibility for addressing it by seeking care. Eban's comments, like those of other participants, suggest that bariatric patients continue to take up psychological models of addiction in discussing obesity.

These findings are consistent with Drew's (2011) research on discursive depictions of weight loss surgery. As discussed in chapter four, her content analysis of mainstream magazine articles on weight loss and bariatric surgery supports the claim of my participants that, popularly, these surgeries are framed as 'the easy way out.'⁵¹ Drew found that in these texts, weight loss surgery was frequently portrayed as an effortless method of weight loss whereas dieting and

⁵¹ These stereotypes are so pervasive that even bariatric surgery nurses hold beliefs that surgery constitutes a quick-fix (Jeffrey & Kitto, 2006).

exercise were portrayed as involving real work, and were thus more virtuous. By choosing a surgical means of having weight loss, bariatric patients were often portrayed as having ‘cheated.’ As well, the findings here reflect Drew’s (2011: 1235) argument that bariatric patients contest the media portrayals of surgery as the easy way out “by talking about their post-surgical health-oriented body work.” They do so by talking about the responsibility they took in seeking medical help with their eating behavior and the post-surgical ‘hard’ work is still required of them to make the right choices. As Throsby (2008a: 120)⁵² states, when bariatric patients emphasize the hard work involved in surgery, “they can be seen as opting into the work of weight management (rather than dodging it), and as positioning themselves as subjects in the ‘war on obesity,’ rather than its vilified objects.”⁵³

Addiction and responsibility

Bariatric patients appeal to notions of food addiction in discussing the reasons why they had become fat and why they needed weight loss surgery. Bariatric procedures, they state, helped them control the uncontrollable. In discussing food addiction, patients take up hybrid understandings of addiction. That is, they speak of addiction as both a disease and a failure of

52 Throsby (2008b) notes that in the United Kingdom, anti-weight loss surgery stigma additionally entails accusations that, by choosing a surgical option for weight loss instead of dieting and exercise, patients are unnecessarily diverting scarce healthcare resources from more crucial areas. Despite having lost a tremendous amount of weight, bariatric patients are nevertheless reinscribed as ‘greedy’ and ‘lazy.’

53 My research suggests that in fact, bariatric surgery is anything but the easy way out. First and foremost, these are risky procedures. Several of my participants nearly died on the operating table or during the months afterward because of side effects. Second, patients contend with life-long, challenging, even life-threatening physiological side effects. Third, the fact that many patients lack ongoing follow-up care, including nutritional care, because it is not covered by third-party payers puts their health in further jeopardy. Forth, because weight loss surgery is not the durable, effective cure for obesity that the bariatric profession states it is, patients truly must work very hard to maintain weight loss. Fifth, many of my participants were self-pay patients who had to save for years to get their procedure. Finally, some patients contended with horrific fat-phobia from airline personal (in Kaia’s case) or medical personal (in Maria’s) on the way to and during their hospital visits to undergo bariatric surgery. For all of these reasons, it is unsurprising that some of the participants I spoke with – as well as many other patients in the bariatric population – are not open about the fact that they have had surgery and instead make vague references to having changed their eating and exercise habits.

the will, and appeal to physiological, psychological, emotional, environmental, and moral elements (Netherland 2011a). Bariatric patients also emphasize that while the surgeries help them to gain control, they are also only tools that they must work with. Specifically, they must actively and continually choose the right behaviors in order to avoid weight regain, as well as common surgery side effects (as discussed in chapter four). As with twelve-step models, the notion here is that while one can be abstinent, one is always an addict. Living with bariatric surgery then, involves ongoing hard work. And ironically, gaining control over food addiction involves a redoubled attention to food and eating (Boero 2012).

Novel neuroscientific treatments like deep brain stimulation or the development of new pharmacological treatments that target the brain's reward centers would seem to offer a different model of responsibility. Because addiction is located in the brain, and more specifically in atypical neurochemistry and neuroanatomy, addressing these pathologies with treatments would seem to return the fat individual to not only thinness but normalcy. However, as Netherland (2011b) notes, neuroscientific models of addiction also require certain kinds of conduct. Drawing on Rose (2009), she argues that addressing neurological deficiencies in order to reach a functional norm through therapies such as medication also requires ongoing work. She states, "Normality becomes a project, part of the work of continually monitoring and managing one's self both through adherence to a medical regime and through participation in 'normal activities'" (234). Thus, although the neuroscientific model does locate the source of pathology within the individual's brain, she is nevertheless responsible for addressing it and monitoring herself to ensure the efficacy of treatments. Thus, like older, twelve-step frameworks, neuroscientific models both suggest that addiction is beyond an individual's responsibility to control but make recovery the responsibility of the addicted individual (Netherland 2011b). Moreover, as Pitts-

Taylor (forthcoming) suggests, advances in neuroscientific research which demonstrate the brain's plasticity – or the notion that the brain changes and develops in response to the environment throughout the lifespan – suggest that individuals not only have a responsibility to take care of one's brain but to enhance and improve it through ongoing work. Thus, although there are important differences between bariatric surgery and new neuroscientific treatments for obesity – the former effectively seeks to control the brain by controlling the body (specifically the digestive system), and the latter promise to control the body by controlling the mind – there are also important overlaps. Both free fat individuals from responsibility for having become fat, but hold patients responsible for staying thin through the ongoing work of self-monitoring.

Conclusion: From Proper Bodies to Proper Selves

Participant narratives of food addiction, the decision to have a bariatric procedure, the hard work involved in weight loss surgery, and ways in which bariatric procedures serve as extraordinary tools that allow individuals to take responsibility for making the 'right choices,' are complex and even contradictory. These narratives can be seen as attempts to make sense of pre-surgical states of fatness and lingering struggles with eating behavior and regain "through the socially and culturally intelligible resources available to them" (Throsby 2007: 567). These narratives are best understood as occurring within a contested terrain of obesity research, the expansion of categories of addiction to include non-substance related behaviors, and a neoliberal political-economic climate.

As noted in chapter one, medical and public health professionals have struggled to uncover not only the causes for obesity but also the reasons why efforts at curbing it have proven unsuccessful. Further, while medical and public health professionals may concur that obesity

rates have been rising, there is little agreement beyond this (Wilson & McAlpine 2006).⁵⁴ In this context of uncertainty, the bariatric industry is expanding, and demand for these procedures is skyrocketing (AHRQ 2007; Encinosa et al 2009). Yet at the same time, the long-term efficacy of this mode of intervention is in question, and the industry is beset by the problem of patients regaining weight after having undergone these highly invasive procedures (Christou et al 2006; Magro et al 2008; Shah et al 2006; Sjöström et al 2004). As I discuss in chapter four, the long term effects of bariatric surgery on health and health expenditures are also increasingly being contested.

The neuroscientific model of obesity offers a challenge to the bariatric industry by suggesting that truly reigning in ‘uncontrolled appetite’ requires a different site of intervention: the brain (see Volkow & O’Brien 2007). Importantly, this challenge arises at a historical moment in which there is a concerted effort to include non-substance related behaviors, like certain forms of gambling and eating behaviors, under the category of addiction in the forthcoming DSM-V, thereby expanding the scope of addiction significantly (see Elliot et al 2012; Frascella et al, 2010; Netherland, 2011a). As discussed earlier, proponents of a common pathways model focus on the similar ways in which the brain’s motivation, and decision-making

54 Flegal et al (2013) have recently reported that obesity rates are no longer rising and have leveled off. See: <http://jama.ama-assn.org/content/early/2012/01/11/jama.2012.39.abstract>

circuitry responds to drugs and to food. The loss of control per se rather than the addictive qualities of a particular substance becomes the defining feature of addiction.

Despite these challenges, both bariatric professionals and patients steadfastly maintain the efficacy of these procedures, in part, by means of a curious contradiction. Both professionals and patients simultaneously describe bariatric surgeries as life saving medical interventions as well as ordinary tools that require proper patient compliance (Salant & Santry 2006). This seeming contradiction must be understood within the political state of neoliberalism.

As discussed in chapter two, under neoliberalism, all citizens are encouraged to take up practices to avoid or reduce health risks (Rose 2007a; Petersen & Lupton 1996). Discourse around health and illness can thus be seen as creating some as proper selves, bodies and citizens while simultaneously producing others as failed and pathological (Crawford 1977; Crawford 1980; Johnson 2008; Metzl 2011; Pitts-Taylor 2010). This is particularly the case with fatness (Guthman, 2009a; Guthman 2009b; LeBesco, 2011). Moreover, subjects themselves take up these assessments. As Crawford (2006: 402) notes, “People come to define themselves in part by how well they succeed or fail in adopting healthy practices and by the qualities of character or personality believed to support healthy behaviors.” Health, Crawford continues, has become a key feature of modern identity.

Within this climate, the bariatric industry successfully shifts the responsibility for achieving both successful weight loss and weight loss maintenance from the surgeries themselves to patients. The industry has generally offered up patient behavioral non-compliance as an explanation for weight regain (Salant & Santry 2006). However, with the increasing amount of scientific and popular attention to uncontrolled appetite as ‘food addiction’ (Corwin & Grigson, 2009; Gearhardt et al, 2009a), the American Society for Metabolic and Bariatric

Surgery also advises practitioners to screen patients for addictive behaviors in advance of surgery (ASMBS 2004). Moreover, some bariatric professionals have specifically suggested that the industry's screening techniques may be improved by scientific research examining the neurological roots of food addiction (Steele et al 2011). Herein, instead of posing a threat, for the bariatric profession, "neuroimaging technology holds the *promise* of making visible that which has heretofore relied largely on 'patient' self-report: the diagnosis of addiction and the efficacy of treatment" (Netherland 2011b: 155, emphasis in the original). Procedures like deep brain stimulation or new pharmaceutical treatments that target the brain's reward center may pose a threat to the bariatric profession in the future. For now, however, bariatric surgeries remain untarnished as the industry underscores the need for more effective tools to screen normal patients from those with vulnerabilities to uncontrolled appetite and food addiction, vulnerabilities which would lead these patients to 'fail' bariatric surgery and regain weight.

Bariatric patients also frame weight loss surgeries as both miraculous interventions and as ordinary tools they must work *with* to address a problem that extends beyond the physiological. When patients take up discussions of food addiction, they do so as a partial explanation for their failure to achieve and maintain weight loss through a traditional dieting approach. However, they also utilize narratives of food addiction as a referent for the daily hard work that is still required of them to make proper choices, control their eating, and thus to become successful bariatric patients. Ironically, proper behavior for bariatric patients looks remarkably like the very dieting practices that weight loss surgery was supposed to free them from. Given that patients experience stigma both because of their fat bodies and for the decision to address them surgically, having been accused of having taken 'the easy way out,' discussing the hard work required of them becomes a technique of "stigma management and maintaining moral legitimacy"

(Drew 2011: 1236). Similar to other research examining patient narratives of addiction, these individuals did not take up ‘food addiction’ in fully neuroscientific vein but rather expressed a ‘hybrid understanding,’ combining moral, behavioral and medical elements (Netherland 2011b; Vrecko 2010).

Advocates of the obesity-as-brain-disorder model argue that a focus on neurological vulnerability may reduce stigma (Barry et al 2009; Gearhardt et al 2011a; Gearhardt et al 2011b; Taylor et al 2010). However, the notion that neuroscience has the potential to reduce stigma has been highly contested (Campbell 2012; Hansen & Roberts 2012; Netherland, 2011b; Pitts-Taylor 2010). Neuroscientific treatments may in fact require the addicted individual to constantly monitor herself to ensure treatments are working – similar to how bariatric patients must obsessively monitor their food and eating behaviors. Notably, recent research by the Yale University Rudd Center for Food Policy and Obesity (DePierre et al 2013) suggests that while ‘food addicts’ are viewed more favorably than other addicts, this finding does not extend to fat people. Instead, labeling an obese person as a food addict actually *increased* stigmatizing attitudes. Further still, it has certainly *not* been the case that bariatric industry’s argument – that obesity is a disease state that can only be treated surgically and cannot be controlled through behavioral efforts alone – has helped to reduce stigma. In effect, bariatric patients have become multiply stigmatized. It is thus worthwhile to recall Zola’s (1972) argument that medicalization does not necessarily free one of the burdens of personal responsibility. Rather, medicalization shifts the target of responsibility from the origin of a problem to the willingness to pursue a solution.

Given this, patient narratives that emphasize the ongoing post-bariatric physiological, psychological and social hard work required of them to lose weight and keep it off are more than

just an accurate assessment. The emphasis on hard work can also be seen as a technique of stigma management that occurs within a contemporary neoliberal social context. Bariatric patients, using the “socially and culturally intelligible resources available to them” (Throsby 2007) – specifically uncontrolled eating as food addiction – critique anti-fat and anti-weight loss surgery stigmas while simultaneously shaping themselves into normative, neoliberal subjects. And in this sense, it is a path for highly stigmatized individuals to demonstrate responsibility and thus to reclaim a ‘proper’ selfhood while also working toward a ‘proper’ body.

In the next chapter of this dissertation, I discuss how online and in-person weight loss surgery forums become new sites of sociality and kinship. I argue that the desire for these spaces is driven by the complexities of navigating post-surgical life. I further contend that these new sites of sociality are spaces in which patients collectively negotiate anti-fat and anti-bariatric surgery while shaping themselves into normative subjects.

Chapter 6:

Banding Together: The Biosociality of Weight Loss Surgery

Obesity surgery patients...deviate from social standards in two ways: they do not have acceptable bodies and they do not transform their bodies by conventional, appropriate means. (Drew 2011: 1235)

[B]odies are not singular, bounded, closed and fixed, but rather open to being affected and affecting others. Within this formulation attention is shifted to what bodies can do, and what relational connections change and alter bodies as they move and sense in the world. (Blackman et al 2008: 17).

Within the contemporary American neoliberal context, weight loss surgery patients are situated at the confluence of a very particular set of experiences: having felt profound hopelessness over a lifelong history of unsuccessful dieting and escalating body weights; having experienced widespread and severe anti-fat stigma; having experienced a profound misfit between the fat body and the material world; having anxiety-laden concerns about further and future weight-related morbidity and mortality; feeling a sense of responsibility for improving health; choosing and undergoing a surgical procedure that drastically alters the digestive process; losing a tremendous amount of weight in a relatively short period of time; being treated differently by others because of the dramatic shift in size and no longer experiencing (or experiencing significantly less) interpersonal and material anti-fat stigma; sensing a shift in selfhood that corresponds to the shift in the physical body; experiencing significant physiological and physical side effects from weight loss surgery; seeking to minimize or hide these side effects from others; being the subject of envy because of successful weight loss; experiencing stigma for having chosen a surgical means of weight loss; feeling the need to defend that choice by referencing a clinical need for surgery; struggling to maintain weight loss and avoid regain; and finally, seeing this ongoing struggle primarily in terms of responsibility for making the 'right choices.'⁵⁵ I contend that the convergence of these experiences does more than create a

⁵⁵ This is, of course, a broad brushstroke picture of the experiences of bariatric patients. It is not a complete description as individual lives are always situated in very particular circumstances and are crosscut by specific relationships to race, class, gender, ability, sexual orientation, and nationality. Moreover, not all participants

particular embodied and psychosocial experience of bariatric surgery: It is also driving the creation of new sites of sociality and kinship. As I will argue in this chapter, these ‘bariatric communities,’ which exist both online and in person, can be seen in light of what Rabinow (1996) termed ‘biosociality’ – or the ways in which advances in biomedicine and clinical treatments shape new forms of identity and collectivity.

In his 1996 essay “Artificiality and Enlightenment: From Sociobiology to Biosociality,” anthropologist Paul Rabinow coined the term ‘biosociality’ as a challenge to what he saw as the crude biological determinism of sociobiology. Instead of explaining social phenomena with recourse to evolutionary biology, Rabinow was interested in how “the social and biological are being (co)-configured in relation to developments in the life sciences” (Gibbon & Novas 2008: 15). More specifically, he sought a method to consider how sociality and identity might emerge, shift, and change during a period of time in which understandings of and treatments for disease were undergoing tremendous change (Gibbon & Novas 2008: 1).

Since Rabinow first introduced the term, a number of researchers have explored these new areas of identity and sociality, looking specifically how they intersect with older categories of classification (cf Rapp & Ginsburg 2001). Some have examined how the internet has facilitated the growth of new biosocial communities, allowing geographically dispersed individuals who share medical diagnoses (as well as parents whose children have been given the same diagnosis) to connect with one another (cf Parr 2002b; Rapp & Ginsburg 2001; Schaffer et al 2008). Using both biosocial and health social movements frameworks, others have traced how certain biomedical communities have become powerful advocacy forces which contest, expand, and even fund and coordinate medical knowledge, research and development for particular

experienced all of these phenomena. However, in general, these experiences are typical of the individuals I spoke with and observed at Obesity Help events.

disease categories⁵⁶ (Brown et al 2004; Novas 2006; Parr 2002).⁵⁷ Work on ‘biological citizenship’ and ‘biomedical citizenship’ has taken up these questions at a different register, examining how developments in the life sciences and global capitalism are shifting notions of citizenship (see Biehl 2005; Rose & Novas 2005; Petryna 2002). Finally, more recent scholarly work on biosociality has explored the relationship between nature/culture itself, as well as the ways in which biological capacities have become an area of scientific inquiry, technological development, and deep capital investment and are creating novel products for the market (cf Sunder Rajan 2006; Waldby & Mitchell 2006). Overall, research on biosociality examines how the “merger of life and capital, science and technology, knowledge and power” (Gibbon & Novas 2008: 4) shifts the ways in which humans understand themselves, how they understand and experience health and illness, how they relate to others, how they relate to institutions of power, and how “local, national, and global economics are being reorganized in the process” (Gibbon & Novas 2008: 4).

In this chapter I explore the formation of identity and community around weight loss surgery. The bulk of this chapter details the physiological, social, psychological, political, and economic factors that contribute to the development of bariatric communities. I discuss the ways in which online and in-person bariatric communities overlap and should not be thought of as entirely separate spaces. I detail the role of Obesity Health as a central organizing force in the

56 As Gibbon & Novas (2008) note, the organization of layperson groups around particular disease categories is not new. However, while in the past such groups largely focused on providing social and economic support to affected individuals and families, today such groups are organized around lobbying for as well as financing and directing scientific research efforts toward developing better tests, treatments, and cures.

57 Brown et al (2004) do not frame their work in terms of biosociality but “embodied health activism” and “health social movements.” While there are important differences, both frameworks examine collectivities formed around a shared disease category. As well, both examine how such collectivities politicize their experiences, challenge dominant conceptualizations of disease categories, advocate for greater treatment and care, and often work in conjunction with medical and scientific professionals. One of the main differences seems to be that work on biosociality frames discussions of these phenomena within a Foucaultian analysis of biopolitics and governmentality whereas the health social movements work does not explicitly do so.

bariatric community, discussing its presence both online and in-person events. Finally, I describe the ways in which as bariatric patients come together around the experience of having had weight loss surgery per se, new tensions, conflicts and divergences emerge.

‘From commonality to community’⁵⁸

In my interviews, I asked participants if they believe that there is a bariatric ‘community.’ Each one answered with a resounding “yes” and nearly all articulated that, for them, it was a vital one. As I have discussed in chapters three and four, both being fat *and* having weight loss surgery involve a great degree of calculation in navigating the social world and the built environment. The new considerations, anxieties, and calculations, whether about the continued desire to binge, the new routine of managing the perils of eating, how to go about dating as a thin individual whose fat history would be revealed on the body in a sexual encounter, or how to avoid regain, were brought to bariatric patient forums. Every individual I spoke with indicated that participating in these forums, online or in-person or both, provided support for and key information about the embodied particularities that come with bariatric surgery. However, as I will discuss, while bariatric communities were important sites of friendship, support, and kinship, they were also fraught with tension and conflict – something that drove the formation of sub-groups, often by surgery type.

“Nobody understands it like somebody who's going through it.”

Boero (2012) suggests that bariatric communities are built around three central experiences: first the experience of having lived as a very fat person. Second, is the experience of having had bariatric surgery. And third, is “the experience of having to learn how to live in a

58 Whyte (2009: 8)

new, externally more normal body that is at the same time facilitated by a distinctively abnormal intestinal structure” (103). Stigma, she argues, is central to all of these experiences. As I will discuss, my research confirms, but also expands, her findings by pointing not only to the factors that help to create bariatric communities but also those that create differences and conflict, effectively fracturing bariatric communities into subgroups.

In discussing why bariatric patient forums were important to them, the participants I interviewed described a need to connect with others who had been through this particular set of experiences. Only other bariatric patients, they argued, could understand what it was like to undergo such a dramatic physical, psychological, and social change, as well as the ongoing work of living with a bariatric procedure. Describing what it was like to be very fat and then become thin within a year’s time, Hanifah stated, “It’s just an enormous part of your life, and to have that kind of severed off so abruptly, there really is no adjustment for it. There really isn’t. You’ve just kind of go to surround yourself with people who do understand what you’re going through.” This experience is so particular, argued Chris, that he felt an instant connection to others who had had surgery: “I think you have like a kinship with people, instantly, if you know they’ve gone through the same thing as you.”

Although he did not personally spend a lot of time in bariatric forums, Eban suggested that because community around fatness per se doesn’t exist and fat activism is still quite marginal, bariatric forums ironically provide that community: “If people weren’t so ashamed and disheartened about being fat there would be more of a fat community. I mean there is a fat community, but there would be more of one.” Describing what might be seen as a form of dual marginality, Eban stated that when bariatric patients saw one another, they could connect not only around the lifelong requirement to work with bariatric surgery, but also around the shared

experience and psychological trauma around having been fat. Similarly, Danielle stated that because fat people spend their entire lives being isolated from others, bariatric forums provided a reprieve: “They all of a sudden are surrounded by people that understand.”

In discussing the need for bariatric-specific communities and forums, participants distinguished themselves from both thin people and from dieters. Skinny people, they argued, just couldn’t understand what it was like to be fat. Although many of the individuals I interviewed were now thin themselves, they were still highly connected to, perhaps even haunted by, the experience of having been very fat. Kaia suggested that the experience of having *shifted* from being very fat to being thin was more significant than the experience of being thin itself. She said, “They’re the only people that really understand how bad life was and how good it is now.” Likewise, Talia argued that thin people took things for granted.

Dieters who sought to lose 10-20 pounds were also not kin, participants argued. As Laura stated, most people can relate to a desire and struggle to lose some weight, but few knew what it was like to lose more than 100 pounds. She quoted her friend, who had lost 200 pounds with the LAP-BAND procedure, to illustrate why she felt that dieters just didn’t get it: “She said, ‘If I go to a Weight Watchers meeting and it’s led by a woman who says, “I lost ten pounds and I’ve kept it off for three years,” what my friends says is, ‘I could shit ten pounds! I really don’t care what that woman has to say.’ Do you know what I mean?’” Similarly, Gail felt that only individuals who had struggled with food addiction related morbid obesity and needed surgery to get their eating habits under control could relate: “I know that they understand where I’m coming from when it comes to not only working with my particular type of surgery, but also with my struggle with food. Most people have that same mode of thinking and doing.” For Yvonne, it was not merely the amount of weight lost or the reasons one had been fat that

distinguished bariatric patients from dieters. Rather, it a long history of failed dieting and the hope that bariatric surgery would provide a way out. She said,

The bariatric community, they've been where you've been. They know what you're thinking; they know what you're feeling. They know you're up against the wall and you have nowhere to go. Most of us we have spent years and years dieting, trying this one, trying that one, knowing it's not going to work. Every next diet is your last diet. You finally get to a point where you just don't know what to do; you don't know what else is next, and hopefully you stumble upon someone who's talking about surgery, or who's had it, or you hear about it on TV or something, and you see a light at the end of the tunnel.

Yvonne continued by saying that bariatric community was also important in “trying to make your way into normalcy.” As discussed in chapter four, the temporalities of dieting also are significantly different than are the temporalities of weight loss surgery. This too, shapes the specific connection bariatric patients feel with one another. As Sarah put it, online bariatric forums provided an outlet to express the dizzying wonder at these rapid changes: “It's someone to run home to and tell, ‘Hey I went from an 18 to a 16 in one week!’ And 500 people comment in literally three seconds going, ‘Oh my God, you're amazing!’ It's an ego boost.”

The embodied particularities of bariatric surgery also drove participants' desire to connect with other patients. Many spoke specifically of the gastrointestinal distress that came having had surgery. Naomi said that she just wasn't going to talk about her bodily functions with people unless they had surgery. Chris was happy to have a romantic partner who was also a bariatric patient: “Your insides kind of do a trick on you really often. So it's very nice, and very important that my partner in life understands that I'm not just farting to be a guy and obnoxious; I'm farting because I had surgery and I can't help it.” When spending time with other bariatric patients, even those who had had different surgeries, Talia felt great relief. For instance, when dining with other bariatric patients, she didn't need to explain a sudden need to get up and go to

the bathroom to regurgitate food stuck in her esophagus. For Calvin, the experience of being around other bariatric patients was relieving because he didn't feel self-conscious about his loose skin in front of them. In discussing his first Obesity Help event he stated, "I was so comfortable! I didn't have to worry, 'is my chest looking weird?' I didn't have to be so self-conscious versus like when I'm outside of that community... The support that I had was just immense. It was an overwhelming experience for me."

For many participants, the need to connect with similarly situated others was not merely driven by a sense of shared experience but the experience of being rebuffed by others who had not had surgery. Candice felt that her close friends were tired of hearing her procedure and she didn't want to burden them with further discussion even though it continued to be a highly salient factor in her life. She said, "They're like, 'Alright, you've done that now. Let's move on from it,' whereas your DS [Duodenal Switch] friends, you know, they understand, they get it." Similarly, Irene's sister told her she was tired of hearing about her procedure. Chris felt like talking to friends who hadn't had surgery about his constant vomiting would be experienced as "bitching." These friends didn't have the first clue what he was going through, he continued, whereas other bariatric patients could relate. Bariatric surgery, he argued, is highly stigmatized and little understood.

"There are a lot of things that even doctors don't know"

According to Livhits et al (2011), although the American Society for Metabolic and Bariatric Surgery (ASMBS) requires Bariatric Centers of Excellence to follow up with patients long-term and hold organized support groups supervised by a healthcare professional, there are

no standardized guidelines for how these support groups should be set up. In addition, the majority of bariatric clinics are not certified as Centers of Excellence, which means they may only offer information sessions on surgery but not support groups afterward. As Talia and Candice reported, they were simply required to attend large information sessions and attend a cursory screening with a mental health professional before surgery. Candice referred to her screening as “a joke.” Sarah stated that the Long Island surgeon who performed her LAP-BAND (she later revised to a gastric sleeve) charged patients \$20 to attend support group meetings, something she could not afford at the time as a 22 year old college student. Decenia commented that her insurance company did not cover a visit to see a nutritionist. Because of this, she said, “You’re really on your own, and you have to learn how to eat and make sure you’re eating it right.” Bariatric forums, she stated, helped fill in the gap. Ironically, despite the fact that weight loss is lauded and even demanded within American society, individuals who seek out bariatric surgery as a durable means of achieving it are not provided with the structured ongoing care or support they need. Rather, they must seek it out and create it for themselves (see also Boero 2012). Thus, the lack of standardized follow-up care and free or reimbursed, structured, supervised support group availability and professional nutritional counsel is another factor that drives the need for bariatric forums and community.

Throsby (2008) states that bariatric patients gain very useful tips and advice from other patients on how to navigate the world as a post-op individual. Schaffer et al (2008: 151) suggest that the advice participants in health-based forums provide one another is “viewed as reliable because it [is] based on extensive biomedical research and real-life experiences.” As my participants discussed, such tips, advice, and information ranged from what patients need to know before surgery, to navigating the days and weeks afterward, to avoiding regain, how to

address complications and when to seek emergency care. Nearly all of the participants I spoke with did extensive research of their online researching procedures and providers and talking things over with other patients before undergoing surgery. After deciding to revise her LAP-BAND to a DS, other DS patients helped Katrina come up with a list of questions to ask her new surgeon. And once Denisa made the decision to have the LAP-BAND, she queried those on gastric banding forums about what she should expect: “I remember people using the word ‘vomiting.’ I was like, ‘You just vomit out of nowhere? How do you live?’ So I started going on message boards and then I realized that people just spit up. You know it's going to happen and you can control it. You just have to excuse yourself and go to a bathroom.” From the moment they decide to have surgery then, other seasoned patients are already guiding prospective patients on what to expect and what to do. In effect, not only does bariatric surgery demand a new form of embodied subjectivity, it is one that is collectively negotiated and moreover, taught.

Interestingly, this phenomenon has a name within the bariatric community and is known as “angeling” – or when an experienced patient takes on the primary support and sometimes advocacy role for a new patient undergoing the same procedure (see also Boero 2012). Nadia, who was more than a decade out of surgery, served as an angel to many DS patients – including some of the participants I spoke with. Even those participants who did not use the term “angel” described a desire to “pay it forward.” Although Kristen was less than a year out of surgery, she stated that now she primarily went to online bariatric forums to help new patients: “I find myself trying to help people that have just had surgery. If they’re asking questions, I’ll tell them, ‘Oh, that’s normal.’ Or, ‘That’s not normal, go to your doctor.’ It feels good to help people that were in the position that I was in. That’s another reason that I go on there.” And Kaia, who was 19 when I interviewed her and had surgery at 16, took responsibility for shepherding new teenagers

that were interested in the DS procedure. She advised them of the maturity required to have bariatric surgery and the necessity of doing their homework. “That’s the most important thing to me, that they know the hard, straight facts about all of their options and that they understand that it’s going to be with them for the rest of their lives.” Angeling and paying it forward, then, not only provide key information and advice, but underscore notions of responsibility for working with the surgeries.

Without question, patients who attend only an information session before surgery are not remotely coached on what life after surgery will truly entail. And within the first few days and months following surgery, regardless of how well they have been prepared, patients seek out others online and in person to ask some variation of the question, “is this normal?” Bariatric patients also turn to other patients to learn how to live with surgery. Online forums in particular, as Danielle noted, were available 24/7 when there was no one else to ask. However, she continued, sometimes the amount of advice and information was both overwhelming and contradictory. She asked, “How can I do everything right if there are so many different answers?” What she realized, she continued, was that while patients should seek advice, they should also weigh it against their own embodied experience to make the choices that they felt are right to them. They needed, she stated, to learn their way through it.

Getting advice and tips from others is necessary, many participants suggested, because other medical providers are woefully unprepared for how to deal with bariatric bodies given that the population is relatively new. For instance, participants noted that pharmacists are just beginning to understand that they metabolize drugs differently than others. As Keller (2012) states, “[Bariatric] surgery may alter the transit, absorption, metabolism, and pharmacokinetics of some drugs” (para. 5) and “appears to raise the risk for acute liver failure (ALF) from

acetaminophen poisoning” (para. 1). Because of this general lack of medical understanding, patients turn to each other and become highly inventive in the process. Sarah stated: “My friend Andrea just came up with a lab tracker [a means by which to collect and store lab test results, supplement guidelines, and other pertinent medical information] for post-ops because our levels on certain things need to be [different] than what a normal person’s does. There’s no panel for bariatric people.”

Often patients take what they’ve learned and end up having to educate their physicians. As Schaffer et al (2008) note, participants in health-based forums must learn to how to understand, evaluate, and communicate medical and scientific information to medical providers so that they are taken seriously. And in collectively negotiating such information, they continue, participants create and reinforce a sense of entitlement to certain rights of citizenship. Hannah, for example, commented:

I tell my doctor at Kaiser, “Once a year I need a whole battery of tests.” I’ve told him what I’m at danger for. He doesn’t necessarily know that, nor do I know if he’s incented at all to go look it up himself. He’s always been very agreeable to me with what I’ve told him. And, he’ll interpret the blood test results, or whatever test I say I need and everything has been fine so far. But, I do know that this surgery only works if you’re the kind of person who’s really going to take charge of your own medical needs. You’ve got to be able to speak up because this isn’t well-known.

Similarly Irene said that having bariatric surgery meant that she had to advocate for herself more, something that she seemed to somewhat resent: “It’s frustrating because I feel like there are surgeons out there, they do their job very well, but as far as the follow up stuff with nutrition, there’s not enough research being done that needs to be [done]. So, again, that goes back to that need for a sense of community with everybody.” As these patient experiences make clear, while the bariatric profession describes weight loss surgery as the most effective cure for obesity available, in order to avoid regain, side effects, and complications, patients must both continually

work to make the ‘right choices’ and proactively ‘take charge’ of their own medical needs because of a lack of structured support and care.

As discussed in chapters four and five, side effects and complications are common in bariatric surgery (Sheipe 2006). Navigating them is also something that weight loss patients do collectively. Several participants told me that they might have suffered very severe consequences, including death, without the support of other bariatric patients. Katrina made an appointment with the surgeon who did her LAP-BAND procedure because she wanted to have it removed so that she could revise to a DS procedure. Her surgeon, however, told her that her lack of adequate weight loss and the complications she was experiencing were not caused by the device but by her own noncompliance. Instead of scheduling her for a removal, her surgeon tightened the band by adding more saline to speed up her weight loss. Afterward, Katrina left with a band so tight that she was unable to swallow any liquids, including saliva. When she got home, she told others in an Obesity Help forum that she hadn’t eaten solid food in a month and could not swallow.

I went on OH and I was like, “Oh my god, I can’t even swallow my own spit. What do I do? What do I do?” They told me, “You need to go to the OR and get that liquid taken out! What the hell was she thinking in doing that?” Somebody told me, “Call [surgeon who specializes in the DS procedure] from [hospital.]” And, I emailed him and within an hour he called me. He told me what to do. He told me, “Come see me immediately,” and he removed all of the liquid in the band.

Because of the advice and support from other patients on Obesity Help, Katrina avoided life-threatening complications and was able to revise her surgery to the DS. Similarly, during the year and a half she spent in the hospital following surgery because of a gastric leak, a blood clot, and then sepsis, Naomi’s online DS friends advocated for her by pretending to be her sisters, called her to check up on her, and came to visit from other areas of the country.

Natalia noted that other patients not only advise you when to seek emergency care, but which hospitals in the area to go to. Despite the rapidly growing number of bariatric procedures, emergency room providers frequently do not understand bariatric procedures and the complications that can arise from them. And although ASMBS created a flow-chart (see figure 1 on the following page) to assist emergency room personal with the care of bariatric patients, the chart is not provided to ERs but rather must be purchased on the ASMBS site. Even if emergency room professionals are aware of bariatric surgery per se, they may not be aware of what different surgeries entail, as Kaia found out. She described blacking out and being taken to the emergency room. “I was trying to tell them what surgery I had, because I’m pretty sure I had some low vitamin levels that caused me to black out. And, I was trying to explain to them that I had the duodenal switch. And they just said, ‘Oh, gastric bypass...’ And, I kept telling them, ‘No, it’s not gastric bypass!’ And, they didn’t understand what my surgery was...and they didn’t test my vitamin levels, which is very important.” Because of the lack of understanding about her procedure, having a community of people who could provide information and support was key for Kaia. Especially important, she stated, were the bariatric patients that were themselves medical providers: “They know how to read their vitamin levels and things like that and they teach us.” When I asked her if she thought she would continue to need this community in the years to come, after her surgery had become more normalized for her, Kaia replied with an emphatic “yes:” “[The] DS is always going to be with me. There’s not a day that I forget that I have it. I will always know.” Her response suggests patients perceive bariatric surgery as not only a life-long embodied transformation, but a life-long intersubjective one.

Clinical Pearls for Emergency Care of the Bariatric Surgery Patient

- ### EMERGENCY PRESENTATIONS:
1. Unstable Vital Signs
 - Fever > 101° F
 - Hypotension
 - Tachycardia > 120 bpm x 4 hours
 - Tachypnea
 - Hypoxia
 - Decreased urine output
 2. Bright Red Blood by Mouth or Rectum, Melena, Bloody Drainage
 3. Abdominal Pain or Colic > 4 hours
 4. Nausea ± Vomiting > 4 hours
 5. Vomiting ± Abdominal Pain

BARIATRIC COMPLICATIONS:

- Intra-Abdominal Bleeding
- Leaks and Sepsis
- Obstruction
- Pulmonary Embolism
- Vomiting ± Abdominal Pain
- Abdominal Compartment Syndrome

IMPORTANT: KNOW THE ANATOMY:
IT CAN BE VERY CONFUSING!
Patients often don't know which procedure they have had, and surgeons vary the procedure dramatically. If you're not the primary surgeon, call the surgeon who performed the procedure.

Principles to Guide Management of Bariatric Emergencies

I. Critical Time Frame

- Diagnose within 6 hours
- To OR within 12-24 hours

II. Critical Warnings

- Call bariatric surgeon early, if not available, call general surgeon on call
- These are not typical abdominal surgery patients; they do not exhibit expected or typical signs and symptoms, and they have no physiological reserve to weather complications.
- NG-tube:
 - Avoid "blind placement" due to risk of perforation
 - Will not decompress the distal stomach
- Avoid NSAIDs, ASA, Plavix, Steroids:
 - Greater risk of ulcer, band erosion and perforation
 - Place on PPI for gastric erosion safeguard
- Thiamine deficiency:
 - Initially avoid glucose in IV fluids (unless hypoglycemia is confirmed)
 - Use RL or NS w/ 100 sample of multivitamin
 - Can result in Wernicke's syndrome, characterized by ataxia, confusion, blurred vision. IV dextrose will increase the risk of permanent neurologic impairment.
- Avoid overloading the gastric pouch with oral fluids or contrast—should only give 6 oz.

Initial Assessments

1. Physical exam and vital signs - may need to be serial.
2. Labs:
 - CBC
 - Comprehensive Chemistry Profile
 - Amylase
3. Imaging:
 - Chest X-Ray
 - CT of Abdomen with oral contrast
 - CT of Chest with IV contrast

Hospital Management of the Bariatric Surgery Patient

"FAST HUG"

- **F**OOD: Establish enteral or parenteral nutrition within 48 hours
- **A**NALGESIA: Control pain for patient comfort
- **S**EDATION: If on ventilator to prevent self-extubation
- **T**HROMBO-EMBOLIC PROPHYLAXIS: Mechanical and chemical
- **H**EAD-OF-BED ELEVATED 30° for aspiration risk
- **U**LCEP PROPHYLAXIS: Proton pump inhibitor
- **G**LUCE CONTROL: Tight control with glucose < 150

● INTRA-ABDOMINAL BLEEDING

I. Emergency Presentation

- Bright Red Blood Oral or Rectal, Melena, Bloody Drainage, Tachycardia, Hypotension, Fainting
- < 48 hrs postop indicates potential bleed from staple line
 - > 48 hrs postop indicates potential marginal ulcer hemorrhage
 - Bleeding via oral route indicates potential pouch source
 - Melena or bleeding via rectal route indicates potential duodenal ulcer or distal stomach or bowel source.

II. Emergency Assessment and Treatment

- Give 2000 mL NS fluid bolus
- Stop Anticoagulants, ASA or Plavix
- Type/Crossmatch PRBCs, may need FFP or platelets
- Serial Hct/Hgb
- Frequent Vital Signs
- Monitor Urine Output
- Check Renal Profile
- Good IV access; may need central line

III. To Surgery if:

- Hypotension
 - Drop in Hct of 20%
 - Falling Hct despite transfusion
 - Tachycardia > 120 x 4 hrs despite fluid bolus or blood transfusion
- NOTE: Consider EGD in OR under general anesthesia to control bleeding. If possible, consider EGD. Check for perforation, Hgb/Hct visualization difficult if frank bleed.

● PULMONARY EMBOLISM

I. Emergency Presentation

- Unstable vital signs with tachypnea ± chest pain

II. Emergency Assessment

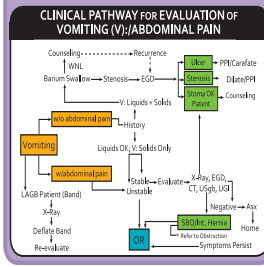
- IV contrast-enhanced chest CT
- Presentation of an intra-abdominal complication such as leak or closed-loop obstruction is often similar to that of PE.

● VOMITING ± ABDOMINAL PAIN

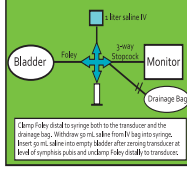
I. Emergency Presentation

- Vomiting associated with abdominal pain needs prompt surgical evaluation and observation until resolved or surgical exploration.

I. Emergency Assessment and Treatment



HOW TO MONITOR BLADDER PRESSURE:



● ABDOMINAL COMPARTMENT SYNDROME

I. Emergency Presentation

- Progressive respiratory insufficiency
- Renal failure
- Intra-abdominal hypertension (25-mm or mmHG bladder pressure)
- Associated with end-organ failure
- Can occur with intra-abdominal sepsis, bleeding or obstruction

II. Emergency Treatment → To Surgery

- Open the abdomen to decompress
- Place VAC dressing

● LEAKS AND SEPSIS

I. Emergency Presentation

- Unstable vital signs within 72 hours of bariatric surgery
- Persistent and progressive tachycardia (>120 bpm > 4 hrs) is the most sensitive indicator of potential surgical emergency.
- Signs of sepsis/leak may be subtle at first and may need to rule out hypovolemia, anemia, bleeding, pulmonary embolism (PE), obstruction and/leak.
- Unstable vital signs at presentation are all signs of sepsis/leak, especially within 72 hours of bariatric surgery: Fever > 101° F, hypotension, tachycardia, tachypnea, hypoxia, decreased urine output.
- Presentation of an intra-abdominal complication, such as leak, is often similar to that of PE. Once PE is ruled out (w/IV contrast-enhanced chest CT), consider immediate surgical exploration.
- A negative abdominal CT does not definitively rule out a complication such as a leak. Abdominal series and gastrografin swallow can be negative even when there is a leak.

II. Emergency Treatment

- Conservative nonoperative management of leaks may be considered if contained leak/abscess is well drained internally or externally with communication to drain documented by imaging and ONLY if the patient is stable clinically (T < 101° F, pulse < 120 bpm, WBC < 15,000, normal renal and respiratory function).
- OTHERWISE:**
- Surgical exploration

● OBSTRUCTION

I. Emergency Presentation

- Abdominal Pain or Colic > 4 hours
- Common postop complaint. Duration of more than 4 hours, or associated with vomiting, requires urgent evaluation and observation until resolved or treated. CT/UGL diagnostic in most cases, but not all.
- No place for NG-tube or conservative management.
- Acute bleed indicates potential obstruction due to clots in GI tract which may cause perforation.
- Consider CT of abdomen with oral contrast or barium swallow with small bowel follow-through to the cecum with contrast to assess for possible obstruction.
- Consider EGD to (A) rule out gastric outlet obstruction or (B) remove gastrografin contrast prior to anesthesia to prevent aspiration.
- X-rays, labs and physical exam often negative in patients with obstruction.
- Closed-loop obstructions and internal hernias are a risk after gastric bypass and may be lethal if dead bowel. Bowel can become ischemic in six hours.
- Adhesions may cause bowel obstructions in any patient after abdominal surgery and be unrelated to bariatric surgery.
- Beware of RED HERRINGS. Gallstones on ultrasound appear to be etiology while the real issue is dead bowel secondary to closed-loop obstruction.
- Beware of aspiration of gastrografin or CT contrast - consider awake endotracheal intubation or EGD prep.

Roux-en-Y Gastric Bypass

Three Sites for Internal Hernias:
Fig. 1 Internal mesenteric openings that could lead to internal hernia after Roux-en-Y gastric bypass. (A) Transverse mesocolon defect. (B) Petersen Hernia (space between mesentery of Roux limb and transverse mesocolon). (C) Ligamentous mesenteric defect.
With permission: Laparobd Adv Surg Tech 2009, 10: 172-5

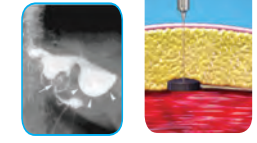
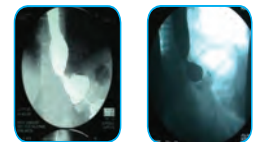
II. Emergency Treatment

- Presentation of an intra-abdominal complication, such as closed-loop obstruction, is often similar to that of PE. Once PE is ruled out (e.g., w/IV contrast-enhanced chest CT) consider immediate surgical exploration.
- Dilated distal stomach or contrast in remnant = obstruction → requires immediate decompression.

Adjustable Gastric Band

- If nausea and vomiting is present, obtain flat plate of abdomen, with band tilted up compared to spine, and barium swallow to assess for possible stenosis or obstruction.
- If slip seen on x-ray → urgent deflate, possibly operate
- To deflate the band, ask patient where their port is located and should be able to palpate on abdominal wall or use fluoroscopy. Can also see it on flat-plate x-ray. Use sterile prep under local. Insert non-coring Huber needle similar to that used for port-caths, as the system is under pressure and will leak. Remove as much fluid as possible, then re-evaluate symptoms and findings.
- Maximum band volume is 4-14 mL depending on model.

Adjustable Gastric Band Obstructions



For more information, please visit www.asmb.org

Figure 1: AMSBS “Clinical Pearls for the Emergency Care of the Bariatric Surgery Patient.”

'We all have bad days. Just go back to your good habits.'

Up to 20% of patients do not lose sufficient weight – typically defined by weight loss surgery professionals as a loss of 50% of excess weight – following bariatric surgery (Livhits et al 2011). In addition, as discussed in chapter five, some degree of regain is common with all bariatric procedures. Although many patients initially believe that having a surgical procedure will free them from dieting, as they learn, continued weight loss and weight maintenance requires ongoing vigilance and hard work. Further, as patients come to understand and as they are told, attending post-operative support groups is associated with greater weight loss over time (Livhits et al 2011).⁵⁹ As I found in my research, this is due to the fact that bariatric forums and support groups provide a degree of accountability, provide non-judgmental understanding about 'bad days,' near evangelical support for getting back to 'good habits,' and promote notions of personal responsibility. Thus, within the context of neoliberalism, a collective fight against the stubborn ontology of fat itself also drives the formation of bariatric support groups.

Denisa stated that after her first year, she stopped going to regular support groups. Now she goes when she's having a 'bad month' to help her get back on track: "If I'm not doing the things I know I should be doing, I'll go to a support group because it always revitalizes me. It makes me say, 'I'm going to get back on my LAPBANDwagon.' It always makes me feel a lot better." When I asked her what it was about the groups exactly that motivated her to change her behavior she replied, "It's just like a lot of great information. You'll always find someone there who has the same issue as you. The fact that you have people who have done so well attending the support groups too makes me feel that I could be like that person. It gives you like a role model there. It just gives you motivation." She continued by saying that having realistic role

⁵⁹ Livhits et al (2011) note that there is no difference in weight loss amongst patients who attend support groups and those who don't at six months post-operatively but this difference becomes significant thereafter.

models was, however, key. If someone had lost ninety pounds by only eating celery, she stated, that was not helpful: “I want to see somebody who actually eats regular food and is able to maintain their weight loss...Those are the people who really interest me -- those who can maintain their weight loss and feel satisfied every day.” Similarly, as relatively new bariatric patient, seeing others struggle with weight loss in support groups was a disheartening for Kristin but also seemed to provide her with the motivation to keep making the right choices.⁶⁰ Many of the individuals struggling, she noted, were not working with their bands. “The band doesn’t stop you from putting 15 cookies in your mouth. You have to kind of stop yourself... You have to work with it.” This notion of working ‘with’ bariatric surgeries like the band (as also discussed in chapter five) suggests that these medical technologies have their own forms of agency. In a Latourian (1987) sense⁶¹ they can be seen as actants which participate in the experience and outcome of having a bariatric procedure, as well as contribute the formation and continuation of bariatric communities.

In addition to advice, information, and role models, support forums online and in person provided other ways of keeping patients on track. For some participants, finding new recipes was key. For band patients, this was especially helpful as the tightness of their band could vary throughout the day, becoming progressively looser as the day went on. Getting a recipe for a meal that they could keep down for breakfast and for lunch, then, was important. For others, online support forums provided an outlet for time that they might have otherwise spent snacking out of boredom. Barbara stated that her weekday routine involved going to work and then going

60 Because of the different challenges bariatric patients face at different times in their post-op lives, one of the bariatric surgeons I interviewed had two different support groups – one for patients who were within the first year of surgery and one for individuals who were 1+ year out of surgery.

61 That is, the notion that social phenomena and social networks are created not just by human interaction, but by non-human objects as well. Here I am suggesting that non-human objects help to create both embodied experiences and biosocial communities that form around those experiences.

to the gym. When she got home, however, she wasn't sure how to occupy herself: "You start wandering. You know? There is nothing in my house that I can't nosh on and be OK with because I only have healthy things to nosh on, at this point. But, it was bothering me that I was doing that. So, if I whip out the computer and I go onto the website, and I get involved in that. It's something to do. And, it reminds me where I am and what I'm doing, and you almost like kind of recommit to it."

Avoiding regain was a popular topic at both of the Obesity Help events I went to. In an Q&A session with paraprofessionals at the September 2011 New Orleans event, one audience member asked for advice about how to help a friend who had stopped coming to the support group. In response, another audience member offered, "If you notice your friends pulling away and regaining, bring them back in." A panelist suggested that patients who asserted that they didn't know why they were regaining were lying. In this session and in workshops on avoiding regain that I attended (amongst the most popular workshops at Obesity Help events) patients and professionals emphasized again and again that it was the patient that failed the surgery, not the surgery that failed the patient. Also at the New Orleans event, bariatric surgeon Dr. Dennis Eschete gave a workshop entitled "Slamming the Door on Regain." In his presentation Dr. Eschete stated that while anatomical and medical issues can lead to regain, 85% of weight regain was caused by falling into old habits. Bariatric support teams were critical to avoiding regain, he argued. At the October 2011 Long Island Obesity Help event, I attended the workshop "Fighting Regain." Workshop leader Colleen Cook – President of Bariatric Support Centers International – proposed a five-step process for getting back on track: 1) Gaining an understanding of the basics of living with bariatric surgery (habits, regular weighing, portion control, making good food choices every day, fluid intake, regular exercise, and ongoing vitamin/mineral

supplementation); 2) Planning how to exchange old habits for new ones; 3) Letting go of old baggage and beliefs about oneself; 4) Understanding ones own metabolism; and 5) Surrounding oneself with supporters who get it. In these workshops, in panels, and in other discussions throughout OH events, the notion of bariatric success was not only linked to personal responsibility for making the right choices, but for joining and staying connected to support groups.

As I attended workshops and panels like the ones described above, a number things became clear: First, the fact of regain (as well as side effects and complications) means that the experience of living bariatric surgery is fraught with both anxiety and ambivalence. Second, this experience helps to create the need for bariatric community as patients collectively work to keep each other on track and emphasize the importance of doing so. By constantly affirming both the need for surgery and the need to work with surgeries, patients mutually negotiate feelings of anxiety and ambivalence. Forth, having bariatric surgery not only radically revises the body but requires a concurrent revision in subjectivity. Fifth, both of these dramatic shifts require intersubjective, communal support to maintain.

Throsby (2008a) notes that it is rare to encounter a bariatric surgery patient who has experienced treatment 'failure' in online bariatric forums. She states, "Instead, outside of those who are publicly 'recommitting' to weight loss, either through renewed discipline or, in some cases, further surgeries, those having negative experiences of surgery (including both serious complications and weight regain) tend to drop out of the discussion forums and are consequently not represented here" (121). Similarly, Sarlio-Lahteenkorva (1998: 206) found that weight loss support groups can sometimes create tensions when some members succeed but others have slow weight loss. These individuals, she notes, often leave peer groups. As with Throsby's and

Sarlio-Lahteenkorva's participants, the individuals that I spoke with who had gained weight felt too embarrassed to return. As Sarah put it:

The difference is that the people who don't attend support groups – look, I'm not saying everyone has to attend three a week. That's crazy, I'm aware of that, but it's my job. It's my life. But even to attend one or two a month – to build that network of people who get it is so important. They don't have that network, so therefore when things are going wrong or they fall off the wagon, as much as I hate that term, they have nobody to call but their surgeon. [And] they don't want to call their surgeon because they're embarrassed.

Notable here in Sarah's comment is the 12-step notion that support group meetings are essential to staying on track. (As I discussed in chapter five, addiction language is common in bariatric patient discussions of the ongoing need to make the right choices.) Nevertheless, some of the participants I spoke with who had regained weight felt that there was a lack of true acknowledgement of the realities of regain which prevented them from continuing to attend support group meetings.

In discussing her regain, Tania stated, "I was one of the first people [in the support group] that had the LAP-BAND surgery and I did really well. So, I was almost like the poster child. When I started gaining the weight back it was just humiliating. And, so I had stopped going. But then I thought to myself, 'This is ridiculous, this is when you need it the most.'" Tania felt that her group was more effective in its support when she was doing well, but less so when she began to struggle. When I asked her how she felt about this, she said: "I'll be honest with you, it angers me. It really does. Sometimes – I can't believe I'm even going to tell you this, but sometimes – I think to myself, 'You just wait, you just wait two years.' You know, 'When you start gaining it back you're going to need help.' I hate to admit that, but I get angry and I get upset."

Naomi also experienced regain with her Roux-En-Y procedure. Despite having founded a Yahoo group for her surgeon, who did not offer a support group, Naomi also dropped out when she began to gain weight because she no longer felt like a good example: “People would put me up on a pedestal...And the funny thing about being put on a pedestal is, you tend to fall off of it.” When I asked her if she thought that the bariatric community adequately addressed the realities of regain, she stated that it did not. I then asked her why she thought that was the case, to which she replied, “Because it will contradict everything that they’re out there touting. That, ‘This is the way to lose weight if you are morbidly obese.’ That ‘this is the way to lose weight.’ That ‘this is a permanent fix.’ And it’s not.” When I asked her what could be done to change this she replied, “I think doctors need to be more honest.”

Throsby (2008) suggests that neoliberal discourse of individual rather than technological failure in bariatric surgery regain facilitates the withdrawal of bariatric patients from support forums. Despite the fervent nature with which participants and individuals at OH events stressed the importance of support groups, this was evident in my research as well. However, I also found that regain both facilitated brief moments of critical interrogation and ultimately resulted in patients’ recommitment to bariatric surgery. For some patients, this meant redoubling efforts to work with the surgeries they had. For others, it meant undergoing a surgical revision.⁶² For instance, Naomi had her surgery revised from to the DS procedure and despite having spent 18 months in the hospital because of revision related complications, was thrilled with the procedure. Tania connected with a small number of patients in her area who had also regained weight and

⁶² As of 2002, up to 25% of bariatric patients had had revisions surgeries, either because of insufficient weight loss or because of complications (Gagner et al 2002). Gumbs et al (2007) report that such surgeries are becoming more common because of the high number of individuals undergoing bariatric procedures. Amongst my participants, 10% had had revisions and at least two others were considering it. With the exception of Naomi (who revised from a RnY to a DS) all of the participants who had had or were considering revision were LAP-BAND patients who were frustrated with insufficient weight loss, regain, and/or complications from the device.

they hired a trainer to help them work out together. When I asked her if she had considered a revision, she remarked that preferred not to have one but would if she had to. She said, “I went and spoke to the doctor who that was doing my fills and he suggested that I have a revision. I don’t want to do that. I truly believe that it is a tool and you have to learn how to use it. And, if I didn’t learn how to use the LAP-BAND, then I don’t know that I’m going to learn how to use any of the other surgeries either.” Learning how to work with bariatric surgery as a tool, then, involves not only learning to make the ‘right choices’ but learning how to live in a surgically altered body. This, in turn, helps to create a very different post-surgical body-self. In all of these processes, the surgeries, once again, serve as actants and are highly involved in the process.

‘There’s a forum for everything’

Unquestionably, the rise of biosocial community and kinship has been fueled by the digital era. As many scholars have documented (Advocat 2009; Novas 2006; Parr 2002b; Rapp & Ginsburg 2001; Rose & Novas 2005; Schaffer et al 2008), the internet facilitates points of contact, the exchange of support and information, and the formation of kinship across geographical boundaries as well as within specific locales. Schaffer et al (2008) argue that the vast amount of online medical and public health resources has situated the internet as a key source of health information for individuals, particularly women who tend to be the primary users. This increase has enabled those with specific diagnoses to share this information with similarly situated others, to both take up and challenge mainstream medical assumptions, and to collectively advocate for better and increased care and treatments (Rose & Novas 2005). Parr (2002) notes that in these online spaces bodies are conceptualized, not as a static biological

entities, but rather as open to reworking. Rather than becoming irrelevant, she continues, the ‘lived-in’ body has become a major focus of online life.

In the case of bariatric surgery, peer-led spaces abound. In addition to Obesity Help (discussed in detail in the next section), which is the largest bariatric surgery patient space online, one can easily find bariatric patient blogs, Twitter accounts, Tumblrs, Yahoo, Google and Facebook groups, and website forums. Interestingly, when I asked participants about the process of deciding to have surgery, many cited Google in their answers. Candice literally Googled: “what to do when you are obese” and came upon the Obesity Help website. She stated, “I was really struggling. In fact, that night when I really made the decision I didn’t know that it was surgery that I was going to do. It was really just like, Google helped me figure this out, you know? They didn’t have Siri then on my iPhone, otherwise I probably would have asked her.” Like the surgeries themselves, digital technologies should also be seen as actants in helping to create bariatric experiences and bariatric communities.

Participants did vary in terms of how much they utilized these online spaces. Some, like Sarah, were highly active in both online and in person groups. Individuals like Denisa checked in occasionally but preferred in person groups. Others, like Talia, only went online when they had a specific question or needed advice. And others still only participated online and never met the people they corresponded with on a daily basis. For example, Gail preferred the combination of flexibility, anonymity, and support that online groups provided. All participants, however, utilized such forums heavily when considering and in the first weeks and months following surgery. Importantly however, as Heath et al (1999) note, one should not assume a separation of online and offline life in social interactions, subjectivities, and other formations. Rather, the two are fundamentally intertwined. For instance, many of the individuals I spoke with participated in

both obesityhelp.com and attended OH events. Others, who did not prefer OH, met groups of friends in surgery-specific sites that they spent time with in person when they could. Finally, many of the in-person support groups, like one run by the Long Island bariatric surgeon I interviewed, also had active Facebook groups that members could access at any time.

As noted above, all participants heavily utilized online spaces while considering and researching surgery. In addition to information-based sites, many were drawn to visually-based bariatric surgery spaces, such as those that heavily featured before and after photos as well as YouTube. Natalia commented that it was amazing to see the before and after photos of people who had lost 150-200 pounds. Calvin and Decenia both spent hours watching YouTube videos of bariatric transformations and journeys. Calvin said, “The YouTube [videos] were more inspirational because I could see the patient... I could see how they were interacting. You could tell the demeanor was a lot different. And, I was craving that. Do you know what I mean? Just seeing the difference in how they move – their body language was very important type of thing.” Decenia found a particular YouTube channel that she would watch for hours. She felt that it was particularly useful because it linked to a journal that documented the patient’s transformation. For these participants, it seemed, online photos and videos not only gave them information on what to expect but also helped them to imagine themselves undergoing similar transformations. Perhaps for this reason, many bariatric surgical sites heavily feature both patient transformation narratives and before and after photos. What was interesting in this case, however, is that participants were most moved by user-generated videos and photographs rather than those carefully selected by the industry to promote surgery.

Heath et al (1999: 452) suggest that online patient forums should not be thought of as single sites, but rather as “the point of intersection for different groups and individuals who join

in the production of biomedical knowledges.” And, as Schaffer et al (2008: 156) have argued, as the significance of such spaces increases, “concerns about other aspects of citizenship – inclusion, exclusion and equity in representation/power within these communities – also increase.” Unsurprisingly then, beyond general bariatric patient sites, there are a large number of surgery specific forums and groups, such as lapbandtalk.com, duodenalswitch.com, rnytalk.com, or verticalsleevetalk.com. As well, on Obesity Help one can find highly specific forums, such those that are region specific, age groups specific, aimed at initial starting BMIs, as well as those geared toward identity groups such as Jewish people or lesbians, gays, bisexuals and transgender people. Finally, there are topical forums on relationship issues like dating, marriage, and divorce after surgery. All of the participants I spoke with reported eventually gravitating toward those sites and forums that best suited their specific needs and identities. Irene sought out online DS community because she was the only “DSer” at the in person support groups in her area. Tired of having to explain her surgery to people, she found her community online.

Many participants cited the fact that the larger forums were often rife with conflict as reasons for finding more specific communities. Kaia referred to some of the forums on OH as “war zones” and said she felt bad for new pre-ops that were now coming to OH looking for information. Hanifah said, “Those people on the forums – they’re crazy. Forums a lot of times bring out the worst in people. I really try to stay out and just, you know, cherry pick the good stuff.” Because she was a blogger, she continued, she tended to associate with other bariatric bloggers. When I asked her what was useful about connections with other bloggers she continued: “It’s like a roller coaster ride: part exhilarating, part scary, and you don’t always know when it’s going to end. While it has been the tool that I have used to my advantage, it hasn’t been easy, it’s still been work. It’s still been a fight...[And] they’re on it with me. It’s

just that simple, they're on it with me. They may be at a different theme park, but we're on it together." Here, both the experience of being on the bariatric journey and the experience of blogging about it are what connect certain patients.

Importantly, digital technologies don't just provide outlets for groups to come together but influence their creation in the first place by allowing similarly situated others to connect across geographical distance. But, in bringing diverse groups of people together along some lines of commonality, other differences emerge in the process. Moreover, digital technologies can often facilitate conflict in that people behave differently in textual forms online than they do in face-to-face interactions. Thus, the fact that bariatric patients both have similar and different experiences with surgery, the fact that people behave differently in digital spaces than in face-to-face ones, and the fact that digital technologies easily allow for a proliferation of group spaces (either by creating new forums within a site or starting a new forum/site) helps to create identity and surgery specific subforums within online bariatric community. Moreover, online subgroups influence in person interactions in larger forums like Obesity Help as well. As I discuss in a later section, these experiences demonstrate that biosocial communities, like bariatric communities, include 'war zones' – or spaces in which new subgroups and sub-identities emerge along lines of conflict and connection.

'Life after weight loss surgery is filled with secrets'

As described in the previous section and in chapter five, both patients and surgeons tend to discuss the realities of bariatric surgery, including side effects and regain, in terms of patient noncompliance. Boero (2012) suggests that this creates a discursive environment in which criticism of surgery is discouraged within bariatric communities and patients experiencing

complications find it difficult to speak up. My findings are somewhat different. Rather than seeing this climate of hostility toward questioning and criticizing bariatric surgery in the bariatric community as repressive, I believe it should be framed as both regulatory and productive. In the latter regard, it has driven the creation of offshoot groups in which such discussions are (somewhat secretly) allowed. I provide two examples below.

On the “Weighty Secrets” blog (discussed in chapter four), bariatric patients anonymously confess those things about post-surgical life that they cannot share in more mainstream forums. On the home page, the following text appears: “A lot of people who undergo weight loss surgery are told that having the surgery would be a cure for their fat ‘disease’ and life. After the honeymoon period of weight loss wears off – and the reality sets in – what then? This blog will give you a peek into the real life of WLS patients and those around them. Life after weight loss surgery is filled with doubts, concerns and often? Secrets.” In 2013 alone, there are posts on developing post-surgical anorexia related to an inability to feel hunger, post-surgical marital issues that stem from a spouse’s preference for larger women, continued food addiction and binge eating, and the use of potentially dangerous fat burning supplements in the bariatric community (described by the poster as the ‘elephant in the room’).

The Yahoo Group Obesity Surgery Support Group (OSSG) has a lesser known, offshoot group entitled OSSG-Gone Wrong. The group is described as a haven for bariatric patients who are experiencing complications such as weight regain, excessive weight loss, vitamin deficiencies and malnutrition, and poor body image after surgery. The site is also described as space where patients can relate horror stories as well as discuss problems they have experienced with medical providers. Currently, the group has over 2,500 members. The main OSSG group, by contrast, has nearly 5,000 members and is far more active. Still, it is notable that ‘Gone

Wrong' has 50% of the membership of the main group, although one should in no way assume that the memberships necessarily overlap.

In a Foucauldian sense, discussions of complications and side effects are not repressed within bariatric communities but are talked about incessantly both online and in person. While these discussions happen openly at OH events, the focus there is seeking advice to get back on track and to better work with bariatric surgeries, although I would note that obesityhelp.com does have a forum called "Weight Loss Surgery Regrets" with eighteen pages of posts. Nevertheless, in general the focus in these discussions is on reaffirming the surgery. Because of this, groups like Weighty Secrets OSSG-Gone Wrong come into being where more stark confessions and conversations can occur.⁶³ These groups also provide space for small resistances to larger discourses of obesity, health, and weight loss. Ultimately, however, these groups do not pose a serious threat to bariatric surgery and can hardly be seen as constituting a significant counter-discourse. More accurately, they illustrate Walkerdine's (2009: 201) assertion that the "take up of regulative discourses and practices around weight and health is complex and indeed cannot be predicted in any simple fashion." Bariatric patients take up neoliberal rhetorics of personal responsibility unevenly, even if the ways in which they are challenge these rhetorics are oblique and sometimes secret. As well, these offshoot groups illustrate Ahmed's (2004) point that anxieties and fears are inherently social, creating collectivities in their circulation. Fears, anxieties, and I would add ambivalences about the very complicated, chaotic, and often unpredictable actuality of living with bariatric surgeries circulate in such a way that they help to create large the large groups of patients working collectively seeking to avoid regain and manage

63 Interestingly, the embodied reality of bariatric surgeries also helps to produce additional online discussions of side effects and complications – specifically those that occur in fat activist spaces. Here, however, these surgeries have not 'gone wrong,' but rather serve, for the authors and commenters, as proof of the fundamentally barbaric nature of these procedures. See: <http://fathealth.wordpress.com/2013/02/24/the-long-term-consequences-of-wls-leathers-story/> and <http://glorifybasecamp.com/why-i-will-never-advocate-weight-loss-surgery/> as examples.

complications, while also producing side groups of individuals who gather, often anonymously, to struggle with their inability to do so and the messy actualities of trying. And, as noted throughout this chapter, both the surgeries themselves and digital technologies are a fundamental actants in the creation and continuance of these collectivities.

Obesity Help and the affirmation of weight loss surgery

The “about us” section of obesityhelp.com states that the organization was founded in 1998 as a peer support community dedicated to helping those faced with “life threatening morbid obesity.” In 1999 the site expanded to include clinicians and professionals. As of 2008, Obesity Help (OH) had over 600,000 members. In addition to providing information on forms of weight loss in general and on types of weight loss surgery, the site features galleries of before and after photographs; topical articles; peer-reviews of bariatric surgeons; topic and identity based groups and forums; information about upcoming events held in different parts of the country; a subscription magazine; health trackers; a chat room; and a full social networking platform. The social networking profiles include dropdown menus and text boxes to provide the following information about oneself: type of surgery; before and after photos; goals; surgeon information; interests; hospital reviews; product reviews; surgery support; a blog area; a introduction section; and space to tell one’s obesity and weight loss story. While clinicians and professionals are undoubtedly involved in running and shaping the site, for example by providing content and purchasing advertising space, the conversations that happen within the obesityhelp.com forums seem to be dominated by patients. Professional influence is, however, much more notable at the in person events, as I describe later in this chapter.

The first OH event was held in 2004, six years after the site debuted. Today, Obesity Help holds approximately three events per year in different parts of the country. In 2011, OH events were held in the greater Seattle area, New Orleans, and central Long Island. As noted earlier, I attended the New Orleans and Long Island events that year as a participant observer. By my estimation, there were approximately 150 attendants at each of the New Orleans and Long Island events. However, the Long Island event felt much larger due to the fact that participants spent more time at the actual conference (as it was over an hour by train to Manhattan) than did those at the New Orleans event (the hotel was a half block from Bourbon Street). Attendees were overwhelmingly white, female, and in the 30-50 years of age range. Interestingly, the participants I spoke with felt that while attendance at OH accurately reflected the higher numbers of women who had surgery, the events were disproportionately white. As Hanifah put it, OH events “draw a particular kind of person.” Throughout both events, I noticed again and again that many of the people of color in attendance socialized and sat together. As well, I noticed age-based social groupings amongst participants.

Both conferences began with a Friday daylong pre-conference professional continuing education event (with a separate registration) entitled “Understanding the Obese Patient,” which I attended in Long Island. For patient attendees, Friday programming included a clothing swap, a Q&A panel, and in the evening, a meet and greet social event. Because the Long Island event was held at the end of October, the Friday meet and greet was also a Halloween costume party. Saturdays included a Conga line, motivational speakers, a professional panel Q&A session, and then afternoon workshop sessions. Saturday nights were devoted to the fashion show, evening entertainment, and dance parties.

In New Orleans, I attended the workshops on regain (described previously), on the Obesity Action Coalition's (OAC) work, on the Weight Loss Surgery Foundation of America's (WLSFA) work, and on revisional surgery. As noted earlier, the workshop "Slamming the Door on Regain" was very well attended. The other three workshops however, were virtually empty. In fact, I was one of two or three people in both the OAC and WLSFA workshops.⁶⁴ This may suggest that participant interests in OH events lie less in advocacy and activism and more in support, information, and socializing. At the Long Island event, therefore, I chose workshops that seemed to attract large numbers of patients and thus I attended a motivational workshop, a workshop on reconstructive plastic surgery, one on fighting regain, and one on how bariatric surgery impacts relationships.

As I noted earlier in discussing the workshop on regain, discussions of what it meant to have and live with bariatric surgery centered on neoliberal notions of individual responsibility and compliance and were always framed positively in terms of empowerment and 'taking control.' Advice and information provided in workshops and on panels focused on helping patients make better, more informed choices. In one workshop, bariatric surgery was described as a gift that entails responsibility. By this, the speaker meant bariatric patients had the duty to make the right choices, not only for themselves, but so that they could serve as good examples

⁶⁴ The OAC describes itself as "The ONLY non-profit organization whose sole focus is representing individuals affected by obesity" (<http://www.obesityaction.org/>, emphasis OAC's). This is arguably false, given that there are a number of fat-activist groups with 501(c)(3) status that are devoted to representing and advocating on behalf of fat people, such as NAAFA (<http://www.naafaonline.com/>). The difference, of course, lies in OAC's framework of fatness as a medical condition in need of redress, whereas NAAFA would define fatness as a part of human variation and not a medical condition per se. Thus, while both OAC and NAAFA combat anti-fat stigma, they do so from very different ideological vantage points. Ironically, they often work on the same campaigns, such as the fight against the Atlanta Strong4Life anti childhood obesity campaign, which both groups considered highly stigmatizing. Like OAC, WLSFA frames obesity as a medical condition beyond patient control. The organization works to "raise funds and gather resources to give away in the form of Surgery Grants to people denied access to the medical treatment of obesity" (<http://www.wlsfa.org/about/>).

for others struggling with obesity. Referring to bariatric patients as ‘ambassadors,’ she stated: “We have a responsibility to do the best we can.”

In my fieldnotes I recorded that conference discussions – both formal and informal – centered on side effects of surgery, eating habits, and weight loss. In discussing eating habits, I noted that patients often suggested that bariatric surgery helped them to develop eating habits were just like those of ‘normal’ people. And when nutritional deficiencies were brought up, the ways in which other patients and providers addressed them served to normalize side effects by suggesting that they something to be managed by adjusting behavior. However, as I detailed in chapter four, bariatric eating practices are far from what could be considered typical. Moreover, the fact that bariatric patients so frequently seek each other out to for tips, advice, and encouragement about eating, nutritional concerns, and side effects makes this clear as well. The side effect of bariatric surgery that was, however, discussed openly at Obesity Help with the most angst and despair was loose skin. When patients brought up issues of dissatisfaction with loose skin, other patients frequently asserted that while loose skin was troubling, and that it was ok to want to look more attractive, it was important to remember that one underwent bariatric surgery for health. Loose skin, then, was an unfortunate but ultimately necessary price to pay for having a life-saving procedure. This suggests two things. First, anxieties and ambivalences that surround physiological side effects and regain – that is health – are quickly realigned with a focus on bariatric surgery as a necessary, life-saving procedure that the patient must attend to responsibly. Second, while bariatric communities can openly acknowledge and grapple with concerns and mixed feelings about the aesthetic side effects of bariatric surgery, these conversations too serve to underscore the necessity of undergoing these procedures for health.

Interestingly, collective negotiations around loose skin also occurred in ways that were highly gendered. For example, a large portion of the Saturday morning Q&A panel in New Orleans was devoted to the issue of loose skin and dating wherein the few men in the audience reassured women that men didn't care, that women were their own worst critics, and that men were frankly far more interested in the potential for sex than loose skin. Women reassured other women with comments such as "A worthwhile man doesn't care," and "Be inventive in how you present yourself" (meaning to camouflage loose skin in by dressing in particular ways). One very large man passionately stated that men had the same insecurities but didn't vocalize them. In these discussions, many women lamented that they could not afford reconstructive and those who had had it frequently described themselves as "lucky." Echoing Boero (2012), the OH events then can be sites in which patients learn how to "negotiate a world of normative gender and sexual expectations that they had previously been outside of by virtue of their fatness" (104). As the exchanges about loose skin that I have described about demonstrate, patients (particularly heterosexual women) must also learn how to navigate the telltale signs of their formerly fat bodies in learning rituals of sex and dating.

Professional Influences

The influence of professionals was notable at both OH events I attended. Moreover, there were a number of professional 'regulars' who seemed to be making their livelihoods off of bariatric communities. For instance, Colleen Cook (mentioned earlier) runs Bariatric Support Centers International (BSC) which offers, amongst other things, the "Back on Track" program. On BSC's website, patients can choose items like a Back On Track three month membership package for \$75, a webinar for \$149, or from a series of booklets that are approximately \$10

each (see <http://www.bsresourcecenter.com/products.php?cat=51&pg=2>). Erin Akey, a frequent speaker on the paraprofessional panels at OH and who lead the motivational workshop I went to, is a self-described “Certified Fitness Nutrition Coach and a Certified Lifestyle and Weight Management Specialist. She also hosts a FM radio show entitled “Fit Living” (see http://fmtalk1065.com/schedule/fit_living_with_erin_achey/) and runs the fitness program “Fit and Flourishing!” which individuals can purchase a paid subscription to (see: http://www.fitandflourishing.com/trial_subscription.html). Similarly, Yvonne McCarthy⁶⁵ appears on regular panels at OH events and is a health and wellness coach (see: <http://wlssuccess.com/about/>). Licensed psychologist Dr. Connie Stapleton, another frequent speaker on OH provider panels, leads pre-conference continuing education workshops on “Understanding the Obese Patient” that I attended in Long Island. Amongst her specialties are recovery programs for obesity-related food addiction. On Stapleton’s website, one can purchase the program “Mind Prep,” designed to support bariatric patients through their food-related emotional issues as well as adjusting to life after surgery (see: <http://www.conniestapletonphd.com/mindprepvideo/#trial>). Although her pre-conference workshops are geared toward professionals, Stapleton led patient workshops on “recovering from obesity” at the OH events and frequently discussed topics of addiction and recovery on the provider panels she spoke on. Chef Dave, a OH panel and workshop regular, is the executive chef for WLS Lifestyles, has written weight-loss related cookbooks, and serves as an advisor on food and product development for corporations such as Keebler and PepsiCo (see

65 Notably, at both OH events I went to, McCarthy frequently asserted that obesity was a food addiction. She managed her food addiction, she claimed, by cultivating a food ‘aversion’ – that is, convincing herself that most food was poisonous. Notably, the cartoon images that are supposed to represent McCarthy on her website are illustrative of the ways in which bariatric surgery may be seen, by some women, as a way to reclaim a youth lost to fatness. Although McCarthy appears to be a woman in her mid to late 50s, the cartoon images of herself on her website portray a Barbie like young woman in her 20s.

http://www.chefdave.org/team/chef_dave). Finally, as noted in chapter four, a number of companies specializing in bariatric vitamins and supplements, protein shakes, and supportive/slimming undergarments like “Slimpressions” (see: <http://slimpressions.com/>) can be found in the vending area of every Obesity Help event.

Along with area-specific bariatric surgery clinics and plastic surgeons, many of these individuals and companies seemed to have been sponsors of the OH events based on advertising in the program, on placards throughout the conference, and based on the items given away in the Saturday morning raffles. The presence of these individuals, clinics, surgeons, and companies is notable for three reasons: First, professional, clinical, and corporate interests should not be seen as distinct from the sectors of the bariatric communities, particularly OH. Rather, they are fundamentally intertwined. Second, as with dieting, the fact of regain amongst bariatric patients and the notion of obesity as food addiction, in combination with the oft emphasized neoliberal rhetoric of self-responsibility, has created an area ripe for capitalization (see also Boero 2012). Third, this area of capitalization is not simply exploited by outside professionals but rather, bariatric patients themselves who have created new livelihoods by finding niche markets within their own communities. These niche markets often address patient needs that are not met by outside professionals, such as the creation of garments that help obscure telltale signs of surgery or bariatric specific cookbooks.

“It’s not what it used to be.”

Ten of the thirty bariatric patients I interviewed had been to an Obesity Help event. Of the other twenty individuals who had not, nearly all of them had heard of the events and many had considered going. Despite the fact that the majority of participants were not heavily

involved in the OH events, every participant I spoke with either currently visited and participated in OH's website or had utilized it in the past. As well, every participant I spoke with cited OH as the first site or amongst the first sites visited when considering and researching bariatric surgery. Those participants who still visited the site tended to gravitate toward surgery specific sub forums because, as noted in the previous section, many felt that the larger forums were now overrun with strife and conflict, a topic I attend to in the next section. Interestingly, both individuals who had had surgery nearly a decade ago and those who had had their surgeries more recently echoed this sentiment.

The general consensus amongst the participants that I spoke with was that the conflict centered around arguments about which surgeries were the best and how one should best work with a particular bariatric surgery afterward, in terms of behaviors taken and things to be avoided. As Kaia put it, "You can't just go in there and ask a simple without getting some person that had the surgery eight years ago and thinks that they know everything just jumping in." As I detail in the below section on divisions within the bariatric community, debates and conflict over surgery types spilled over into the in person OH spaces as well. Despite the feeling that the tenor OH had changed, in terms of both the website and the in person events, all of participants that had utilized the OH site or had been to events stated it had been invaluable to them, even if it was not a space that they currently participated in.

Commonality and conflict

Prior to interviewing DS patients⁶⁶ I had noticed that lines of conflict around reconstructive plastic surgery and original starting weight occurred within bariatric communities.

⁶⁶ Because of the fact that I primarily utilized a snowball sample to find participants, I tended to interview similar types of patients during certain periods of time. For the first five months of my research, these participants tended to

As I began to interview these patients, however, I realized that tensions also existed within these communities around surgery type. All of these tensions were never more apparent in my research than at the OH events such as Halloween meet and greet and the fashion shows. I describe each of these bariatric community divisions in detail below.

‘Even in the weight loss surgery community, we are outsiders’

Chef Dave was a guest speaker at the pre-conference continuing education event I attended in Long Island, “Understanding the Obese Patient.” During his presentation “Healthy Eating and Cooking Behaviors,” he discussed what were, in essence, food and nutritional ‘best practices’ for the bariatric patient. As he talked, I began to notice that a woman in the row in front of me, who had identified herself as a therapist from Connecticut and also a DS bariatric patient, began to shake her head in frustration. Angrily, she stated that nutritionists and support group leaders needed to realize that there were different nutritional needs and diets for different types of bariatric surgery. Patients who had the DS procedure, she continued, malabsorbed fat and so needed to consume far more fat and protein than did other bariatric patients. As she spoke, I noted that her comment was acknowledged but not particularly taken up by either Chef Dave or Stapleton. This was my first insight into the fact that DS patients felt both misunderstood and maligned within bariatric communities.

As I interviewed DS patients, I found that many of them spoke readily and without prompting about the discrimination they felt from other bariatric patients. I interviewed Nina approximately six weeks after we both attended the Long Island OH event, which was her first

be LAP-BAND and Roux-en-Y patients, although I did interview two patients who had had the gastric sleeve. After interviewing Nadia, a long time DS patient who was an angel to many other DS patients, this began to change. With her help, I had dozens of DS participants willing to be interviewed within a few hours of her posting about my study online. Within a couple of months, I had interviewed ten DSers, either in person or by phone.

OH conference. After asking her about her experiences there, she stated she felt like an outsider. She said, “I thought it was very oriented towards other surgeries than mine specifically.” Nina, like many of the other DS patients I interviewed, felt that because Roux-en-Y patients were the most numerous at the conference,⁶⁷ workshops, information, and even the food served tended to cater to their interests and needs.

But it wasn't just that DS patients felt ignored, they felt actively resented. Some DS participants said they felt actively hated by other bariatric patients. When I inquired as to why this might be the case, I was told again and again that other bariatric patients were jealous. The DS procedure is the most extreme and the most risky of the bariatric procedures but is also associated with the most durable weight loss over time. As well, because of the malabsorption of fat, DS patients can still consume foods that other bariatric patients must heavily limit or avoid. Candice said, “DSers understand where I'm coming from when I'm stuffing cheese in my face. RnYers think I'm crazy for eating the amount of calories I eat per day, or eating the amount of fat that I eat per day.” Similarly, Irene stated that because they didn't understand her dietary needs, RnYers frequently told her she was endangering her health. “I have a friend. She's sweet. She's an RnYer, and she's just like almost obsessed and she's just like, ‘Oh, I saw this research I did about how, you know, you guys eat too much fat and you're going to have bad cholesterol.’ I'm like, ‘My cholesterol runs low.’ Like, I physically have to [consume large amounts of fat] because I malabsorb so much.”

⁶⁷ The Roux-en-Y has been considered the gold standard of bariatric procedures and is much older than the LAP-BAND or gastric sleeve, although versions of gastric banding had been performed previously. As well, the duodenal switch is not commonly performed because of the complicated and potentially high-risk nature of the surgery. For all of these reasons, RnY patients tend to be the most populous in general bariatric forums, both online and in person. Interestingly almost all of the RnY, sleeve, and DS patients spoke ill of the LAP-BAND procedure, none of the LAP-BAND patients I interviewed discussed feeling marginalized in bariatric communities.

While most DS patients speculated that jealousy over both the ability to eat fatty foods and maintain weight loss was at the heart of other bariatric patients' jealousy, Katrina's friend confided in her that this was actually the case: "My friend, who's a gastric bypass patient says, 'Do you know what the problem is? And I'll be honest, do you know why they don't like you guys?...Because you can eat all of these things and as unhealthy as they are for us, they're not for you because you don't absorb it. So, yes, we're pissed at you.'" Katrina's friend also confessed that, had she known about the DS procedure at the time she had undergone surgery, she would have chosen it instead of the RnY. Nadia also felt that this was the source of jealousy: "There are a lot of people who hate switchers because we fought for our surgery. We understood what we were getting. We understood what we wanted. A lot of people just knew that they had to do something and they walked in the door and the doctor said, 'OK, I can do the gastric bypass,' and they just went, 'Yes, yes, yes, yes, yes, yes...' without doing all of the research."

At times DS patients felt not only that they were resented or the objects of envy, but that they were actively hated. This was one of the primary reasons that they formed surgery specific subgroups, both online and in person. Katrina said that she had been told by other bariatric patients that DSers had uncontrollable diarrhea and emitted a foul odor: "I was like, 'No, we have poop that smells. But, then again the last time I checked nobody pooped roses.' There's so much ignorance!" Nina had been told that DS patients chose their surgeries because they were unwilling to change their eating habits. "So even in the weight loss surgery community we are outsiders ourselves. I think that's why we stick together so much." And while most DS patients felt angry that they were outcasts in the larger bariatric communities like OH, some, like Irene, expressed sadness. She said, "We're all in this together. We're all people who used to be heavy. There should be some kind of like brother and sisterhood."

Although LAP-BAND patients did not report feelings of being isolated or discrimination, the particularities of living with a medical device seemed to drive their desire to congregate with one another. More specifically, it was particular experience of living with adjustments that fueled a desire to connect with other band patients. Describing her experience with this particular surgery, Denisa said:

Unless you have a band, you cannot possibly understand that you cannot get food down, or the tightness you feel in your chest. You only get that in the support group. I can't really talk about that with other people in my life. My boyfriend will say, "Well, just get loosened." That's not the answer. It's not just to get loosened because then, I'll always be loose. I have to figure out a way to work around my restriction. Only another band patient will know what that means, will know what that feels like.

Similarly Talia stated LAP-BAND adjustments were not an “exact science” and so there was a day-by-day relearning of what worked, what didn't, and what to do about it. Connecting with other gastric banding patients was especially helpful because they could help each other figure out what was going on: ““What are you eating? What are you not eating? How is it going? Are you too tight?” Like sometimes it's not clear.”

This constant physiological and life adjustment for LAP-BAND patients was often a source of conflict with their romantic partners. When Laura would experience digestive discomfort and plugging, her husband expressed his wish that she would get her band removed – something that she refused to do. “If I get it out,” she said, “I would be back to square one. I'll gain back the 90 pounds that I still have kept off and I really, really don't want to do that. So I'm not going to have it taken out.” Similarly Denisa said her boyfriend was frustrated by not knowing what she would be able to eat on a daily basis. “He's not happy. He goes, ‘Oh my God! You're getting a new adjustment? I'll go eat outside.’”

These experiences facilitated the association with others who understood, amongst other things, how to work *with* the band to reduce or avoid the discomfort that can be part and parcel of having the procedure without getting it loosened or removed – something that would slow down the weight loss process or cause regain. As Sanz Porras (2006: 117) suggests, the turbulent, unpredictable surgically altered digestive system of the bariatric patient is generative of a new set of relations – both the relations between the patient and her body, and, as I argue here, between specific types of patients. Specifically, the surgeries themselves work as actants, creating particular relations to the body and the self, which in turn help to create surgery-specific forms of community in which these new forms of selfhood and embodiment are collectively negotiated.

'They cross into the skinny girl category'

As Boero (2012) notes, OH events serve as locales in which bariatric patients relearn rituals and norms of gender and heterosexuality. However, I would argue that these rituals also unintentionally work to reinforce mainstream class-based beauty norms and hierarchies, creating divisions within the community in the process. For example, the Friday night entertainment of the Long Island OH conference consisted of a Halloween costume party, with prizes awarded for categories such as 'most sexy' and 'most innovative.' Most of the individuals who attended came dressed in store-bought costumes. And while I saw more men that night than I had seen at OH up until that point, women still outnumbered men approximately ten to one. As well, the scene was overwhelmingly white, although I noticed a table of African American men and women who sat together in the corner. The atmosphere felt like something of a high school

reunion, with individuals and groups embracing one another warmly, smiling, talking, and taking photographs.

Before the contest portion of the night began, a contingent of four tall, thin, white, 30-something women entered the room dressed to the nines in various ‘sexy’ outfits, such as ‘sexy nurse’ and ‘sexy cop.’ As they entered, heads turned and I could not help but notice the looks of visible discomfort on the faces of group of women who sat in a table nearby and wore more conservative, loose costumes. Whereas the women in the ‘sexy’ contingent were thin and showed none of the telltale signs of rapid weight loss, the women who sat at the table were still somewhat large and had noticeable, loose skin. It was then that I began to wonder more about how issues of original starting weight, loose skin, and access to reconstructive plastic surgery affected the dynamics of the bariatric community.

None of the participants I spoke with had had reconstructive plastic surgery, although many hoped to have it at some point. For most, however, these surgeries were either completely out of their reach financially, or would take a long time to save up for. As I noted previously, the issue of loose skin was a topic of much angst and upset for many women at OH, particularly when it came to sex and dating. Nevertheless, panelists did their best to reassure other women that “worthwhile men wouldn’t care.” These reassurances continued throughout the OH events. For instance, at her motivational workshop, Erin Akey encouraged attendees not to compare themselves to others and to be happy with themselves. “Whoever you are,” she stated, “you are always going to be someone else’s ideal.” Despite these reassurances, it was clear that access to reconstructive plastic surgery was a point of contention and envy within the OH community, one necessarily entwined with both issues of class and notions of normative gender presentation. It is

for this reason I suspect those who had had plastic surgeries frequently downplayed the access they had by referring to themselves as “lucky.” Still, it seemed as if resentments abounded.

In describing different groups of women at the conference, Nina said that there were “the women who have plastic surgery and now have these great bodies that were reconstructed and now can wear bikinis and can wear mini-skirts and can wear tight dresses. Then there’s the women who lose weight and still have all of this excess skin and they still need to be conservative with their dressing.” When I asked how this affected the dynamics between community members she stated that those with access to plastic surgery crossed over into the “skinny girl category” and became the source of intimidation and envy for others. “And, so even though you had surgery, you still feel out of place,” she continued, “You feel like you don’t fit in.”

As Katrina commented, the envy that other women feel toward those who better ‘pass,’ either because they’ve had reconstructive surgery or didn’t have much loose skin to contend with after weight loss (something related to individual biology, age at the time of surgery, and original starting weight) is palpable. In discussing the first OH event she went to, she recalled the great hostility she felt from others. She said, “It was just so odd, because I felt like I was being discriminated [against]...I heard a woman saying, ‘What is that girl doing here? This is not the event for her, you know, looking like a model like that. She probably doesn’t even know what being fat a day in her life is like.’” Stunned at the comment, Katrina confronted the woman behind her. “I turned around and I said, ‘Actually I lost 212 pounds. Now [it’s] 190, because I have gained weight back.’ And she looked at me and she was like, ‘Yeah, you probably had major plastic surgery.’ It was almost bickering and I’m like, ‘Actually I haven’t, and I had a baby three months ago.’ I mean it was almost like I had to defend myself!” Katrina surmised

that a number of the women who chastised her had ‘failed’ weight loss surgery and were thus miserable and envious of her success. She described their feelings of envy as “Why me and not you?” Although she could understand this, as she was once a LAP-BAND patient who had not lost a significant amount of weight, she felt as if the women had a responsibility to take action like she did and to have a revision. Larger forces of sexism, classism, and neoliberalism thus facilitate these forms of competitiveness between bariatric patients along lines of both health and appearance.

You better work

The Saturday night entertainment at all OH events consists of a fashion show followed by a dance. Some events have additional entertainment, such as the Long Island conference I attended at which Calvin performed. Calvin, a tall, thin African American man in his early 20s and a R&B singer, began his performance by relating his bariatric surgery journey story to the audience. First, he described the pre-surgical health problems he had: a stroke that occurred while he was performing on stage, a heart attack, and diabetes that nearly caused him to lose toes. Then he reported his pre-surgical biomarkers such as blood pressure, cholesterol, and blood glucose levels. In response, the audience audibly gasped. Calvin continued by discussing his decision to have surgery, the amount of weight he lost, and his current biomarkers of health. As he did so he vamped for the crowd, much to their delight. Weight loss surgery, he said, had saved his life. The audience exploded in a thunderous applause. Calvin then sang a few of his original songs, flirting with women in the audience as he did so. After he left the stage, the fashion show portion of the evening began.

When I first read about the fashion show in the conference program, I assumed it would feature different designers, including plus size designers. What I realized as the event began, however, was that the fashion show is designed to feature patients' dramatic weight loss transformations and new, more normatively attractive bodies. As each model walked out on to the runway in the center of the hotel ballroom, the two emcees reported her name, the type of surgery she had, her surgery date, and her total weight loss. Flashed on the monitors above the runway was a 'before' photograph. The greater the total weight loss of the model, and the longer she had kept it off, the greater the response from the audience. On the whole, the average model was a woman who had the RnY procedure and who had lost approximately 150 pounds. There were a few men who walked, however, as well as a couple who came out in their wedding attire. The groom, we were told, had proposed at the OH event exactly one year ago and the couple had just recently been married. The audience responded with great applause. Notably, the models whose weight losses totaled less than 100 pounds and those who had had the LAP-BAND procedure got significantly less response from the audience. This was also true for the one woman who walked that had lost 55 pounds through dieting, exercise, and going to support groups, an illustration of the fact that while Obesity Help purports to support all forms of weight loss, it heavily promotes bariatric surgery.

As Boero (2012: 110) reports, the fashion show serves as another opportunity within the bariatric community for patients to be reintroduced to, learn, and perform "expectations of normative heterosexuality after having lived on the constitutive outside of acceptable sexuality during their lives as fat people." I would argue that the fashion show also demonstrates other dynamics within the bariatric community. Beyond being an illustration of the ways in which the

RnY procedure dominates OH, the audience reception to models in the fashion show demonstrates divisions in the community based on starting weight.

While all of the participants I interviewed felt a sense of kinship with other bariatric patients as a whole, many also felt that they couldn't relate as well to patients who, relatively speaking, hadn't had to lose that much weight. For example, Nina commented on the tensions between 'lightweights' and 'heavyweight's in the community:

I don't judge when it comes to that. I think if you have tried everything and you can't lose weight and this is your last option, then there's no reason for you not to do it. But, I do feel that you should not tell someone who's my size, "Oh, you look great. You should be happy with where you are. Look how far you've gotten," because you had surgery at my weight. Don't tell me that this is OK when you choose to go get yourself cut open and your anatomy rearranged to get from where I was to where you are now.

Similarly, Talia spoke about how it made her feel to see smaller women in the waiting room of her bariatric clinic who were there for a surgery consult: "When I was like 220, like there were people there who were there [at that weight] to have the surgery. And I'm thinking like, 'I lost almost 200 pounds,' do you know what I mean? I'm thinking never in a million years at 225 pounds would I consider weight loss surgery... It's not that I have like any cut-off when it's OK and when it's not, but the thought of people weighing like 200, 210, 220 feeling like they need weight loss surgery, it makes me a little crazy."

When I asked Nina if she better related to other heavyweights as compared to lightweights, she said that she did and mentioned the OH forums based on starting weight. "I think it's easier for me to talk to someone that has been in my shoes. If I go and ask someone a question, for example, who started at my weight right now and in ten months they're 130 pounds, to me that's a joke, you know? Like, 'Oh, wow, in tens months you went from being obese to being normal. I'm sorry, but you don't really know what it's like to go through being

400 pounds.’ Like I can’t feel a connection with them.” Unlike the lightweights, people like her, she continued, had to struggle with the fact that they might stay where they were, and that this would be it. “It’s rough when you have lost 170 pounds and you’re still fat. You know? Like, people who are lightweights, they don’t know what that’s like. They lose 80 pounds, they lose 100 pound -- bam, they’re thin.”

In this sense, the difference in applause based on total weight loss may illustrate the tensions that occur within the bariatric community around starting weight. Greater weight losses demonstrate the dramatic transformation participants hope will be afforded by surgery, particularly for those who began their surgery journeys at heavier weights. As well, greater weight losses may demonstrate a greater degree of struggle and of ‘work’ on behalf of the patient. This is particularly the case when patients have kept off dramatic weight losses for a number of years for, as I have noted throughout this dissertation, the specter of weight regain haunts the bariatric community. Calvin’s remarks about divisions within the OH community were insightful in this regard. He said, “It was very, very competitive to see who looked better....I’m sitting there like, ‘Well, shouldn’t we all be happy for each other, period?’ I think most of them are kind of obsessed with putting something in their mouth and gaining the weight back... Like this one girl, she was crying basically in my arms because she had gained ten pounds back.”

The OH fashion shows are more than a performance of normative gender and sexuality. Rather, at these shows, dramatic weight loss and weight loss maintenance also become embodied demonstrations of struggle, hard work, and taking responsibility for health. As well, the fact that the ‘heavyweight’ transformations are most celebrated at these events suggests that new ethics based on biosocial configurations of the self is also performed at these fashion shows.

Specifically: within a neoliberal healthist climate, bodies that showcase the most dramatic transformations also seemingly demonstrate the most proper selfhoods.

Bariatric Biosociality: Pushed together, pulled apart

As I have noted in this chapter and this dissertation as a whole, a number of factors push bariatric patients together and work to create biosocial communities around bariatric surgery: First, dramatic rises in three key phenomena: population level body weights, discourse and anxieties surrounding obesity, and bariatric surgeries. Second, a neoliberal context in which citizens are seen as having a national duty to maintain good health and in which fatness is seen as a marker of failed citizen – something that is always entangled with sedimented discourses and anxieties around race, class, gender, and disability. Third, for patients, the common experiences of having been very fat, having had bariatric surgery, having lost a significant amount of weight, and living with a highly unpredictable and surgically rearranged digestive system. Fourth, the lack of structured, free or reimbursable post-operative support and care as well as medical knowledge about the particularities of bariatric bodies. Fifth, accusations bariatric patients face from others and in the media for having taken the ‘easy way out.’ Sixth, the fact of complications, side effects, and regain that are endemic to bariatric surgery. Seventh, the surgeries themselves become actants in patient experiences and are something they must work with in order to reduce or avoid side effects and regain. Finally, digital technologies also serve as actants in creating not only communities across wide geographical areas but subgroups by surgery type, identity category, lifestyle interests, and original starting weight. As well, digital technologies help to create semi-secret offshoot of individuals who speak freely, and often anonymously, about complications and the messy actualities of living with bariatric surgery.

However, as this biosocial community comes together around these commonalities, other differences emerge and often create conflict. First, tensions exist around surgery type, with DS patients feeling as if they are marginalized within larger bariatric communities because of their greater weight loss successes. Although LAP-BAND participants did not report any discrimination within the bariatric community, it was clear that this surgery is very much maligned by patients who have had other surgeries. Unlike the DS patients, communion for band patients was driven by the physiological and social realities of living with LAP-BAND adjustments while trying to make the ‘right’ choices and work with the band. The surgically specific divisions within bariatric communities need to be understood in the context of tremendous fear and anxiety over weight regain. Terrified that they might regain weight, patients seek to situate their surgeries as the most effective, durable interventions into obesity. Both surgeries that are associated with higher rates of regain, as well as those that are associated with the best outcomes, are maligned with bariatric communities. As well, while patients provide support to one another about ‘staying on track,’ regain is portrayed as noncompliance. Second, those who have had the economic access to reconstructive surgery become objects of envy for those who lack the same class privilege. Community members attempt to downplay these differences by referring to the ability to have surgery as ‘lucky’ and focusing on health and self-acceptance rather than appearance. Still, tensions abound around the ability to achieve a better passing physique. Finally, while patients relate to one another on the whole, original starting weight does matter to bariatric communities.

Emotions of envy, anxiety, ambivalence, and hate thus work alongside mainstream and sexist beauty norms, class based inequalities, neoliberal rhetorics of responsibility for health, the biology of the body, bariatric surgeries themselves, and digital technologies to produce

subgroupings within this community. Biosociality community around bariatric surgery should not, in this sense, be thought of as a coherent and harmonious whole. Rather, one should see these as biosocial *communities* that serve as “points of intersection for different groups and individuals who join in the production of biomedical knowledges” (Heath et al 1999: 456) and who come together to learn how to navigate the social, psychological, physical, and physiological shifts that come with having had bariatric surgery.

Limitations of biosociality

The concept of biosociality has been subject to a number of critiques, most notably for my purposes here that biosociality overemphasizes the salience of health and illness based relationships, and that the concept better reflects new structures of kinship and sociality amongst affluent individuals in the global North than elsewhere. Whyte (2009), for example, argues that the focus on emergent health identities runs the risk of overemphasizing the importance of biosocial connections in the lives of those who participate in diagnosis-specific forums. She states:

[F]ocusing narrowly on relations among people with the same health condition excludes all the other relations and domains of sociality that actually fill most of their daily lives. In fact, those other relations may strongly influence the ways that health comes to shape their identities and subjectivities. By defining research problems based on identifications like diabetic, Down syndrome, HIV+, we essentialize, fragment, and decontextualize what is really only part of a life. (13).

Her point is well taken in that the participants I spoke with did vary greatly in terms of how frequently and how deeply they participated in bariatric communities. Some, like Sarah, had made the bariatric community a defining feature of their lives. Sarah went to multiple support group meetings a week, got her Master of Social Work so that she could work with other

bariatric patients, spent a great deal of time in online communities, was primarily friends with other bariatric patients, and attended multiple bariatric surgery conferences and events. She said, “It’s my social life, my career. It is my life.” Others, like Laura, Candice and Katrina, had made number of surgery-specific friendships with other bariatric patients that they chatted with online and occasionally spent time with in person, but didn’t heavily participate in general forums or frequently attend support groups. Finally some participants, like Eban, Danielle and Talia, hadn’t made any bariatric surgery specific friendships and rarely participated in forums, except for when they needed support or information that only other patients could give.

However, Rapp & Ginsburg (2001: 540), suggest that “the complexities of mobilizing the necessary medical, therapeutic, and social support reveal the limits of kinship within a gendered nuclear family structure.” This fact, they continue, necessitates the reimagining of “the boundaries and capacities of kinship” (540). While their research focuses on caretakers of disabled infants, I suggest that their argument holds for bariatric patients and bariatric communities as well. For example, although Danielle didn’t participate in bariatric communities frequently, the connections she made were nevertheless important *because* they didn’t extend into the other areas of her life: “We can talk to each other about things that we might not necessarily talk [about] with other people in our lives, partially because there’s an understanding there, but also partially because it’s specific, limited -- it’s an isolated friendship... In a way there’s like a closeness there because of the distance.”

In this sense, although relationships with other bariatric patients are not *central* to the lives of some participants, they are nonetheless very *significant* to them. And they are significant precisely because the particular set of physiological, psychological, physical, and social experiences bariatric patients undergo and continue to live with are simply not shared with

the key individuals in their lives (unless of course, these individuals have also undergone surgery, as is sometimes the case when multiple members of a family or romantic partners choose to have surgery). What's more, these individuals often need support from other patients around the shifts and changes that their dramatic weight losses cause within their central relationships, as discussed in chapter four. Ironically, then, this distance allows patients to share highly personal and sensitive information about their lives and get support – something they cannot get from or do with those with whom they are otherwise most close.

The literatures on biosociality and on governmentality, a framework that is usually discussed in tandem with biosociality, have also been criticized as reflecting only the experience of (relatively) affluent individuals in the global North (Braun 2007; Whyte 2009). These literatures, on the whole, suggest that contemporary forms of governance rely on pastoral techniques and rhetorics of advice, empowerment, and choice. In a neoliberal climate, individuals are asked to take responsibility for their own health and well-being through such things as “purchasing private health insurance, being informed citizens, actively investigating health conditions, [and] joining with others in support groups” (Braun 2007: 11). Biological citizenship, then, is made up from below rather than being actively shaped by the disciplinary power of the state. Braun (2007) suggests that the biosociality and governmentality scholarship overlooks the fact that some populations do continue to experience harsh, disciplinary powers of the state, particularly those in the global south who are defined in relation to biosecurity risks. As well, he argues, it misses the fact that social and medical life are traversed not just by pastoral experts but are actively shaped by areas of intensive capitalization and the production of biovalue. Despite these critiques, neither Braun nor Whyte (2009) completely reject analyses of the relationship between biological and political life that draw upon biosociality and

governmentality. Whyte (2009: 11) suggests that such work is best grounded in ethnographic research that can focus “on the variety of ways in which actors try to make claims and relate to agencies and institutions through health identities.” For Braun (2007) the task is to understand how biosociality, biovalue, and biosecurity are related.

Notably, Rose (2006: 147) contends that forms of biosociality that exist in North America, Europe, and Australia “have no visible presence in many geographical regions” (quoted in Pálsson 2009: 294.) Rather, he continues, biosociality and biological citizenship in such regions look quite different. As well, Rabinow (2008: 192) maintains that, “The term [biosociality] was not intended as a universal. It does not apply everywhere and at all times.” Nevertheless, the critiques raised by Braun (2007) and Whyte (2009) are apt. This dissertation does not make universal claims but rather grounds discussions of governmentality and biosociality in a very particular context. Through the use of interviews, participant observation, and textual analysis, I have attempted to animate how a very particular set of phenomena come together in the early 21st century United States to create not only a larger bariatric biosocial community but also smaller, subgroup specific groupings produced along the lines of conflict.

Braun’s concerns are more challenging to address and certainly this dissertation cannot do them justice. Nevertheless, I have attempted to show how discourses of risk and preemption as well as anxieties around obesity become tied to the future economic and military health of the nation, creating populations of failed citizens in the process (chapter two). Contra Elliott (2007: 140) who argues that, “The narrative of the failed citizen... transcends gender. In this context, the obese body is, ironically, democratic – open to all, irrespective of gender, race, or class,” I have discussed the ways in which such populations are always already linked to deeper, sedimented discourses and anxieties around race, class, gender, and disability (chapters two and

three). Finally, I have discussed how the stubborn ontology of fatness along with norms of beauty, and neoliberal healthist discourses work together to create an area ripe for capitalization (chapters five & six). Specifically, I have discussed the rise of bariatric surgery, bariatric revisions, bariatric reconstructive plastic surgery, bariatric conferences, and products and services that are marketed to bariatric patients. This dissertation does not address issues of biosecurity in the global South. However, to the extent that the ability of the nation state to address such emergent risks is tied not only to advances in information technologies but the biological capacities of future soldiers, this dissertation does speak to that concern in some small way. Moreover, as neoliberal models of healthcare have expanded and become globalized, there has been a concurrent globalization of anti-fat stigma. As Brewis et al (2011) demonstrate, even within cultures that were previously more accepting of fat bodies, notions of fatness as pathological, an ethos of personal responsibility for maintaining a ‘proper’ body weight, and the social undesirability of fat bodies are now commonplace. Notably, Brazil and Mexico now rank second and fourth in performing the largest number of bariatric surgery operations worldwide (Buchwald & Olen 2013). Given that rates of obesity, anti-fat stigma, and bariatric surgery are rising globally, this work may provide some insights into how surgery as means of working toward not only a ‘proper’ body, but also ‘proper’ self may become globalized as well.

Finally, Braun’s (2007) concerns are related to one further critique of note. Probyn (2008) argues that feminist works which take a critical approach to obesity narrowly focus on the ways in which fat bodies are shamed and classed, and overly focus on discussions of neoliberalism and governmentality. “The usual conclusion,” she states, “is that fat bodies are rendered fodder for the machine that produces ‘better’ citizens – the spectacular analysis of the obvious (403). In addition to demonstrating the obvious point, Probyn continues, these works

“do little to intervene in a situation where people are increasingly terrorized and seriously damaged by what they eat” (403). I would argue that Probyn’s collapsing of weight, health, and health disparities is too simplistic and does not do this complex relationship justice.

Nevertheless, her point about the necessity of linking discussions of bodies, neoliberalism, and governmentality to discussions of health disparities is apt. In response, I would remind her that because rates of obesity are higher amongst women, those of lower socioeconomic status, and people of color, these groups are particularly targeted for weight loss interventions, such as bariatric surgery. Unsurprisingly given the ways in which norms of beauty and norms of health are entangled, women make up 85% of bariatric patients even though only 60% of individuals considered to be morbidly obese are female (Santry et al., 2005; Smoot et al., 2006). Women have a thus disproportionate amount of these surgeries. And, with a side effect and complication rate as high as 38% (Sheipe 2006), women are effectively trading one set of health concerns for another. In this sense, weight loss interventions like bariatric surgery do not resolve health disparities but merely shift them into new territories.

I do agree that race and class-based health disparities unquestionably exist and that social justice oriented structural change is imperative to address them. However, to suggest that people (presumably women, people of color, and those of lower socioeconomic status) are “terrorized and seriously damaged” by the (bad) foods they prepare and consume treads on exactly those forms of elitism that Kirkland (2011) and Guthman (2011) warn of – in effect defining low income communities of color as ignorant victims in need of both education and rescuing. Probyn’s own intervention into what she sees as the irresponsibility of feminism may therefore do different work than she intends. Ultimately, while Probyn and I may disagree on the politics of obesity, I affirm her assertion that feminist work that critically takes up fatness must also

address the issue of health disparities. Such a discussion would be incomplete, however, without also including a discussion of the health disparities caused by weight loss interventions themselves, a topic I have tried to address in this dissertation work.

Chapter 7:
Conclusion and Implications

This dissertation has examined the state of fatness in the contemporary political, economic, and social context of neoliberalism and healthism. I have shown that during the late 20th and early 21st centuries, the United States saw a rapid increase in not only in average population body weight, but the discourse surrounding it as well. In national public health addresses and in media reports, obesity is commonly described as an epidemic, despite the fact that it does not meet the classical definition of one. Obesity is also frequently discussed in alarmist terms, with increasing population body weights linked to burdensome increases in healthcare costs, lost economic productivity, and weakened national security. Within the contemporary neoliberal context, in which rights imply duties, maintaining good health in the present and preemptively addressing future health concerns has become a mark of proper citizenship. The degree to which one succeeds or fails in achieving health becomes a means by which individuals not only assess themselves, but others (Crawford 2006). Fatness, by this logic, suggests irresponsibility, moral laxity, and failed citizenship. Unsurprisingly then, the United States has seen a concurrent rise in anti-fat stigma and discrimination during this same time period. Anti-fat discrimination has increased despite a growing and well-documented medical literature that suggests that dieting fails to produce durable results and, over the long term, actually causes escalating body weights. Under siege from widespread discrimination and contending with what can only be seen as the intractable nature of fatness, individuals medically classified as obese or morbidly obese are thus increasingly seeking out bariatric surgeries as a long-term solution to body weight. The increase in these surgeries has been so dramatic over the past two decades that they are amongst the fastest growing procedures in hospitals today.

The bulk of this dissertation has been devoted to tracing the experience of individuals who were medically classified as obese or morbidly obese, underwent bariatric surgery, and then

became thin or significantly thinner. As noted in chapter three, participants cited health concerns as a main motivating factor in choosing weight loss surgery. In choosing surgery, participants were both seeking to address current health issues as well as acting preemptively to ward off future morbidity and (early) mortality. Such actions demonstrate what Adams et al (2009) describe as the state of constant anticipation that is characteristic of neoliberal societies.

By taking drastic action to lose weight, participants also sought to demonstrate responsibility and thus secure proper subjectivities and citizenship. In this sense, concerns, anxieties and fears about health cannot be disentangled from the experience of anti-fat stigma and discrimination. As I have shown, dismay over systemic and widespread anti-fat stigma also drove participants' decisions to have weight loss surgery. Importantly, anti-fat bias, for these participants, was more than discursive: it operated through the circulation of emotion and was often experienced in a very material sense. Emotion, following Ahmed (2004) is fundamentally productive. Rather than being an interior state of the psyche, emotions work to constitute the borders and boundaries of subjects and collectivities. Hate, fear and anxiety, argues Ahmed (2004) are particularly powerful in this regard. Widespread anxiety over and fear and hatred of fatness was something participants experienced directly and which signaled to them that they were less than human. The desire for weight loss, for these individuals, was partially a desire to become normal. In Butler's (2004) terms, it was the desire for a 'livable life.' As Butler notes, social norms and relations of power foreclose some ways of being in the world, making some groups less recognizable as human and others not recognizable at all. The desire to gain recognition, she suggests, is the desire for a livable life.

A livable life, for these participants, also included a desire for a seamless fit with the built environment. The individuals I spoke with were never more ashamed of their fatness than when

they experienced a ‘misfit,’ in Garland Thomson’s (2011) terms, between their bodies and the material world. Traversing the built environment involved a high degree of calculation and anticipation about how to navigate the many obstacles they would face in daily life, particularly for those that lived in densely populated urban areas like New York City. Misfitting also resulted in a high degree of isolation for these individuals. As Garland Thomson argues, to misfit is to be defined as irrelevant to the social and economic world; it is to be cast out.

Following surgery, as I have described, participants did experience significant improvements in health. Undoubtedly, these health improvements alone can be said to have improved quality of life for these participants. However, it was not just the alleviation of health concerns that shifted post-surgery, but the alleviation of anti-fat stigma as well. The ability to finally ‘fit’ and experience the world as normal and to avoid hateful weight based comments from all sectors of society was the source of great joy and pleasure for these individuals. Nearly all described their surgeries as the best decisions they ever made. This is significant particularly because, as I have demonstrated in chapter four, life after bariatric surgery was not easy, and in many respects participants traded one set of concerns for another.

Losing weight freed up participants from both anti-fat stigma, and obstacles and calculations involved in navigating the urban built environment as very fat person. However, post-operatively, these calculations shifted. Individuals who have bariatric surgery must learn how to navigate the interior spaces of their surgically altered bodies and exterior social relations in new ways – calculations about how to keep up with coworkers going out to lunch become calculations about how to keep Shabbat dinner down without having to excuse oneself to throw up and raising eyebrows in the process. As I document in chapters four and five, these shifts centered around a few key phenomena. First, participants had to learn how to explain and often

hide the particularities of their bariatric bodies, both in terms of digestive realities and the fact of significant loose skin. Although they sought to minimize these particularities to others, they were nevertheless highly salient to such bariatric patients. Second, they had to contend with both criticisms for having had bariatric surgery and envy over their dramatic weight losses. Finally, they had to navigate the disorienting experience of rapid weight loss, a resulting increase in new attentions, and questions over who they now were.

Having weight loss surgery is thus a deeply social experience, as dramatically transforming the body results in dramatic social shifts as well. In some cases, having weight loss surgery and losing weight contributed to the ending of relationships for the individuals I spoke with. In other cases, relationships with coworkers, friends, and family significantly changed, as participants now felt more emboldened and asserted themselves more forcefully. Such personality shifts were not always well received by others. And in other cases still, new relationships were formed – something that was simultaneously exciting, confusing, and angering for participants as they now wondered if they were liked for who they were or how they looked.

While the first year to two years of weight loss surgery were periods of dramatic change and readjustment, following this ‘honeymoon’ period, participants confronted the realities of living with weight loss surgery. Specifically, they faced the potential for regain that is increasingly understood as common within several years after having a bariatric procedure. As I discuss in chapter five, neuroscientific research on the causes of both obesity in general and regain after bariatric surgery increasingly looks to the brain for explanation. More specifically, this research generally asserts that neurochemical and neuroanatomical anomalies in the brain result in ‘food addiction,’ or uncontrollable eating, particularly of ‘hyper palatable’ foods.

Although this new research might seem threatening to weight loss surgeons, in fact, the bariatric profession may be looking to neuroscience for better screening tools. For this industry, when patients regain weight following surgery, it is not the surgery that fails, but rather the patient that fails the surgery through noncompliance with recommended eating behaviors. Therefore, some members of the bariatric industry contend that better screening tools may help to evaluate which patients are most likely to regain weight following a bariatric procedure.

Many bariatric patients, while not taking up the concept of food addiction in a fully neuroscientific vein, did discuss their pre-surgical states of fatness in terms of food addiction. The individuals I spoke with contended that their pre-surgical body weights were due, in large part, to uncontrollable eating. Surgery was therefore a medically necessary intervention and seeking out surgery was an act of taking responsibility. More specifically, participants described bariatric procedures as tools that allowed them to finally gain control over compulsive eating and food addiction. In discussing life after surgery, participants emphatically discussed the ‘hard work’ involved in living with bariatric surgery. In doing so they accurately described the fact of effectively having to diet to maintain weight loss in the years following the honeymoon period. But in stressing the ongoing, careful attention they were required to pay to proper eating and exercise, patients refuted the notion that surgery was the ‘easy way out.’

Together, these experiences help to produce the desire for and the creation of new spaces of sociality and kinship. Bariatric communities become spaces in which individuals who have had weight loss surgery collectively negotiate the physical, physiological, psychological, and social changes that are typical of post-operative life. These spaces become necessary, in part, because of a lack of structured medical care and information about bariatric bodies. Patients thus must create the supports and information they need for themselves. As well, these communities

are sites in which individuals collectively negotiate anti-weight loss surgery stigma. Finally, they serve as sites in which patients collectively negotiate regain and complications that are common with weight loss surgeries, as well as the anxieties that surround them. In doing so, however, new divisions and conflicts are created in the process.

In a context of neoliberal healthism, bariatric surgeries thus produce new physiologies, new physical bodies, new body-self relations, new subjectivities, and new communities. Given both the high rates of complications and side effects endemic to these surgeries as well as a lack of structured, ongoing clinical care and support, these surgeries also produce new gendered health disparities. Finally, bariatric surgeries create new hierarchies along the lines of surgery type, original starting weight, and access to reconstructive plastic surgery, affirming older, more sedimented ideals around beauty, class, and health in the process. This, in turn, helps to create new bariatric subgroups, which are formed along the lines of communality and conflict.

Contributions

This dissertation makes a number of original contributions to the medical sociology, sociology of the body, feminist, disability studies, and biosociality literatures. First, this work speaks to the literature on biomedicalization. Following Clarke et al (2003), I have shown how neoliberal forms of governance; healthiest norms that suggest that improving health is a duty of citizenship; discourses of alarm as well as fears and anxieties over obesity; broad based anti-fat stigma; and the intensive and recursive capitalization allowed by the entrenched nature of obesity, collectively serve as dividing practices that produce fat individuals as populations of failed and reviled citizens. I have argued that having weight loss surgery, however, does not serve to diminish stigma for formerly fat individuals but rather reinscribes them as lazy for

having taken the 'easy way out.' Not only have I discussed these processes theoretically, I have shown how these dividing practices are lived, felt, and negotiated.

Secondly, this work speaks to the sociology of the body and feminist literatures. Kuhlmann & Babitsch (2002) argue that feminism has been defined by a 'disassociation' between gender studies and research on women's health. They argue that a starting point for feminists to begin examining gender, health, and embodiment together would take up "such divergent dimensions as cultural inscriptions, medical discourse, living conditions, and individual feelings and perceptions, as well as biological processes inside the body" (440). I believe that this dissertation has made a contribution to this gap by examining how fat and bariatric bodies are simultaneously political, social, biological, and technological. In showing how life for bariatric patients shifts before and after surgery, I have illustrated the linkages and slippages between the 'outside' and the 'inside' of the body. As well, I have demonstrated the unexpected ways in which surgically manipulated bodies and medical technologies work as actants in creating not only patient experiences and outcomes, but biosocial forms of kinship. In doing so, I have troubled the notion of nature and culture as distinct but rather have shown their inseparability. Likewise, in discussing the ways in which being fat and then having weight loss surgery shifts social relations, I have discussed the ways in which bodies are "not singular, bounded, closed and fixed but rather open to being affected and affecting others" (Blackman et al 2008: 18). At the same time, I have highlighted how achieving a passing, normative appearance but living with the very queer physical and physiological results of surgery helps to reinscribe and reaffirm norms and inequalities along the lines of race, class, gender, sexuality, and disability. In doing so, I have also demonstrated the ways in which the body's fluidity and multiplicity co-exists with "stability and exploitative continuity" (Blackman et al 2008: 19).

Specifically then, I have shown how “surgery produces and reinscribes bodies as [simultaneously] normative and non-normative” (Doyle & Roen 2008: 2).

Third, this dissertation makes contributions to disability studies. As Williams and Busby (2000) argue, scholarship on disability that follows a strict social model ignores both the realities of impairment in the lives of disabled individuals as well as how the complex ways in which such impairments are negotiated in daily life. In addressing this concern, I have discussed how deeply felt issues of impairment – both current and future – shaped the decision to have surgery. As well, I have addressed how having bariatric surgery can be seen, arguably, as trading one form of impairment for another and I have discussed how this transition is negotiated. This dissertation also speaks to the disability studies literature by expanding Garland Thomson’s (2011) notion of misfitting to illustrate how size is materialized at the interface of flesh and society, creating exclusions in the process, and how fat individuals negotiate this encounter and these exclusions. In doing so, this work dissertation also adds to the sociology and anthropology of space and place literatures by animating the “materiality and meaning of the body and its messy processes” in my discussion of the relations between “health and place, the environment and disease, spaces of healing and healthcare” (Parr 2002a: 247).

Finally, this dissertation addresses the biosociality literatures. I have argued that the desire to transform the fat body through surgical means and the experience of doing so is axis around which some individuals interact, create identity and community, *and* collectively negotiate the particularities that are part of, in effect, shaping themselves into normative subjects. As I have shown, sites of kinship and sociality are form not just around durable biomedical conditions of the body but liminal, surgically altered ones as well. Moreover, I have shown that while a number of forces cohere to push bariatric patients together, other conditions pull them

apart, creating tensions and divisions, and driving the formation of very specific subgroups. Rather than seeing these divisions as a fracturing of otherwise whole biosocial communities, it may be the case that this form of sociality depends on conflict and division. Overall, I have shown that bariatric biosocialities are spaces in which bariatric patients work toward proper selves as they work toward proper bodies, but always in ways that reflect highly complex, sometimes divergent, and often ambivalent frameworks of understanding and experience.

References

- Abou-Rizk, Z. & Rail, G. (2012). "Disgusting" fat bodies & young Lebanese-Canadian women's discursive constructions of health. *Women's Health & Urban Life*, 11(1): 94-123.
- Adams, V.; Murphy, M. & Clarke, A.E. (2009). Anticipation: Technoscience, life, affect, temporality. *Subjectivity*, 28(1): 246-265.
- Advocat, J. (2009). Internet clinical trials: Examining new disciplinary experiments in health care. *Anthropology Matters*, 7(1): 1-8.
- Agency for Healthcare Research and Quality. (2007, January 10). Obesity surgeries have jumped dramatically since 1998. [Press release]. Retrieved April 2013 (<http://archive.ahrq.gov/news/press/pr2007/obesjumppr.htm>).
- Agency for Healthcare Research and Quality. (2009). The complications and costs of obesity surgery are declining. [Newsletter]. Retrieved April 2013 (<http://www.ahrq.gov/news/newsletters/research-activities/aug09/0809RA15.html>).
- Ahmed, S. (2004). Affective economies. *Social Text*, 22(2): 117-139.
- Akey, E. *Fit Living*. [Website]. Retrieved April 2013 (http://fmtalk1065.com/schedule/fit_living_with_erin_achey/).
- Akey, E. *Fit and Flourishing*. [Website]. Retrieved April 2013 (http://www.fitandflourishing.com/trial_subscription.html).
- Alford, R.R. (1998). *The Craft of Inquiry: Theories, Methods, Evidence*. New York: Oxford University Press.
- American Society for Metabolic and Bariatric Surgery. (2004). Pre-surgical psychological assessment. Retrieved April 2013 (<http://asmbs.org/2012/06/pre-surgical-psychological-assessment/>).
- American Society for Metabolic and Bariatric Surgery. (2005). Story of obesity surgery. Retrieved April 2013 (<http://asmbs.org/story-of-obesity-surgery/>).
- American Society for Metabolic and Bariatric Surgery. (2006). Clinical pearls for the emergency care of the bariatric surgery patient. Retrieved April 2013 (http://s3.amazonaws.com/publicASMBS/ASMBS_Store/ASMBS_ER_Poster9-20-10.pdf).
- American Society for Metabolic and Bariatric Surgery. (2007). Benefits of bariatric surgery. Retrieved April 2013 (<http://asmbs.org/benefits-of-bariatric-surgery/>).

American Society for Metabolic and Bariatric Surgery. (2011). Fact sheet: Metabolic and bariatric surgery overview. Retrieved April 2013 (<http://s3.amazonaws.com/publicASMBS/MediaPressKit/MetabolicBariatricSurgeryOverviewJuly2011.pdf>).

Aphramor, L. (2009). Disability and the anti-obesity offensive. *Disability & Society*, 24(7): 897-909.

Arterburn, D.E.; Bogart, A.; Sherwood, N.E.; Sidney, S.; Coleman, K.J.; Haneuse, S.; O'Connor, P.J.; Theis, M.K.; Campos, G.M. & McCulloch, D. (2013). A multisite study of long-term remission and relapse of type 2 diabetes mellitus following gastric bypass. *Obesity Surgery*, 23(1): 93-102.

Assarito, L. (2009). The rise of the corporate curriculum: Fatness, fitness and whiteness. In J. Wright & V. Harwood (Eds.), *Biopolitics and the 'obesity epidemic: ' Governing bodies*, (pp. 183-198). New York: Routledge.

Austin, S.B. (1999). Fat, loathing and public health: The complicity of science in a culture of disordered eating. *Culture, Medicine and Psychiatry*, 23(2): 245-268.

Bacon, L.; Keim, N.L.; Van Loan, M.D., Derricote, M.; Gale, B.; Kazaks, A. & Stern, J.S. (2002). Evaluating a "non diet" wellness intervention for improvement of metabolic fitness, psychological well-being and eating and activity behaviors. *International Journal of Obesity*. 26(6): 854-865.

Bacon, L.; Stern, J. S.; Van Loan, M.D. & Keim, N.L. (2005). Size acceptance and intuitive eating improve health for obese, female chronic dieters. *Journal of the American Dietetic Association*, 105(6): 929-936.

Bacon, L. & Aphramor, L. (2011). Weight science: Evaluating the evidence for a paradigm shift. *Nutrition Journal*, 10(9): 1-13.

Bandsters. [Yahoo Group]. Retrieved April 2013 (<http://health.groups.yahoo.com/group/Bandsters/>).

Barad, K.M. (2007). *Meeting the Universe Halfway: Quantum Physics and the Entanglement of Matter and Meaning*. Durham: Duke University Press.

Barry, D.; Clarke, M. & Petry, N.M. (2009). Obesity and its relationship to addictions: Is overeating a form of addictive behavior? *The American Journal on Addictions*, 18(6): 439-451.

- Bartoshuk, L. (2010). The "obesity epidemic:" An interview with Katherine Flegal. *Observer*, 23(1). Retrieved April 2013 (www.psychologicalscience.org).
- Bashir, M. & Sherwood, R. (2009, March 9). "A frontier of medicine:" Brain surgery for weight loss. *ABC news* [Web page]. Retrieved April 2013. (abcnews.go.com: <http://abcnews.go.com/Health/frontier-medicine-brain-surgery-weight-loss/story?id=7023288>).
- Beck, U. (2006). Living in the world risk society. *Economy and Society*, 35(3): 329-345.
- Bennett, J. (2009). *Vibrant Matter a Political Ecology of Things*. Durham: Duke University Press.
- Berg, B.L. (2009). *Qualitative Research Methods for the Social Sciences*. Boston: Allyn & Bacon.
- Berlant, L.G. (2007). Slow death: Sovereignty, obesity, lateral agency. *Critical Inquiry*, 33(4): 754-780.
- Berlant, L.G. (1997). *The Queen of America goes to Washington city: Essays on sex and citizenship*. Durham, NC: Duke University Press.
- Biehl, J.G. (2005). *Vita: Life in a zone of social abandonment*. Berkeley: University of California Press.
- Biltekoff, C. (2007). The terror within: Obesity in post 9/11 U.S. life. *American Studies*, 48(3): 29-48.
- Birkmeyer, N. J. & Gu, N. (2012). Race, socioeconomic status, and the use of bariatric surgery in Michigan. *Obesity Surgery*, 22(2): 259-265.
- Blackman, L.; Cromby, J.; Hook, D.; Papadopoulos, D. & Walkerdine, V. (2008). Creating subjectivities. *Subjectivity*, 22(1): 1-27.
- Blair, D. & Sobal, J. (2006). Luxus consumption: Wasting food resources through overeating. *Agriculture & Human Values*, 23(1): 63-74.
- Blumenthal, D.M. & Gold, M.S. (2010). Neurobiology of food addiction. *Current Opinion in Clinical Nutrition & Metabolic Care*, 13(4): 359-365.
- Blundell, J.E. & Finlayson, G. (2011). Food addiction not helpful: The hedonic component – implicit wanting – is important. *Addiction*, 106(7): 1216-1218.
- Boero, N. (2007). All the news that's fat to print: The American "obesity epidemic" and the media. *Qualitative Sociology*, 30(1): 41-60.

Boero, N. (2012). *Killer Fat: Media, Medicine, and Morals in the American "Obesity Epidemic."* New Brunswick: Rutgers University Press.

Bondi, L. (2005). Working the spaces of neoliberal subjectivity: Psychotherapeutic technologies, professionalisation, and counselling. *Antipode*, 37(3): 497-514.

Bondi, L. & Laurie, N. (2005). Working the spaces of neoliberalism: Activism, professionalisation and incorporation: Introduction. *Antipode*, 37(3): 393-401.

Bordo, S. (1993). *Unbearable Weight: Feminism, Western Culture, and the Body.* Berkeley: University of California Press.

Braun, B. (2007). Biopolitics and the molecularization of life. *Cultural Geographies*, 14(1): 6-28.

Brewis, A.A.; Wutich, A. Falletta-Cowden, A. & Rodriguez-Soto, I. (2011). Body norms and fat stigma in a global perspective. *Current Anthropology*, 52(2): 269-276.

Brolin, R.E. & LaMarca, L.B. (2002). Binge eating among gastric bypass patients at long-term follow-up. *Obesity Surgery*, 12(2): 270-275.

Brown, H. (2012, September 17). More data suggests fitness matters more than weight. *New York Times*. Retrieved April 2013 (http://www.nytimes.com/2012/09/18/health/research/more-data-suggests-fitness-matters-more-than-weight.html?_r=0).

Brown, P.; Zavestoski, S.; McCormick, S.; Mayer, B.; Morello-Frosch, R. & Gasior Altman, R. (2004). Embodied health movements: New approaches to social movements in health. *Sociology of Health & Illness*, 26(1): 50-80.

Buchwald, H. & Oien, D.M. (2013). Metabolic/bariatric surgery worldwide 2011. *Obesity Surgery*. [Published first online 1/22/2013]

Butler, J. (2004). *Undoing Gender*. New York: Routledge.

Bynum, C. W. (1999). Jefferson lecture in the humanities. National Endowment for the Humanities. Washington, DC. Retrieved April 2013 (<http://www.neh.gov/news/archive/19990322b.html>).

Cafaro, P.J.; Primack, R.B. & Zimdahl, R.L. (2006). The fat of the land: Linking American food overconsumption, obesity, and biodiversity loss. *Journal of Agricultural and Environmental Ethics*, 19(6): 541-561.

Cahnman, W.J. (1968). The stigma of obesity. *The Sociological Quarterly*, 9(3): 283-299.

Campbell, N. D. (2012). Medicalization and biomedicalization: Does the diseasing of addiction fit the frame? In J. Netherland (Ed.), *Advances in Medical Sociology* (Vol. 14, pp. 3-25). Bingley, U.K.: Emerald Group Publishing Limited.

Campos, P.; Saguy, A.; Ernsberger, P.; Oliver, E. & Gaesser, G. (2006). The epidemiology of overweight and obesity: Public health crisis or moral panic? *International Journal of Epidemiology*, 35(1): 55-60.

Carmona, R. (2003). The obesity crisis in America. Testimony before the Subcommittee on Education Reform, Committee on Education and the Workforce. Retrieved April 2013 (<http://www.surgeongeneral.gov/news/testimony/obesity07162003.html>).

Carmona, R. (2006). University of South Carolina School of Law. Johnson & Johnson Healthcare Lecture [MP3 recording]. Retrieved April 2013 (<http://law.sc.edu/jandj/20060301>).

Cawley, J. (2004). The impact of obesity on wages. *Journal of Human Resources*, 39(2): 451-474.

Chang, V.W. & Christakis, N.A. (2002). Medical modeling of obesity: A transition from action to experience in a 20th century American medical textbook. *Sociology of Health & Illness*, 24(2): 151-177.

Charmaz, K. (2006). *Constructing Grounded Theory: A Practical Guide Through Qualitative Analysis*. London: Sage.

Chauhan, V.; Vaid, M.; Gupta, M.; Kalanuria, A. & Parashar, A. (2010). Metabolic, renal, and nutritional consequences of bariatric surgery: Implications for the clinician. *Southern Medical Journal*, 103(8): 775-785.

Chef Dave [website]. Retrieved April 2013 (http://www.chefdave.org/team/chef_dave).

Christakis, N.A. & Fowler, J.H. (2007). The spread of obesity in a large social network over 32 years. *New England Journal of Medicine*, 357(4): 370-379.

Christeson, W.; Taggart, A. D.; & Messner-Zidell, S. (2010). Too fat to fight: Retired military leaders want junk food out of America's schools: A report by Mission: Readiness. [Report].

Christou, N.V.; Look, D. & MacLean, L.D. (2006). Weight gain after short-and long-limb gastric bypass in patients followed for longer than 10 years. *Annals of Surgery*, 244(5): 734.

- Chu, U. (2011, September 10). Revisional surgery, opening the door to losing it again. [Presentation, Obesity Help Conference, New Orleans, LA]. (<http://www.obesityhelp.com/events/2011-new-orleans-event.html>.)
- Clarke, A.E.; Shim, J.K.; Mamo, L.; Fosket, J.R. & Fishman, J.R. (2003). Biomedicalization: Technoscientific transformations of health, illness, and U.S. biomedicine. *American Sociological Review*, 68: 161-194.
- Clough, P.T. & Halley, J. (2007). *The Affective Turn: Theorizing the Social*. Durham: Duke University Press.
- Coleman, R. (2010). Dieting temporalities: Interaction, agency and the measure of online weight watching. *Time & Society*, 19(2): 265-285.
- Collier-Cool, L. (2011, April 21). Are you addicted to food? *Yahoo! Healthline* [Web page]. Retrieved April 2013 (<http://health.yahoo.net/experts/dayinhealth/are-you-addicted-food>).
- Colls, R. & Evans, B. (2009). Introduction: Questioning obesity politics. *Antipode*, 41(5),
- Cook, C. *Bariatric Resource Centers International*. [Web page]. Retrieved April 2013 (<http://www.bsresourcecenter.com>).
- Cooper, C. (1997). Can a fat woman call herself disabled? *Disability & Society*, 12(1): 31-42.
- Cooper, M. (2006). Pre-empting emergence the biological turn in the war on terror. *Theory, Culture & Society*, 23(4): 113-135.
- Corwin, R.L. & Grigson, P. S. (2009). Symposium overview: Food addiction: Fact or fiction? *The Journal of Nutrition*, 139(3): 617-619.
- Crawford, R. (1977). You are dangerous to your health: The ideology and politics of victim blaming. *International Journal of Health Services*, 7(4): 663-680.
- Crawford, R. (1980). Healthism and the medicalization of everyday life. *International Journal of Health Services*, 10(3): 365-388.
- Crawford, R. (2006). Health as a meaningful social practice. *Health*, 10(4): 401-20.
- Dackis, C. & O'Brien, C. (2005). Neurobiology of addiction: Treatment and public policy ramifications. *Nature Neuroscience*, 8(11): 1431-1436.
- Davis, D.A. (2007). Narrating the mute: Racializing and racism in a neoliberal moment. *Souls*, 9(4): 346-360.

Davy, S.R.; Benes, B.A. & Driskell, J.A. (2006). Sex differences in dieting trends, eating habits, and nutrition beliefs of a group of Midwestern college students. *Journal of the American Dietetic Association*, 106(10): 1673-1677.

Dean, M. (1999). Risk, calculable and incalculable. In D. Lupton (Ed.), *Risk and Sociocultural Theory: New Directions and Perspectives* (pp. 131-159). Cambridge: Cambridge University Press.

Dedoose. [Computer Software] Retrieved April 2013 (www.dedoose.com).

DeMaria, E.J.; Pate, V.; Warthen, M. & Winegar, D.A. (2010). Baseline data from American Society for Metabolic and Bariatric Surgery-designated bariatric surgery centers of excellence using the bariatric outcomes longitudinal database. *Surgery for Obesity and Related Diseases*, 6(4): 347-355.

DePierre, J.A.; Puhl, R.M. & Luedicke, J. (2013). A new stigmatized identity? Comparisons of a "food addict" label with other stigmatized health conditions. *Basic and Applied Social Psychology*, 35(1): 10-21.

DiNapoli, T.P. (2012, October 24). *Soaring health care costs highlight need to address childhood obesity*. [Press release]. Retrieved April 2013 (www.osc.state.ny.us: <http://www.osc.state.ny.us/press/releases/oct12/102412.htm>).

Doyle, J. & Roen, K. (2008). Surgery and embodiment: Carving out subjects. *Body & Society*, 14(1): 1-7.

Drew, P. (2008). Weight loss surgery patients' negotiations of medicine's institutional logic. *Research in the Sociology of Health Care*, 26: 65-92.

Drew, P. (2011). "But then I learned...": Weight loss surgery patients negotiate surgery discourses. *Social Science & Medicine*, 73(8): 1230-7.

Edwards, P. & Roberts, I. (2008). Transport policy is food policy. *The Lancet*, 371(9625): 1661

Elliott, C.D. (2007). Big persons, small voices: On governance, obesity, and the narrative of the failed citizen. *Journal of Canadian Studies/Revue D'études Canadiennes*, 41(3): 134-149.

Elliott, L.; Ream, G. & McGinsky, E. (2012). Video game addiction: User perspectives. In J. Netherland (Ed.), *Advances in Medical Sociology* (Vol. 14, pp. 225-243). Bingley, U.K.: Emerald Group Publishing Limited.

Encinosa, W.E.; Bernard, D.M.; Du, D. & Steiner, C.A. (2009). Recent improvements in bariatric surgery outcomes. *Medical Care*, 47(5): 531-535.

Engel, S.G.; Mitchell, J.E.; Steffen, K.J. & de Zwann, M. (2012). Eating disorders and eating problems pre- and postbariatric surgery. In J. Mitchell & J. de Zwann (Eds.), *Psychosocial Assessment and Treatment of Bariatric Surgery Patients* (pp. 87-98). New York: Taylor & Francis.

Ernsberger, P. (2009). Does social class explain the connection between weight and health? In E.D. Rothblum & S. Solovay (Eds) *The Fat Studies Reader* (pp. 25-41). New York: NYU Press.

Evans, B. & Colls, R. (2009). Measuring fatness, governing bodies: The spatialities of the body mass index (BMI) in anti-obesity politics. *Antipode*, 41(5): 1051-1083.

Evans, J.; Davies, B. & Rich, E. (2008). The class and cultural functions of obesity discourse: Our latter day child saving movement. *International Studies in Sociology of Education*, 18(2): 117-132.

Evans, J.; Rich, E. & Davies, B. (2004). The emperor's new clothes: Fat, thin, and overweight. The social fabrication of risk and ill health. *Journal of Teaching in Physical Education*, 23(4): 372-391.

Farmer, P. (2005). *Pathologies of Power: Health, Human Rights, and the New War on the Poor*. Berkeley: University of California Press.

First, Do No Harm: Real Stories of Fat Prejudice in Health Care. (2013, February 24). The long term consequences of WLS: Heather's Story. [website] Retrieved April 2013 (<http://fathealth.wordpress.com/2013/02/24/the-long-term-consequences-of-wls-heathers-story>).

Fikken, J.J. & Rothblum, E.D. (2012). Is fat a feminist issue? Exploring the gendered nature of weight bias. *Sex Roles*, 66(9-10): 575-592.

Finkelstein, R.; Garcia, A.; Netherland, J. & Walker, J. (2008). Toward an age-friendly new york city: A findings report. [Report]. New York: New York Academy of Medicine.

Flegal, K.M.; Graubard, B.I.; Williamson, D.F. & Mitchell, J.G. (2005) Excess deaths associated with underweight, overweight, and obesity. *Journal of the American Medical Association*, 293(15): 1861-1867.

Flegal, K.M.; Carroll, M.D.; Kit, B.K.; & Ogden, C.L. (2012). Prevalence of obesity and trends in the distribution of body mass index among US adults, 1999-2010. *Journal of the American Medical Association*, 207(5): 491-497.

Flegal, K.M.; Kit, B.K.; Orpana, J. & Graubard, B. (2013). Association of all-cause mortality with overweight and obesity using standard Body Mass Index categories: A systematic review and meta-analysis. *Journal of the American Medical Association*, 309(1): 71-82.

Flum, D.R.; Salem, L.; Elrod, J.A.B.; Dellinger, E.P.; Cheadle, A. & Chan, L. (2005). Early mortality among Medicare beneficiaries undergoing bariatric surgical procedures. *The Journal of the American Medical Association*, 294(15): 1903-1908.

Foucault, M. (1990). *The History of Sexuality: An Introduction*. New York: Knopf Doubleday Publishing Group.

Foucault, M. (1991). Governmentality. In P. Miller, G. Burchell, & C. Gordon (Eds.), *The Foucault Effect: Studies in Governmentality*. Chicago: University of Chicago Press.

Foucault, M. (2003). *"Society Must be Defended": Lectures at the Collège de France, 1975-1976* (Vol. 3). New York: Picador.

Fox, N. & Ward, K. (2006). Health identities: From expert patient to resisting consumer. *Health*, 10(4): 461-79.

Frank, A.W. & Jones, T. (2003). Bioethics and the later Foucault. *Journal of Medical Humanities*, 24(3): 179-186.

Frascella, J.; Potenza, M.N.; Brown, L.L. & Childress, A.R. (2010). Shared brain vulnerabilities open the way for nonsubstance addictions: Carving addiction at a new joint? *Annals of the New York Academy of Sciences*, 1187(1): 294-315.

Fraser, S.; Maher, J. & Wright, J. (2010). Between bodies and collectivities: Articulating the action of emotion in obesity epidemic discourse. *Social Theory & Health*, 8(2): 192-209.

Friedman, R.R., & Puhl, R.M. (2012). Weight bias: A social justice issue. [Policy Brief]. Yale Rudd Center for Food Policy & Obesity.

Gable, S. & Lutz, S. (2000). Household, parent, and child contributions to childhood obesity. *Family Relations*, 49(3): 293-300.

Gaesser, G.A. (2002). *Big Fat Lies: The Truth About Your Weight and Your Health*. Carlsbad, C.A.: Gurze Books.

Gagner, M.; Gentileschi, P.; de Csepe, J.; Kini, S.; Patterson, E.; Inabnet, W.B.; Herron, D. & Pomp, A. (2002). Laparoscopic reoperative bariatric surgery: Experience from 27 consecutive patients. *Obesity Surgery*, 12(2): 254-260.

Galvin, R. (2002). Disturbing notions of chronic illness and individual responsibility: Towards a genealogy of morals. *Health*, 6(2): 107-137.

Gard, M. & Wright, J. (2005). *The Obesity Epidemic: Science, Morality, and Ideology*. London; New York: Routledge.

Garland Thomson, R. (2005). Feminist disability studies. *Signs*, 30(2): 1557-1587.

Garland Thomson, R. (2011). Misfits: A feminist materialist disability concept. *Hypatia*, 26(3): 591-609.

Gearhardt, A.N.; Corbin, W.R. & Brownell, K.D. (2009a). Preliminary validation of the Yale food addiction scale. *Appetite*, 52(2): 430-436.

Gearhardt, A.N.; Corbin, W.R. & Brownell, K.D. (2009b). Yale food addiction scale. Yale Rudd Center for Food Policy and Obesity. Retrieved April 2013 (www.yaleruddcenter.org/.../addiction/FoodAddictionScale09.pdf).

Gearhardt, A.N.; Grilo, C.M.; DiLeone, R.J.; Brownell, K.D. & Potenza, M.N. (2011a). Can food be addictive? Public health and policy implications. *Addiction*, 106(7): 1208-1212.

Gearhardt, A.N.; Yokum, S.; Orr, P.T.; Stice, E.; Corbin, W.R. & Brownell, K.D. (2011b). Neural correlates of food addiction. *Archives of General Psychiatry*, 68(8): 808.

Gibbon, S. & Novas, C. (2008). *Biosocialities, Genetics and the Social Sciences: Making Biologies and Identities*. London: Routledge.

Gill, R. (2000). Discourse analysis. In M. W. Bauer & G. Gaskell (Eds.), *Qualitative Researching with Text, Image and Sound: A Practical Handbook for Social Research* (pp. 172-190). London: SAGE.

Glaser, B.G. & Strauss, A.L. (2009). *The Discovery of Grounded Theory: Strategies for Qualitative Research*. Piscataway, N.J.: Transaction Publishers.

Glenn, N.M. (2012). Weight-ing: The experience of waiting on weight loss. *Qualitative Health Research*, 23(3):348-60.

Glorify Basecamp for the Fat Acceptance Web. (2013, February 8). Why I will never advocate weight loss surgery. [Website.] Retrieved April 2013 (<http://glorifybasecamp.com/why-i-will-never-advocate-weight-loss-surgery>).

Goffman, E. (1963). *Stigma: Notes on the Management of Spoiled Identity*. New York: Simon & Schuster.

Gold, M.S.; Graham, N.A. Cocores, J.A. & Nixon, S.J. (2009). Food addiction? *Journal of Addiction Medicine*, 3(1): 42-45.

Grabe, S. & Hyde, J.S. (2006). Ethnicity and body dissatisfaction among women in the United States: A meta-analysis. *Psychological Bulletin*, 132(4): 622.

Granberg, E.M. (2011). "Now my 'old self' is Thin:" Stigma exits after weight loss. *Social Psychology*, 74(1): 29-52.

Greener, J.; Douglas, F. & Van Teijlingen, E. (2010). More of the same? Conflicting perspectives of obesity causation and intervention amongst overweight people, health professionals and policy makers. *Social Science & Medicine*, 70(7): 1042-1049.

Greenhalgh, S. (2012). Weighty subjects: The biopolitics of the U.S. War on fat. *American Ethnologist*, 39(3): 471-487.

Groskopf, B. (2005). The failure of bio-power: Interrogating the "obesity crisis." *Journal for the Arts, Sciences and Technology*, 3(1): 41-47.

Grosz, E.A. (1994). *Volatile Bodies: Toward a Corporeal Feminism*. Bloomington: Indiana University Press.

Grosz, E.A. (1999). Bodies-cities. In J. Price & M. Shildrick (Eds) *Feminist Theory and the Body: A Reader*. (pp. 381-387). New York: Routledge.

Gumbs, A.A.; Pomp, A. & Gagner, M. (2007). Revisional bariatric surgery for inadequate weight loss. *Obesity Surgery*, 17(9): 1137-1145.

Guthman, J. (2009). Teaching the politics of obesity: Insights into neoliberal embodiment and contemporary biopolitics. *Antipode*, 41(5): 1110-1133.

Guthman, J. (2011). *Weighing in: Obesity, Food Justice, and the Limits of Capitalism*. Berkeley: University of California Press.

Guthman, J. & DuPuis, M. (2006). Embodying neoliberalism: Economy, culture, and the politics of fat. *Environment and Planning D: Society and Space*, 24(3): 427-448.

Halpern, C.H.; Wolf, J.A.; Bale, T.L.; Stunkard, A.J.; Danish, S.F.; Grossman, M.; Jaggi, J. L.; Grady, M.S. & Baltuch, G. H. (2008). Deep brain stimulation in the treatment of obesity: A review. *JNS: Journal of Neurosurgery*, 109(4): 625-34.

- Haddock, C.K. & Dill, P.L. (2000). The effects of food on mood and behavior: Implications for the addictions model of obesity and eating disorders. *Drugs & Society*, 15(1): 1-2.
- Halse, C. (2009). Bio-citizenship: Virtue, discourses, and the birth of the bio-citizen. In J. Wright & V. Harwood (Eds.), *Biopolitics and the 'obesity epidemic': Governing bodies*. (pp. 45-59). New York: Routledge.
- Hamza, N.; Darwish, A.; Ammori, M.B. Abbas, M.H. & Ammori, B. J. (2010). Revision laparoscopic gastric bypass: An effective approach following failure of primary bariatric procedures. *Obesity Surgery*, 20(5): 541-548.
- Hansen, E.P.; Metzsch, C.; Henningsen, E. & Toft, P. (2012). Severe scurvy after gastric bypass surgery and a poor postoperative diet. *Journal of Clinical Medicine Research*, 4(2): 135.
- Hansen, H. & Roberts, S. K. (2012). Two tiers of biomedicalization: Methadone, buprenorphine, and the racial politics of addiction treatment. In J. Netherland (Ed.), *Advances in Medical Sociology* (Vol. 14, pp. 79-102). Bingley, U.K.: Emerald Group Publishing Limited.
- Haraway, D. (2004). Situated knowledges: The science question in feminism and the privilege of partial perspective. In D. Haraway & S. Harding (Eds) *The Feminist Standpoint Theory Reader: Intellectual and Political Controversies*. (pp 81-101). New York: Routledge
- Harwood, V. (2009). Theorizing Biopedagogies. In J. Wright & V. Harwood (Eds.), *Biopolitics and the 'obesity epidemic': Governing bodies*. (pp. 15-30). New York: Routledge.
- Heath, D.; Koch, E.; Ley, B. & Montoya, M. (1999). Nodes and queries linking locations in networked fields of inquiry. *American Behavioral Scientist*, 43(3): 450-463.
- Herndon, A.M. (2003). Disparate but disabled: Fat embodiment and disability studies. *NWSA Journal*, 14(3), 120-137.
- Herndon, A.M. (2005). Collateral damage from friendly fire?: Race, nation, class and the “war against obesity.” *Social Semiotics*, 15(2): 127-141.
- Heyes, C.J. (2006). Foucault goes to Weight Watchers. *Hypatia*, 21(2): 126-149.
- Hutter, M.M. (2006). Does outcomes research impact quality? Examples from bariatric surgery. *The American Surgeon*, 72(11): 1055-1060.
- Ifland, J.R.; Preuss, H.G.; Marcus, M.T.; Rourke, K.M.; Taylor, W.C.; Burau, K.; Jacobs, J.W. & Manso, G. (2009). Refined food addiction: A classic substance use disorder. *Medical Hypotheses*, 72(5): 518-526.

Inge, T.H.; Krebs, N.F.; Garcia, V.F.; Skelton, J.A.; Guice, K.S.; Strauss, R.S.; Albanese, C.T.; Brandt, M.L.; Hammer, L.D. & Harmon, C.L. (2004) Bariatric surgery for severely overweight adolescents: Concerns and recommendations. *Pediatrics*, 114(1): 217-223.

Jackson, B. (2009, June). Fatties cause global warming. *The Sun*. Retrieved April 2013 (www.thesun.co.uk: <http://www.thesun.co.uk/sol/homepage/news/article2387203.ece>).

JANA Editors. (1999). Obesity Declared An Epidemic in the United States. *Journal of the National Medical Association*, 91(12): 645.

Jeffrey, C. A. & Kitto, S. (2006). Struggling to care: Nurses' perceptions of caring for obese patients in an Australian bariatric ward. *Health Sociology Review*, 15(1): 71-83.

Jerant, A. & Franks, P. (2012). Body Mass Index, diabetes, hypertension, and short-term mortality: A population-based observational study, 2000-2006. *Journal of the American Board of Family Medicine*, 25(4): 422-431.

Joanisse, L. (2005). "This is who I really am:" Obese women's conceptions of self following weight loss surgery. In C. E. Miall, D. Pawluch, & W. Shaffir (Eds.), *Doing Ethnography: Studying Everyday Life*, (pp. 248-59). Canada: Canadian Scholars' Press.

Johnson, D. (2008). How do you know unless you look?: Brain imaging, biopower, and practical neuroscience. *Journal of Medical Humanities*, 29(3): 147-161.

Johnston, G. (2012, October 25) New York's Fatties Cost Us \$12 Billion Last Year: Comptroller. *Gothamist*. Retrieved April 2013 (http://gothamist.com/2012/10/25/new_yorks_fatties_cost_us_12_billio.php).

Jutel, A. (2006). The emergence of overweight as a disease entity: Measuring up normality. *Social Science & Medicine*, 63(9): 2268-2276.

Kalarchian, M.A.; Wilson, G.T.; Brolin, R.E. & Bradley, L. (1998). Binge eating in bariatric surgery patients. *International Journal of Eating Disorders*, 23(1): 89-92.

Karlsson, J.; Sjöström, L. & Sullivan, M. (1998). Swedish obese subjects (SOS): An intervention study of obesity. Two-year follow-up of health-related quality of life (HRQL) and eating behavior after gastric surgery for severe obesity. *International Journal of Obesity*, 22(2): 113-126.

Kassirer, J. P. & Angell, M. (1998). Losing weight: An ill-fated New Year's resolution. *The New England Journal of Medicine*, 338(1): 52.

Katz, C. (2005). Partners in crime? Neoliberalism and the production of new political subjectivities. *Antipode*, 37(3): 623-631.

Keane, H. (2002). *What's wrong with addiction?* Melbourne: Melbourne University Publishers.

Keener, D.; Goodman, K.; Lowry, A.; Zaro, S. & Kettel Khan, L. (2009, July). Recommended community strategies and measurements to prevent obesity in the United States: Implementation and measurement guide. [Report]. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention.

Keller, D. (2012, November 21). Bariatric surgery linked to acetaminophen liver failure risk *Medscape News*. Retrieved April 2013 (<http://www.medscape.com/viewarticle/774958>).

Kelly, M. (2008). Self, identity, and radical surgery. *Sociology of Health & Illness*, 14(3): 390-415.

King, W.C.; Chen, J.Y.; Mitchell, J.E.; Kalarchian, M.A.; Steffen, K.J.; Engel, S.G.; Courcoulas, A.P.; Pories, W.J. & Yanovski, S. Z. (2012). Prevalence of alcohol use disorders before and after bariatric surgery. *The Journal of the American Medical Association*, 307(23): 2516-25.

Kirkland, A. (2003). Representations of fatness and personhood: Pro-fat advocacy and the limits and uses of law. *Representations*, 82(1): 24-51.

Kirkland, A. (2008). Think of the hippopotamus: Rights consciousness in the fat acceptance movement. *Law & Society Review*, 42(2): 397-432.

Kirkland, A. (2011). The environmental account of obesity: A case for feminist skepticism. *Signs*, 36(2): 463-485.

Kohn, M.; Rees, J.M.; Brill, S.; Fonseca, H.; Jacobson, M.; Katzman, D.K.; Logmani, E.S.; Neumark-Sztainer, D. & Schneider, M. (2006). Preventing and treating adolescent obesity: A position paper of the society for adolescent medicine. *Journal of Adolescent Health*, 38(6), 784-787. Retrieved from Google Scholar.

Kuhlmann, E. & Babitsch, B. (2002). Bodies, health, gender: Bridging feminist theories and women's health. *Women's Studies International Forum*. 25: 433-442.

Larner, W. (2000). Neo-liberalism: Policy, ideology, governmentality. *Studies in Political Economy*, 63: 5-25.

Latour, B. (1987). *Science in Action: How to Follow Scientists and Engineers Through Society* Cambridge, Mass.: Harvard University Press.

Lawrence, R.G. (2004). Framing obesity: The evolution of news discourse on a public health issue. *The Harvard International Journal of Press/Politics*, 9(3): 56-75.

LeBesco, K. (2004). *Revolting Bodies?: The Struggle to Redefine Fat Identity*. Amherst: University of Massachusetts Press.

LeBesco, K. (2011). Neoliberalism, public health, and the moral perils of fatness. *Critical Public Health*, 21(2): 153-164.

Lewis, S.; Thomas, S.L.; Blood, R.W., Castle, D.J.; Hyde, J. & Komesaroff, P.A. (2011). How do obese individuals perceive and respond to the different types of obesity stigma that they encounter in their daily lives? A qualitative study. *Social Science & Medicine*, 73(9): 1349-56.

Liu, Y.; von Deneen, K.M.; Kobeissy, F.H. & Gold, M.S. (2010). Food addiction and obesity: Evidence from the bench to bedside. *Journal of Psychoactive Drugs*, 42(2): 133-145.

Livhits, M.; Mercado, C.; Yermilov, I.; Parikh, J.A.; Dutson, E.; Mehran, A.; Ko, C.Y.; Shekell, P.G. & Gibbons, M.M. (2011). Is social support associated with greater weight loss after bariatric surgery?: A systematic review. *Obesity Reviews: An Official Journal of the International Association for the Study of Obesity*, 12(2): 142-148.

Livingston, E. H. (2013). Is bariatric surgery worth it? Comment on “Impact of bariatric surgery on health care costs of obese persons.” *JAMA Surgery*, [Online first 2/20/2013]: E1.

Longhurst, R. (2011). Becoming smaller: Autobiographical spaces of weight loss. *Antipode*, 44(3): 871-888.

López, J.N. (2009). Socio-anthropological analysis of bariatric surgery patients: A preliminary study. *Social Medicine*, 4(4): 209-217.

Luke, A. (1995). Text and discourse in education: An introduction to critical discourse analysis. *Review of Research in Education*, 21: 3-48.

Lyons, R. (2011). The spread of evidence-poor medicine via flawed social-network analysis. *Statistics, Politics, and Policy*, 2(1), Article 2.

Maciejewski, M.L.; Livingston, E.H.; Smith, V.A.; Kahwati, L.C.; Henderson, W.G. & Arterburn, D.E. (2012). Health expenditures among high-risk patients after gastric bypass and matched controls. *Archives of Surgery*, 147(7): 633-640.

Magro, D.O.; Geloneze, B.; Delfini, R.; Pareja, B.C.; Callejas, F. & Pareja, J. C. (2008). Long-term weight regain after gastric bypass: A 5-year prospective study. *Obesity Surgery*, 18(6): 648-651.

Mann, T.; Tomiyama, A.J.; Westling, E., Lew, A.M.; Samuels, B. & Chatman, J. (2007). Medicare's search for effective obesity treatments. *American Psychologist*, 62(3): 220-233.

Martin, R. (2007). *An Empire of Indifference: American War and the Financial Logic of Risk Management*. Durham: Duke University Press.

McCarthy, Y. *WLS Success*. [Web page]. Retrieved April 2013 (<http://wlssuccess.com/about/>).

McHugh, M.C. & Kasardo, A.E. (2012). Anti-fat prejudice: The role of psychology in explication, education and eradication. *Sex Roles*, 66(9-10): 617-627.

McPhail, D. (2009). What to do with the "tubby hubby?": "Obesity," the crisis of masculinity, and the nuclear family in early cold war Canada. *Antipode*, 41(5): 1021-1050.

Melamed, J. (2006). The spirit of neoliberalism from racial liberalism to neoliberal multiculturalism. *Social Text*, 24(4_89): 1-24.

Meleo-Erwin, Z.C. (Forthcoming). Queering the linkages and divergences: The relationship between fatness and disability and the hope for a livable world. In S. Murray; C. Pause, & J. Wykes (Eds) *Queering Fat Embodiment*. London: Ashgate.

Metropolitan Transit Authority. [Website]. Retrieved April 2013 (www.mta.info).

Metzl, J. (2010). Introduction: Why "against health?" In J. Metzl & A.R. Kirkland (Eds.), *Against Health: How Health Became the New Morality*, (pp. 1-14). New York: NYU Press.

Mokdad, A.H.; Serdula, M.K.; Dietz, W.H.; Bowman, B.A.; Marks, J.S. & Koplan, J.P. (1999). The Spread of the Obesity Epidemic in the United States, 1991-1998. *Journal of the American Medical Association*. 282(16): 1519-1522.

Mokdad, A.H.; Marks, J.S.; Stroup, D.F. & Gerberding, J.L. (2004) Actual causes of death in the United States, 2000. *Journal of the American Medical Association*, 291(10): 1238-1245.

Monaghan, L. (2008). Men, physical activity, and the obesity discourse: Critical understandings from a qualitative study. *Sociology of Sport Journal*, 25(1): 97-129.

Munn, N. (2003). Excluded spaces: The figure in the Australian aboriginal landscape. In S. Low & D. Lawrence-Zuniga (Eds.), *The Anthropology of Space and Place: Locating Culture*, (pp. 92-109). Oxford: Blackwell Publishing.

Murray, S. (2008). Pathologizing fatness: Medical authority and popular culture. *Sociology of Sport Journal*, 25(1): 7-21.

Murray, S. (2009). Banded bodies: The somatechnics of gastric banding. In N. Sullivan & S. Murray (Eds.), *Somatechnics: Queering the technologisation of bodies*, (pp. 153-170). Farnham, U.K.: Ashgate

Murray, S. (2010). Women under/in control? Embodying eating after gastric banding. *Radical Psychology*, 8(1). Accessed April 2013 (<http://www.radicalpsychology.org/vol8-1/murray.html>).

NAAFA. [Website]. Retrieved April 2013 (www.naafa.org).

Neovius, M.; Narbro, K.; Keating, C.; Peltonen, M.; Sjöholm, K.; Agren, G.; Sjöström, L. & Carlsson, L. (2012). Health care use during 20 years following bariatric surgery. *The Journal of the American Medical Association*, 308(11): 1132-41.

Netherland, J. (2011a). *Becoming Normal: The Social Construction of Buprenorphine and New Attempts to Medicalize Addiction*. [Dissertation.] The Graduate Center of the City University of New York.

Netherland, J. (2011b). We haven't sliced open anyone's brain yet": Neuroscience, embodiment and the governance of addiction. *Advances in Medical Sociology*, 13: 153-177.

Nicholas, C. & May, R. (2010, May). The fifth annual HealthGrades bariatric surgery trends in American hospitals study. *HealthGrades*. [Report]. Retrieved April 2013 (<http://hg-article-center.s3-website-us-east-1.amazonaws.com/01/24/e03cbddd44c3a999db0960652614/HealthGradesBariatricSurgeryTrendsStudy2010.pdf>).

Noel, H. & Nyhan, B. (2011). The "unfriending" problem: The consequences of homophily in friendship retention for causal estimates of social influence. *Social Networks*, 33(3): 211-218.

Novas, C. (2006). The political economy of hope: Patients' organizations, science and biovalue. *BioSocieties*, 1(3): 289.

- Novas, C. & Rose, N. (2000). Genetic risk and the birth of the somatic individual. *Economy and Society*, 29(4): 485-513.
- Obesity Action Coalition. [Website]. Retrieved April 2013 (<http://www.obesityaction.org/>).
- Obesity Help. [Website]. Retrieved April 2013 (www.obesityhelp.com).
- O'Donnell, K. (2011). Severe micronutrient deficiencies in RYGB patients: Rare but potentially devastating. *Practical Gastroenterology*, 35(11): 13-27.
- Oliver, J.E. (2005). *Fat Politics: The Real Story Behind America's Obesity Epidemic*. Oxford: Oxford University Press.
- Oliver, J.E. (2006). The Politics of Pathology: How Obesity Became an Epidemic Disease. *Perspectives in Biology and Medicine*, 49(4): 611-27.
- Omalu, B.I.; Ives, D.G.; Buhari, A.M.; Lindner, J.L.; Schauer, P.R.; Wecht, C.H. & Kuller, L.H. (2007). Death rates and causes of death after bariatric surgery for Pennsylvania residents, 1995 to 2004. *Archives of Surgery*, 142(10): 923-928.
- Overeaters Anonymous. [Website]. Retrieved April 2013 (<http://www.oa.org/newcomers/about-oa/>).
- Parr, H. (2002a). Medical geography: Diagnosing the body in medical and health geography, 1999–2000. *Progress in Human Geography*, 26(2): 240-251.
- Parr, H. (2002b). New body-geographies: The embodied spaces of health and medical information on the Internet. *Environment and Planning*, 20(1): 73-96.
- Parr, J. & Rasmussen, N. (2012). Making addicts of the fat: Obesity, psychiatry and the "fatties anonymous" model of self-help weight loss in the post-war united states. In J. Netherland (Ed.), *Advances in Medical Sociology* (Vol. 14, pp. 81-200.). Bingley, U.K.: Emerald Group Publishing Limited.
- Pálsson, G. (2009). Biosocial relations of production. *Comparative Studies in Society and History*, 51(2): 288-313.
- Petersen, A.R. (2003). Governmentality, critical scholarship, and the medical humanities. *Journal of Medical Humanities*, 24(3-4): 187-201.
- Petersen, A.R. & Lupton, D. (1996). *The New Public Health: Health and Self in the Age of Risk*. London: SAGE.

Petersen, A.R.; Davis, M.; Fraser, S. & Lindsay, J. (2010). Healthy living and citizenship: An overview. *Critical Public Health*, 20(4): 391-400.

Petryna, A. (2004). Biological citizenship: The science and politics of chernobyl-exposed populations. *Osiris*, 250-265.

Pisapia, J.M.; Halpern, C.H.; Williams, N.N.; Wadden, T.A.; Baltuch, G.H. & Stein, S. C. (2010). Deep brain stimulation compared with bariatric surgery for the treatment of morbid obesity: A decision analysis study. *Neurosurgical Focus*, 29(2): E15.

Pitts, V. (2003). *In the flesh: The cultural politics of body modification*. New York: Palgrave Macmillan.

Pitts-Taylor, V. (2010). The plastic brain: Neoliberalism and the neuronal self. *Health*, 14(6): 635-652.

Pitts-Taylor, V. (Forthcoming). *The brain's body: Neuroscience and the politics of embodiment*. Durham, NC: Duke University Press.

Pollack. (2011, February 16). Allergan's lap-band is approved for less obese. *New York Times* Retrieved April 2013 (http://www.nytimes.com/2011/02/17/health/17obese.html?_r=0).

Potenza, M. N. (2006). Should addictive disorders include non-substance-related conditions? *Addiction*, 101(s1): 142-151.

Poulose, B.K.; Holzman, M.D.; Zhu, Y.; Smalley, W.; Richards, W.O.; Wright, J. K.; Melvin, W. & Griffin, M.R. (2005). National variations in morbid obesity and bariatric surgery use. *Journal of the American College of Surgeons*, 201(1): 77-84.

Powell, L.H.; Calvin, J.E. & Calvin, J.E. (2007). Effective obesity treatments. *American Psychologist*, 62(3): 234-246.

Powers, P.S.; Perez, A.; Boyd, F. & Rosemurgy, A. (1999). Eating pathology before and after bariatric surgery: A prospective study. *International Journal of Eating Disorders*, 25(3): 293-300.

Probyn, E. (2008). IV. Silences behind the mantra: Critiquing feminist fat. *Feminism & Psychology*, 18(3): 401-404.

Puhl, R.M. & Brownell, K.D. (2003). Psychosocial origins of obesity stigma: Toward changing a powerful and pervasive bias. *Obesity Reviews*, 4(4): 213-227.

Puhl, R.M., & Heuer, C.A. (2009). The stigma of obesity: A review and update. *Obesity*, 17(5): 941-964.

- Puhl, R.M. & Heuer, C.A. (2010). Obesity stigma: Important considerations for public health. *American Journal of Public Health*, 100(6): 1019-1028.
- Rabinow, P. (1996). Artificiality and enlightenment. In *Essays in Anthropology of Reason* (pp. 91-111). Princeton: Princeton University Press.
- Rabinow, P. & Rose, N. (2006). Biopower today. *BioSocieties*, 1(2): 195-217.
- Rabinow, P. (2008). Afterward: Concept work. In S. Gibbon & C. Novas *Biosocialities, Genetics and the Social Sciences: Making Biologies and Identities*. (pp. 188-194). London: Routledge.
- Rail, G. (2009). Canadian youth's discursive constructions of health in the context of obesity discourse. In J. Wright & V. Harwood (Eds.), *Biopolitics and the 'Obesity Epidemic': Governing bodies*, (pp. 141-157). New York: Routledge.
- Rail, G.; Holmes, D. & Murray, S.J. (2010). The politics of evidence on "domestic terrorists:" Obesity discourses and their effects. *Social Theory & Health*, 8(3): 259-279.
- Rapp, R. & Ginsburg, F.D. (2001). Enabling disability: Rewriting kinship, reimagining citizenship. *Public Culture*, 13(3), 533-556.
- Rasmussen, N. (2012). Weight stigma, addiction, science, and the medication of fatness in mid-twentieth century America. *Sociology of Health & Illness*, 34(6): 880-895.
- Rich, E. (2011). "I see her being obese!:" Public pedagogy, reality media and the obesity crisis. *Health*, 15(1): 3-21.
- Rich, E. & Evans, J. (2005). 'Fat ethics:' The obesity discourse and body politics. *Social Theory & Health*, 3(4): 341-358.
- Richardson, D. (2005). Desiring sameness? The rise of a neoliberal politics of normalisation. *Antipode*, 37(3): 515-535.
- Riva, G.; Bacchetta, M.; Cesa, G.; Conti, S.; Castelnuovo, G.; Mantovani, F. & Molinari, E. (2006). Is severe obesity a form of addiction?: Rationale, clinical approach, and controlled clinical trial. *Cyberpsychology & Behavior*, 9(4): 457-479.
- Rogers, P. J. (2011). Obesity: Is food addiction to blame? *Addiction*, 106(7): 1213-1214.
- Rose, N. (1996). Governing "advanced" liberal democracies. In A. Barry, T. Osborne, & N. Rose (Eds.), *Foucault and Political Reason: Liberalism, Neo-liberalism, and Rationalities of Government* (pp. 37-65). Chicago: University of Chicago Press.

- Rose, N. (2003). The neurochemical self and its anomalies. In R.C. Ericson & Aaron Doyle (Eds) *Risk and Morality*. (pp. 407 - 437). Toronto: University of Toronto Press.
- Rose, N. (2006). Will biomedicine transform society? *Kritikos*, 3: 1-25.
- Rose, N. (2007a). Molecular biopolitics, somatic ethics and the spirit of biocapital. *Social Theory & Health*, 5(1): 3-29.
- Rose, N. (2007b). Beyond medicalisation. *The Lancet*, 369(9562): 700-702.
- Rose, N. S. (2009). *The politics of life itself: Biomedicine, power, and subjectivity in the twenty-first century*. Princeton: Princeton University Press.
- Rose, N. & Novas, C. (2005). Biological citizenship. In A. Ong & S.J. Collier *Global Assemblages: Technology, Politics, and Ethics as Anthropological Problems*. (pp. 439-463). Malden, M.A.: Blackwell Publishing.
- Rose, N. & Miller, P. (2008). *Governing the Present: Administering Economic, Social and Personal Life*. Cambridge: Polity.
- Sabin, J. (2004). Ethical issues associated with bariatric (weight loss) surgery. [Ethics Advisory Group Consultation Report] Harvard University. Retrieved April 2013 (https://www.harvardpilgrim.org/pls/portal/docs/PAGE/PROVIDERS/RESOURCES/ETHICS/2004_MEETING_MINUTES/1.14.04_BARIATRIC_SURGERY.PDF)
- Saguy, A. (2012). Why fat is a feminist issue. *Sex Roles*, 66(9-10), 600-607.
- Saguy, A.C. & Riley, K.W. (2005). Weighing both sides: Morality, mortality, and framing contests over obesity. *Journal of Health Politics, Policy and Law*, 30(5), 869-923.
- Saguy, A.C. & Almeling, R. (2008). Fat in the fire? Science, the news media, and the obesity epidemic. *Sociological Forum*, 23(1): 53-83.
- Salant, T. & Santry, H.P. (2006). Internet marketing of bariatric surgery: Contemporary trends in the medicalization of obesity. *Social Science & Medicine*, 62(10): 2445-2457.
- Santry, H.P.; Gillen, D.L. & Lauderdale, D.S. (2005). Trends in bariatric surgical procedures. *Journal of the American Medical Association*, 294(15): 1909-1917.
- Sanz Porras, J. (2006). Configuring bariatric bodies: Exploring obesity surgery beyond the hospital. *Athenea Digital: Revista De Pensamiento E Investigación Social*, (10): 103-120.
- Sarljo-Lähteenkorva, S. (1998). Relapse stories in obesity. *The European Journal of Public Health*, 8(3), 203-209.

- Sarlio-Lähteenkorva, S. (2000). "The battle is not over after weight loss:" Stories of successful weight loss maintenance. *Health*, 4(1), 73-88.
- Saunders, R. (1999). Binge eating in gastric bypass patients before surgery. *Obesity Surgery*, 9(1): 72-76.
- Sawer, D.B. & Dilks, R.J. (2011). Overview of the psychological and behavioral aspects of bariatric surgery. *Bariatric Times*, 8(2): 18-24.
- Schafer, H. & Ferraro, F. (2011). The stigma of obesity: Does perceived weight discrimination affect identity and physical health? *Social Psychology Quarterly*, 74(1): 76-97.
- Schaffer, R.; Kuczynski, K. & Skinner, D. (2008). Producing genetic knowledge and citizenship through the internet: Mothers, pediatric genetics, and cybermedicine. *Sociology of Health & Illness*, 30(1): 145-59.
- Schwartz, H. (1986). *Never Satisfied: A Cultural History of Diets, Fantasies, and Fat*. New York: Anchor Books.
- Schwartz, M.B.; O'Neil Chambliss, H.; Brownell, K.D.; Blair, S.N. & Billington, C. (2003). Weight bias among health professionals specializing in obesity. *Obesity Research*, 11(9): 1033-1039.
- Shah, M.; Simha, V. & Garg, A. (2006). Long-term impact of bariatric surgery on body weight, comorbidities, and nutritional status. *Journal of Clinical Endocrinology & Metabolism*, 91(11): 4223-4231.
- Sheipe, M. (2006). Breaking through obesity with gastric bypass surgery. *The Nurse Practitioner*, 31(10): 12-14.
- Shilling, C. (2003). *The Body and Social Theory*. London: Thousand Oaks.
- Shugart, H.A. (2011). Shifting the balance: The contemporary narrative of obesity. *Health Communication*, 26(1), 37-47.
- Slimpressions. [Website]. Retrieved April 2013. (<http://slimpressions.com>).
- Sjöström, L.; Lindroos, A.K.; Peltonen, M.; Torgerson, J.; Bouchard, C.; Carlsson, B.; Dahlgren, S.; Larsson, B.; Narbro, K. & Sjöström, C. D. (2004). Lifestyle, diabetes, and cardiovascular risk factors 10 years after bariatric surgery. *New England Journal of Medicine*, 351(26): 2683-2693.
- Smith, N. (1998). Giuliani time: The revanchist 1990s. *Social Text*, 57: 1-20.

Smoot, T.M.; Xu, P.; Hilsenrath, P.; Kuppersmith, N.C., & Singh, K.P. (2006). Gastric bypass surgery in the United States, 1998-2002. *American Journal of Public Health*, 96(7): 1187.

Snow, V.; Barry, P.; Fitterman, N.; Qaseem, A. & Weiss, K. (2005). Pharmacologic and surgical management of obesity in primary care: A clinical practice guideline from the American college of physicians. *Annals of Internal Medicine*, 142(7): 525-531.

Sogg, S. (2007). Alcohol misuse after bariatric surgery: Epiphenomenon or "Oprah" phenomenon? *Surgery for Obesity and Related Diseases*, 3(3): 366-368.

Sogg, S. Candidates: The clinical interview. In J. Mitchell & J. de Zwann (Eds.), *Psychosocial Assessment and Treatment of Bariatric Surgery Patients* (pp. 15-36). New York: Taylor & Francis.

Stapleton, C. [Website]. Retrieved April 2013.
(<http://www.conniestapletonphd.com/mindprepvideo/#trial>).

Steele, K.E.; Magnuson, T.H.; Lidor, A.O.; Wong, D.F.; Schweitzer, M.A. & Steele, M. (2011). Obesity and the brain: Implications for the surgeon. *Bariatric Times*, 8(7): 12-13.

Stein, R.J.; O'Byrne, K.K.; Suminski, R.R. & Haddock, C.K. (2000). Etiology and treatment of obesity in adults and children: Implications for the addiction model. *Drugs & Society*, 15(1-2): 103-121.

Sunder Rajan, K. (2006). *Biocapital the Constitution of Postgenomic Life*. Durham: Duke University Press.

Suzuki, J.; Haimovici, F. & Chang, G. (2012). Alcohol use disorders after bariatric surgery. *Obesity Surgery*, 22(2): 201-207.

Taylor, V.H.; Curtis, C.M. & Davis, C. (2010). The obesity epidemic: The role of addiction. *Canadian Medical Association Journal*, 182(4): 327-328.

Thompson, J.K. & Heinberg, L.J. (1999). The media's influence on body image disturbance and eating disorders: We've reviled them, now can we rehabilitate them? *Journal of Social Issues*, 55(2): 339-353.

Thorpe, L.E.; List, D.G.; Marx, T.; May, L.; Helgeson, S.D. & Frieden, T.R. (2004). Childhood obesity in New York City elementary school students. *Journal of Information*, 94(9): 1496-1500.

Throsby, K. (2007). "How could you let yourself get like that?" Stories of the origins of obesity in accounts of weight loss surgery. *Social Science & Medicine*, 65(8): 1561-71.

Throsby, K. (2008a). Happy re-birthday: Weight loss surgery and the 'new me'. *Body & Society*, 14(1): 117-133.

Throsby, K. (2008b). "That's a bit drastic:" Risk, blame in accounts of obesity surgery. In F. Alexander & K. Throsby (Eds.), *Gender and Interpersonal Violence: Language, Action and Representation*, (pp. 83-99). London: Palgrave Macmillan.

Throsby, K. (2012). 'I'd kill anyone who tried to take my band away': Obesity surgery, critical fat politics and the 'problem' of patient demand. *Somatechnics*, 2(1): 107-126.

United States Department of Health and Human Services, Centers for Disease Control and Prevention (2010). Obesity Halting the Epidemic by Making Health Easier: At A Glance 2010. [Report]. Retrieved April 2013

(<http://www.cdc.gov/chronicdisease/resources/publications/AAG/obesity.htm>).

United States Department of Health and Human Services, National Institutes of Health. (2011, March). Strategic Plan for NIH Obesity Research. [Report]

United States Department of Health and Human Services, National Institutes of Health. (2012, October 19). Weight loss does not lower heart disease risk from type 2 diabetes. *NIH News*. [Press release]. Accessed April 2013 (<http://www.nih.gov/news/health/oct2012/niddk-19.htm>).

United States Department of Health and Human Services, Office of the Surgeon General. (1994, December 6). Dr. C. Everett Koop Launches A New "Crusade" to Combat Obesity in America. [Press Release]. Retrieved April 2013 (www.shapeup.org: http://www.shapeup.org/about/arch_pr/120694.php).

United States Department of Health and Human Services, Office of the Surgeon General. (2001). The Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity. [Report]. Rockville, MD.

United States Department of Health and Human Services, Office of the Surgeon General. (2010, January). The Surgeon General's Vision for a Healthy and Fit Nation, 2010. [Report]. Rockville, MD.

Van Wageningen, B; Berends, F.J.; Van Ramshorst, B. & Janssen, I.F.M. (2006). Revision of failed laparoscopic adjustable gastric banding to Roux-en-Y gastric bypass. *Obesity Surgery*, 16(2): 137-141.

Volkow, N.D. & O'Brien, C. P. (2007). Issues for DSM-V: Should obesity be included as a brain disorder? *American Journal of Psychiatry*, 164: 708-710. Retrieved April 2013 (<http://ajp.psychiatryonline.org/article.aspx?articleID=98310>).

Volkow, N.D. & Wise, R.A. (2005). How can drug addiction help us understand obesity? *Nature Neuroscience*, 8(5): 555-560.

Vrecko, S. (2010). "Civilizing technologies" and the control of deviance. *BioSocieties*, 5(1): 36-51.

Wadden, T.A.; Sarwer, D.B.; Fabricatore, A.N.; Jones, L.; Stack, R. & Williams, N.S. (2007). Psychosocial and behavioral status of patients undergoing bariatric surgery: What to expect before and after surgery. *The Medical Clinics of North America*, 91(3): 451-69.

Waldby, C. & Mitchell, R. (2006). *Tissue Economies Blood, Organs, and Cell Lines in Late Capitalism*. Durham: Duke University Press.

Walkerdine, V. (2009). Biopedagogies and beyond. In J. Wright & V. Harwood (Eds.), *Biopolitics and the 'Obesity Epidemic:' Governing Bodies*, (pp. 199-207). New York: Taylor & Francis.

Wang, S.S.; Brownell, K.D. & Wadden, T.A. (2004). The influence of the stigma of obesity on overweight individuals. *International Journal of Obesity*, 28(10): 1333-1337.

Warman, J.L. (2005). The application of laparoscopic bariatric surgery for treatment of severe obesity in adolescents using a multidisciplinary adolescent bariatric program. *Critical Care Nursing Quarterly*. 28(3): 276-287.

Washington Times. (2005, May 1). Blubber About Obesity. *Washington Times*. Retrieved April 2013 (<http://www.washingtontimes.com/news/2005/may/1/20050501-091513-4251r/>).

Weight Loss Surgery Foundation of America. [Website]. Retrieved April 2013 (<http://www.wlsfa.org/>).

Weighty Secrets [Website]. Retrieved April 2013 (<http://www.weightysecrets.com/>).

Weiner, J.P.; Goodwin, S.M.; Chang, H.Y.; Bolen, S.D.; Richards, T.M.; Johns, R.A.; Momin, S.R. & Clark, J.M. (2013). Impact of bariatric surgery on health care costs of obese persons: A 6-year follow-up of surgical and comparison cohorts using health plan data. *JAMA Surgery*. [Online first 2/20/2013]: 1-8.

Weis, L. & Fine, M. (2000). *Speed Bumps: A Student-Friendly Guide to Qualitative Research*. New York: Teachers College Press.

- Whyte, S.R. (2009). Health identities and subjectivities. *Medical Anthropology Quarterly*, 23(1): 6-15.
- Wilkerson, A.L. (1998). *Diagnosis Difference: The Moral Authority of Medicine*. Ithaca, NY: Cornell University Press.
- Williams, G. & Busby, H. (2000). The politics of 'disabled' bodies. In S. J. Williams, J. Gabe, & M. Calnan (Eds.), *Health, Medicine and Society: Key Theories, Future Agendas*, (pp. 169-185). London: Routledge.
- Williams, S.J.; Higgs, P. & Katz, S. (2012). Neuroculture, active ageing and the "older brain:" Problems, promises and prospects. *Sociology of Health & Illness*, 34(1): 64-78.
- Wilson, A.R. & McAlpine, D.D. (2006). The effectiveness of screening for obesity in primary care: Weighing the evidence. *Medical Care Research and Review*, 63(5): 570-598.
- Wilson, B. (2011, February 14). Fat, the first lady, and fighting the politics of health science. [Lecture]. The Graduate Center of the City University of New York.
- Wilson, E.A. (1998). *Neural Geographies: Feminism and the Microstructure of Cognition*. New York: Routledge.
- Wilson, G. T. (2010). Eating disorders, obesity and addiction. *European Eating Disorders Review*, 18(5): 341-351.
- Wright, J. (2009). Biopower, biopedagogies, and the obesity epidemic. In J. Wright & V. Harwood, (Eds.), *Biopolitics and the 'Obesity Epidemic:' Governing Bodies*, (pp. 1-14). New York: Taylor & Francis.
- Yahoo Group Obesity Surgery Support Group [Yahoo Group]. Retrieved April 2013 (<http://health.groups.yahoo.com/group/OSSG/>).
- Yahoo Group Obesity Surgery Support Group - Gone Wrong. [Yahoo Group]. Retrieved April 2013 (<http://groups.yahoo.com/adultconf?dest=%2Fgroup%2FOSSG>).
- Yancey, A.K.; Leslie, J. & Abel, E.K. (2006). Obesity at the crossroads: Feminist and public health concerns. *Signs*, 31(2): 425-443.
- Zola, I.K. (1972). Medicine as an institution of social control. *The Sociological Review*, 20(4), 487-504.