

REDUCING AND REVISIONING THE BODY: WOMEN'S EXPERIENCES OF WEIGHT LOSS  
SURGERY

By

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**WOMEN'S EXPERIENCES OF WEIGHT LOSS SURGERY**

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## ABSTRACT

This dissertation examines the experience of 30 women, 15 Canadians and 15 Americans, who have undergone bariatric (weight loss) surgery. Bariatric surgery is reserved for morbidly obese persons; that is, those who weigh more than twice their ideal weight. An integrated model of the insights from stigma and feminist theory is used as the conceptual framework of the study.

In semi-structured, in-depth interviews following the format of a life review, the participants discussed the wide-ranging effects of morbid obesity on their lives. My participants' weight negatively affected their family relationships, romantic relationships, and employment prospects. Their weight also had a negative impact on their health and self-image. Dieting and other weight loss strategies proved to be futile. The decision to undergo surgery was not taken lightly, and the majority of the sample maintained they underwent surgery to resolve medical problems and to increase their quality of life.

Twenty of the participants had a successful surgery, although most did not attain a normative weight. The remaining 10, however, experienced massive weight regain or suffered such severe complications that the procedure had to be reversed. The women whose surgeries were successful reported that weight loss had a dramatic, positive impact on their lives, health and identities. This subgroup discovered a new relationship between the postoperative body and the self, a process that I describe as re-embodiment. The majority of the women whose surgeries failed became empowered through self-acceptance and the influence of the size acceptance movement. These women have also constructed a new relationship between the body and the self, and I refer to this process as re-selvement.

Interestingly, the stigma of obesity is a greatly diminished factor in the postoperative lives of both sub-groups. I argue that the satisfaction of the surgical successes neutralizes the effects of stigma. The women whose surgeries failed but who have become self-accepting neutralize stigma by challenging their devalued status.

This dissertation contributes to knowledge by adding to the sparse literature on the subjective experiences of obese people. My research yields insights into the complexities involved when the body undergoes a dramatic transformation.

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## CHAPTER ONE

### INTRODUCTION

On August 7, 1999 singer Carnie Wilson underwent gastric bypass surgery, a weight loss procedure reserved for very obese people for whom conventional (nonsurgical) weight loss therapies have failed.<sup>1</sup> She subsequently lost 150 pounds and has become an ambassador for the surgery, which hitherto had been largely unknown to the public. Wilson has been very public about her experience, having the procedure broadcast live on the Internet and has become a ubiquitous media presence.<sup>2</sup> She married soon after the operation and her singing career has been revived. Wilson credits the transformation in her life to the success of her bariatric surgery.

Wilson's weight loss and the subsequent positive events in her life represents the modern version of such fairy tales as *The Ugly Duckling*, *The Frog Prince*, etc., in which the unveiling of the "true" body inevitably results in happiness and fulfillment. Obese people are offered their own fairy tale in the aphorism "inside every fat person is a thin person trying to get out."<sup>3</sup> The implied assumption is that "[t]he 'thin person within,' waiting to burst through the fat, is somehow a more exciting, sexy, competent, successful self" (Seid 1994:4). Wilson has come to embody the happier, sexier, thin person allegedly lurking inside every fat person, and her success has offered a last beacon of hope for very fat people, who are known in the medical profession as "morbidly obese." The American Society for Bariatric Surgery (ASBS) credits Wilson for helping to popularize the procedure (36,700 bypasses were performed in 2000; in 2001 the figure was 62,400) (cited in Scott and Wihlberg 2002:102).

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<sup>1</sup> Weight loss surgery is also known as bariatric surgery, derived from the Greek *barros*, meaning "heavy." The terms weight loss surgery and bariatric surgery are used interchangeably throughout this dissertation. Bariatric surgery is also popularly known as "stomach-stapling surgery." A detailed description of conventional (i.e., nonsurgical) weight loss treatments can be found in Appendix A. A description of bariatric surgical procedures is presented in Appendix C.

<sup>2</sup> See also Dam and Wihlberg (2001). Actress Roseanne and singer Ann Wilson (no relation to Carnie Wilson) have also revealed they have had weight loss surgery.

<sup>3</sup> According to Schwartz (1990:407), this saying was apparently inspired by British essayist Cyril Connolly who wrote during the Second World War, "Imprisoned in every fat man a thin one is wildly signalling to be let out."

Using semi-structured interviews, this study is a feminist analysis of the lived experiences of 30 women who have undergone weight loss surgery. My primary interests are to understand a woman's motivations for having the surgery and how she negotiates the transition involved in acquiring a different body. What changes when the body changes? Does the self change? What happens if the surgery fails to work?

The following sections illustrate that fatness is a multidimensional phenomenon. While fatness has been increasingly pathologized, I argue obesity is as much a social condition as it is a medical and physical condition, and as such, can only be properly understood when located in the wider sociocultural context. Examining obesity in its sociocultural context helps us understand that since the thin ideal has emerged as an archetype for women, excess weight is also a gendered issue with significant implications for women.

#### **Excess Fatness: A Latter-Day Scourge**

*The Purpose of Fat.* Fat, along with proteins and carbohydrates, is an essential nutrient that fuels the body. Norgan (1998:738) describes fat as “the most important form of stored energy.” Without it, the body would not be able to utilize fat-soluble vitamins (A, D, E, and K), insulate its internal organs or maintain a normal temperature (Rodin 1992). Women tend to have higher fat levels than men. Under normal conditions, the adult female body is composed of 22 to 26 percent fat, while the fat level of the adult male is about 15 to 18 percent (Bray and Gray 1988; Brownell 1991; Norgan 1998). Women need more fat to meet the increased energy needs required by pregnancy and lactation (Norgan 1998). The female body's reproductive capability falters when fat levels drop even by a small amount (Frisch and McArthur 1974).

*Defining Obesity.* The terms overweight and obese are used interchangeably, but they are not synonymous. The conceptual definition of obesity essentially refers to an excess of body *fat* and overweight is a condition in which the body weight exceeds a reference level (Allison and Saunders 2000; Bray and Gray 1988).<sup>4</sup> Clinical definitions of overweight and obesity, however, have varied over time and

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<sup>4</sup> The cause of obesity is more complex than an imbalance of calories ingested, calories expended. The dominant explanations for the etiology of obesity are described in Appendix B.

at times have provoked controversy (Allison and Saunders 2000; Kuczmarski and Flegal 2000).<sup>5</sup> The weight standards that predominated before 1980 were the Metropolitan Life Insurance Company (MLIC) “ideal weight” tables based on gender, height, and body frame. Using the MLIC tables, overweight was defined as weighing more than 10 percent above ideal weight, while obesity was defined as weighing more than 20 percent above ideal weight. A person was considered morbidly obese if he or she weighed more than 100 percent above ideal weight (Cogan and Rothblum 1992; Council on Scientific Affairs 1988).

The MLIC tables were associated with numerous problems<sup>6</sup> and the World Health Organization (WHO) (1998) recommends that the Body Mass Index (BMI) should be used as a reliable guideline for healthy weights for adults.<sup>7</sup> The BMI can be calculated by dividing body weight in kilograms by height in meters squared. There are five BMI categories: underweight is defined as <18.5; normal weight as 18.5-24.9; overweight as 25.0-29.9; obesity as >30; and morbid obesity as >40. A BMI of 30 corresponds to about 30 pounds overweight (Bray and Gray 1988), and a BMI of 40 corresponds to about 100 pounds overweight. Obesity can be further classified as moderate (Class I, BMI 30-34.9); severe (Class II, BMI 35-39.9) or very severe (Class III, BMI 40 or greater). (See Table 1.)

**Table 1 – Classification of Overweight and Obesity by BMI**

Classification	BMI	Obesity Class
Underweight	< 18.5	
Normal	18.5 - 24.9	
Overweight	25.0 - 29.9	
Obese (moderate)	30.0 - 34.9	I
(severe)	35.0 - 39.9	II
(very severe)	> 40.0	III

While the WHO recommends these definitions of overweight and obesity, there exists no international consensus about the exact cut-off point for obesity (Ciliska 1993; Hubbard 2000; Lau 1999).

<sup>5</sup> Definitions of underweight and overweight have been steadily declining; for instance, until 1998 overweight was defined as a BMI of >27 and underweight as defined as <20. I argue this trend takes place within the context of a thin-obsessed culture, a topic examined in the next section.

<sup>6</sup> For example, see Bennett and Gurin (1982); Deitel (1989); Ritenbaugh (1982) and Seid (1989).

<sup>7</sup> For the limitations associated with using the BMI as a sole clinical diagnostic criterion of obesity, see Hubbard (2000); Kuczmarski and Flegal (2000); Lau (1999).

Nor does there even appear to be national agreement about the point at which overweight ends and obesity begins. For example, in the February 1999 issue of the *Canadian Medical Association Journal*, two researchers used 27 as a cut-off point, while another used 30. As definitions of overweight and obesity vary, so do estimates of its prevalence.<sup>8</sup>

*Prevalence of Obesity.* Both Canada and the United States are said to be in the throes of an obesity epidemic (Hill, Wyatt, and Melanson 2000; Lau 1999). Using a BMI of >27 as a measure of obesity, a large-scale survey conducted by MacDonald et al. (1997) found that close to half of adult Canadians are overweight and 32 percent are obese. Thirty-five percent of Canadian men are obese, compared to 27 percent of women. A recent study, using a BMI of >30, estimates that approximately 15 percent of Canadians are obese (Katzmarzyk 2002). Katzmarzyk estimates that the prevalence of obesity in Canada doubled between 1985 and 1998.

Canadian children between the ages of 7 and 13 are also becoming progressively more overweight according to Tremblay and Willms (2000).<sup>9</sup> These authors have found that between the years 1981 to 1996, the prevalence of overweight among boys increased from 15 percent in 1981 to 28.8 percent in 1996 and among girls from 15 percent to 23.6 percent. The prevalence of obese children more than doubled over that period to 13.5 percent for boys and to 11.8 percent for girls. Similarly, O'Loughlin et al.'s (2000) study of low-income children aged 9 through 12 living in inner-city neighborhoods in Montreal showed that between the years 1993 to 1994, the prevalence of overweight and obesity among these children increased by approximately 1.3 percent and 1 percent respectively, per year.

U.S. statistics suggest even greater prevalence rates of overweight and obesity in that country. The weight of the American population has been rising steadily, particularly since 1980 (Flegal et al. 1998; Flegal and Troiano 2000; Kuczmarski et al. 1994; Mokdad et al. 1999; Mokdad et al. 2001; National Heart, Lung, and Blood Institute [NHLBI] Obesity Education Initiative 1998). Data gathered from a recent national examination survey indicate that 64.5 percent of American adults are overweight (BMI >25), while

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<sup>8</sup> See also NIH Technology Assessment Conference Panel (1992).

<sup>9</sup> For children and adolescents, the BMI indicating overweight varies with age, so the adult definitions of overweight and obesity do not apply. Instead, children are identified as overweight if they are above the age- and gender-specific percentiles of weight (see Troiano et al. 1995; Troiano and Flegal 1998; Seidell 1999).

30.5 percent are obese (BMI >30) (Flegal et al. 2002). Unlike the pattern observed in Canada, women in the United States are more likely to be obese than men: 33.4 percent of American women are obese, compared to 27.5 percent of men (Flegal et al. 2002). National surveys show that American children and adolescents are also experiencing increasing prevalence rates of overweight and obesity since the mid-1970s and particularly since 1980 (Gortmaker et al. 1987; Troiano et al. 1995; Troiano and Flegal 1998). Twenty-five percent of American children are considered to be overweight and obese (Troiano and Flegal 1998).<sup>10</sup>

High body weight is not randomly distributed in the Canadian and U.S. populations. Blacks, Hispanics and Natives of both sexes have higher rates of obesity than whites (Allison and Saunders 2000; Flegal et al. 2002; Klesges, DeBon, and Meyers 1996; Østbye et al. 1995; Rand and Kuldau 1990). Social class and education are inversely correlated with obesity among white women (Evers 1987; Goldblatt, Moore, and Stunkard 1965; Rand and Kuldau 1990; Sobal and Stunkard 1989). Age is positively correlated with obesity. The prevalence of obesity tends to rise steadily between the ages of 20 to 60, at which point it begins to decline (Allison and Saunders 2000; MacDonald et al. 1997; Østbye et al. 1995; Rand and Kuldau 1990).<sup>11</sup>

*Perils of Obesity.* Since the 1950s, the medical profession has increasingly defined fatness as a pathogenic agent (Bennett and Gurin 1982; Fraser 1997; Seid 1989; Stearns 1997). Obesity is associated with numerous, significant health problems. These range from dyslipidemia; high blood pressure; coronary heart disease; strokes; Type 2 diabetes; various cancers; gallbladder disease; sleep apnea; osteoarthritis; musculoskeletal problems, and premature death (Allison et al. 1999; Allison and Saunders 2000; Bray and Gray 1988; Field et al. 2001; MacDonald et al. 1997; Manson et al. 1995; Must et al. 1999; NHLBI Obesity Education Initiative 1998; Rabkin et al. 1997). According to Mun et al. (2001:669), “[f]our of five obese people have at least one debilitating illness associated with the underlying obesity.” Women who are overweight or obese during their first pregnancy are at higher risk of developing medical complications during pregnancy and delivery (Cnattingius et al. 1998; Wolfe 1998). High maternal prepregnancy weight

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<sup>10</sup> See also Flegal and Troiano (2000) and Ogden et al. (2002).

<sup>11</sup> See also Sobal (1995a).



is also associated with higher rates of premature delivery, stillbirths and fetal anomalies (Cnattingius et al. 1998; Wittgrove et al. 1998; Wolfe 1998).

The direct medical costs attributable to adult obesity in Canada are conservatively estimated to have been \$1.8 billion in 1997, or 2.4 percent of the total health care budget (Birmingham et al. 1999).<sup>12</sup> This figure is similar to figures obtained for New Zealand, Australia and France but somewhat lower than those for Germany, the United States and Sweden (Kurcheid and Lauterbach 1998).

*Prevalence of Morbid Obesity.* Two percent of Canadian men and 4 percent of women in Canada are morbidly obese (MacDonald et al. 1997).<sup>13</sup> The prevalence of morbid obesity in the United States is about 3.1 percent in men and 6.7 percent in women (Freedman et al. 2002).<sup>14</sup> Freedman et al. found that the prevalence of morbid obesity in the United States has increased almost three-fold between 1990 and 2000.<sup>15</sup>

*Hazards of Morbid Obesity.* The term “morbidly obese” refers to its close association with diseases, known in the medical profession as “morbidity” (Van Itallie 1980). Morbidly obese persons are at even higher risk than obese people of developing obesity-related diseases. Morbid obesity is strongly correlated with premature mortality (Angel, Winocur, and Roncari 1989; Balsiger et al. 2000a; Fettes and Williams 1996; Mun et al. 2001; Sjöström 1992). Angel et al. (1989:22) note, “[i]n moderate obesity, the risk of diabetes is about ten times that which would be expected in normal-weight people. In those who are 45% or more overweight, the risk is increased by 30-fold.” In addition, morbid obesity is associated with chronic venous stasis disease, immobility, urinary incontinence, gastroesophageal reflux disease, fatty liver, sex hormone dysfunction and clinical depression (Deitel 1989; Mun et al. 2001). Menstrual irregularities, reduced fertility, and infertility are common among morbidly obese women (Deitel 1989; Lake, Power, and Cole 1997). Because of mechanical reasons, morbidly obese persons are particularly prone to serious

<sup>12</sup> Birmingham et al. suspect the actual cost is probably closer to \$4 billion.

<sup>13</sup> The definition of morbid obesity in this study was BMI >35.

<sup>14</sup> This finding is noteworthy, given that there is a greater percentage of Canadian men in the obese category than women, and yet, women are more likely to become morbidly obese. This switch needs further investigation; however, some relevant factors appear to be higher fat levels in women, effects of pregnancy, and history of sexual abuse (Angel et al. 1989; Fettes and Williams 1996).

<sup>15</sup> See also Flegal et al. (2002) and Gladwell (1998).

accidents (Angel et al. 1989:23). Finally, morbid obesity severely impairs an individual's quality of life (Kral, Sjöström, and Sullivan 1992).

*Weight Loss Surgery for Morbid Obesity.* Conventional (nonsurgical) treatment modalities are almost always ineffective for morbidly obese persons (Balsiger et al. 2000a; Deitel 1998; National Institutes of Health [NIH] Consensus Development Conference 1992; Powers and Rosemurgy 1989; Van Itallie 1980). (See also Appendix A.) These therapies produce only modest weight losses, amounts which would be irrelevant to the morbidly obese. Moreover, these weight losses are rarely maintained.

Weight reduction surgery is perhaps the most effective weight loss treatment for the morbidly obese. Patient selection criteria for surgical treatment of obesity were developed by the 1991 NIH Consensus Development Conference Panel and include patients with a BMI >40 or BMI >35 who are afflicted with obesity-related diseases. Additional criteria include acceptable medical/operative risks and proof of failed attempts at nonsurgical weight reduction, among others.<sup>16</sup>

Bariatric surgery is an umbrella term for different types of surgical techniques involved in reducing the size of the stomach. The two most popular operative procedures are vertical banded gastroplasty (VBG) and Roux-en-Y gastric bypass surgery (RNY).<sup>17</sup> Average weight loss in the twelve months following surgery is between 25 percent and 35 percent of preoperative weight, which corresponds to approximately 100 pounds and approximately 50 percent of excess weight (Kral 1992a). Maintenance of weight loss following bariatric surgery is better than that associated with other treatments for morbid obesity (Sjöström 2000). Success rates and side effects vary according to type of operation.

*Weight Loss Surgery as a Gendered Phenomenon.* A particularly interesting feature of bariatric surgery, although it tends to be overlooked in the medical literature, is that its population is comprised almost entirely of women. At least 80 percent of the surgical recipients are female (NIH Consensus Development Conference 1992). Other estimates suggest that this figure is even higher. Data compiled by the International Bariatric Surgery Registry (IBSR) indicate that women may comprise as much as 87 percent of its surgical population (Mason, Renquist, and Jiang 1992). Ernsberger (1991) maintains that the

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<sup>16</sup> See also Deitel (1989).

<sup>17</sup> Carnie Wilson had the latter procedure.

recipients are 90 to 95 percent female. This over-representation of women is particularly striking, given that the ratio of morbidly obese women to men is only 2:1.

The disproportionate numbers of women seeking bariatric surgery mirrors the trend of women's overrepresentation in other weight loss pursuits. It has been estimated that women comprise 90 percent of all weight loss programs (Cogan and Rothblum 1992; Freedman 1986; Millman 1980). Women are more likely than men to diet, even when they are not overweight (Green et al. 1997; NIH Technology Assessment Conference Panel 1992; Rand and Kuldau 1990; Reeder et al. 1992). At any given time, 40 percent of all women and 61 percent of female adolescents and young adult women in the United States are dieting (Berg 1999). Dieting appears to have become a rite of passage into adulthood for females, as it is estimated that the average Canadian girl has dieted at least once by the time she reaches 18 (Sheinin 1990; Jones et al. 2001). The literature is replete with studies that indicate prepubescent girls are dieting at ever-younger ages. Researchers have found that eight- and nine-year-old girls living in the United States and Britain express dissatisfaction with their bodies and engage in dieting behaviors—whether or not they are overweight (Hill, Draper, and Stack 1994; Hill and Pallin 1998; Schur, Sanders, and Steiner 2000). A recent study has found that American girls as young as five years old are worrying about their weight (Davison and Birch 2001). Similarly, five-year-old girls in Canada reported limiting food intake because they were afraid of gaining weight (Feldman, Feldman, and Goodman 1988).<sup>18</sup> Women and girls are also more likely to use prescription drugs and to initiate smoking behaviors to control their weight (Austin and Gortmaker 2001; Khan et al. 2001; Wiseman et al. 1998).

Why are women and girls so afraid of fatness? Why are they so amenable to radical weight loss strategies such as surgery and drugs? These weight control behaviors can be better understood when they are examined within their sociocultural context, a context in which thinness has become a cultural and

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<sup>18</sup> Body shape concerns and dieting behaviors among adolescent girls are also observed in other Western countries such as the Netherlands, Belgium, Spain, and Australia (Braet and Wydhooge 2000; Brugman et al. 1997; Sánchez-Carracedo, Saldafia, and Domènech 1996; Tiggemann and Rothblum 1988). Japan, while not a Western country, has experienced rapid rates of Westernization since 1945. A study conducted by Matura et al. (1992) found that young Japanese women expressed a preference for a low weight as a body ideal. The women who reported the lowest weights were most likely to describe themselves as “contented” with their weight.

moral imperative for women. The rise of the thin ideal and its implications for women is discussed in the next section.

### **The Sociocultural Aspect of Fatness: The Varying Meanings of Weight for Women**

According to historian Zeldin (1977:440), one of the noticeable features of the twentieth century has been the triumph of the thin woman over the fat woman. The work of other social historians (Schwartz 1986; Seid 1989; Stearns 1997; Walden 1985) shows that slenderness as a dominant feminine appearance norm is indeed a twentieth century construction. Until 1890, plumpness in women was not only considered beautiful but healthy and indicative of lush fertility (Seid 1989). Statues of ancient fertility goddesses such as the Venus of Willendorf, are all obese with large, pendulous breasts, an enormous abdomen and heavy hips and thighs (Brown and Jasper 1993; Wooley 1994). The association between female fatness and fertility dominated for centuries. “[b]etween 1400 and 1700, the maternal role was idealized, and fat was considered both fashionable and erotic” (Freedman:1986:148). During this period, the “reproductive figure” was idealized by artists (Bennett and Gurin 1982; Fallon 1990). For example, the cavorting nudes featured in the paintings of sixteenth-century artist Rubens are fleshy women, boasting ample breasts, wide hips and slightly protuberant bellies. The fullness of the stomach symbolized fertility (Bennett and Gurin 1982; Fallon 1990). Stearns (1997) notes that the artistic tradition of portraying full-figured women as idealized women lasted until the nineteenth century.

During this period, maternity was a woman’s primary role. As Fallon (1990:85) observes, “womanhood and motherhood were synonymous.” Women mothered their husbands as well as their children, and plumpness was evidence of this maternalism. Plumpness in women was also an indicator of a “clean, temperate life...decency, calm, and dignity” (Seid 1989:76). Fatness in men was evidence of prosperity (Seid 1989; Stearns 1997). As Seid (1989:76) observes, “[t]he dignified paunch of a successful businessman bespoke a similarly well-cushioned savings account....For the wives of successful men, fat was a ‘silken layer’.”

From the late nineteenth century onwards, a number of significant changes took place that affected attitudes toward body weight and shape (Seid 1989).<sup>19</sup> Notable among these was that the stability and abundance in the food supply was achieved in the United States; thus, fatness was no longer emblematic of access to scarce resources (Brown and Jasper 1993; Fallon 1990; Seid 1989). The importance in fertility decreased as infant mortality rates dropped and birth control techniques became more widely used (Bennett and Gurin 1982; Brown and Jasper 1993). Women no longer had to spend their lives being pregnant and nursing, and the significance of the motherhood role declined.

Numerous scholars have noted a correlation between slenderness in women at the same time as they obtain greater social and political freedoms (Bordo 1993; Chernin 1981; Stearns 1997). For example, in the 1920s when women obtained the right to vote, the flat-chested, narrow-hipped flapper with her bobbed hair became the epitome of middle-class female beauty (Fallon 1990). The flapper's reign was cut short by the Depression and the Second World War (Fallon 1990). As is traditional after war, emphasis was placed on reproduction. The 1950's stressed women's roles as homemakers, mothers and sex objects. This cultural prescription was embodied in the voluptuousness of Hollywood screen stars such as Marilyn Monroe and Jayne Mansfield (Brown and Jasper 1993; Fallon 1990; Seid 1989).

In 1966, in the midst of the turbulence of the civil rights movement and second wave feminism, a seventeen-year-old English schoolgirl nicknamed Twiggy was unveiled as the latest fashion sensation. Twiggy weighed 97 pounds and her measurements were 31-24-33. *Vogue* and other trend-setting magazines cast her as a symbol of the 1960s: Her long hair and boyish body represented youth, unfettered femininity, and freedom from moral expectations and the burdens of motherhood. Thinness—as opposed to the curvaceousness of Marilyn Monroe and Jayne Mansfield—was embraced by early second wave feminists who viewed an angular body as overt renunciation of women's traditional associations with family, food, and nurturing (Bordo 1993; Freedman 1986; Seid 1989; Wolf 1991). As Bordo (1993:206) concludes, second wave feminists embraced the “‘new look’ ... [because it represented] liberation from a domestic, reproductive destiny.” Probably more than anything else, the new look embodied the feminist

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<sup>19</sup> See also Fraser (1997); Schwartz (1986); Stearns (1997); Turner (1991); Walden (1985).

demand that women have the right to control their own bodies (Bordo 1993; Germov and Williams 1999; McKinley 1999; Seid 1989). Bordo (1993:209) argues that as women entered the labor force in unprecedented numbers, the masculinized female body embodied masculine values of detachment, self-containment, self-mastery and control.

Twiggy's own popularity as a fashion model was short lived, but she launched the trend for underweight as a prerequisite for cultural beauty icons. The weight of models and other prototypes of female beauty has steadily continued to decline since the 1960s. For example, Garner et al. (1980) note that the winners of the Miss America pageant grew one inch taller and became five pounds thinner between 1954 and 1978. An update conducted by Wiseman et al. (1992) shows that this trend was maintained between 1979 and 1988. Finally, Rubinstein and Caballero (2000) examined the height and weight of recent Miss America winners and found that the BMI of a substantial number of these women is under 18.5, the WHO's cut-off point for underweight (see Table 1). Models now weigh 23 percent less than women in the general population (Seid 1989; Wolf 1991).<sup>20</sup> According to Seid (1989), the ideal female weight has progressively decreased to that of the thinnest 5 to 10 percent of American women. Thinness has now become a normative part of the feminine gender role (Rodin, Silberstein and Striegel-Moore 1984).

At the same time that thinness has gained ascendance, fatness has been increasingly reviled. The literature shows obese people are considered lazy, gluttonous, and immoral, among other negative stereotypes (Allon 1982; DeJong and Kleck 1986). Fatness which was once associated with health, beauty, affluence, and temperance is now associated with ugliness, disease, and low socioeconomic status—a complete inversion of earlier values (Seid 1989, 1994; Stearns 1997). Stigmatization increases in proportion to the degree of overweight, so it is logical to infer that morbidly obese people suffer more than those who are moderately obese. Moreover, negative attitudes toward fatness are not gender neutral. Fat women are stigmatized to a significantly greater extent than are fat men (Allon 1982; Breseman, Lennon, and Schulz 1999; Rothblum 1992). These findings indicate that obese women are penalized for their

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<sup>20</sup> See also Morris, Cooper, and Cooper (1989).

failure to exemplify the dominant feminine ideal. However, that so many women are desperate never to become fat illustrates that the ramifications of non-conformity are significant not only for fat women but also for all women. The significance of weight as a mechanism of social control of women and its relevance to women's cultural oppression is a central theme of this dissertation.

### **FOCUS OF THE DISSERTATION**

Gender analysis and critique are glaringly absent in the medical literature on obesity surgery. An exhaustive review of this literature revealed many instances—particularly in articles written prior to the 1990s—where the researchers did not even provide a gender breakdown of their sample. Mason et al. (1997) note that 13 percent of patients who have bariatric surgery are male. Surely the fact that females constitute 87 percent of the patient population is more relevant, yet the authors do not highlight this point. This blatant inattention to the significance of gender exemplifies what Eichler (1988) terms gender insensitivity and androcentricity.<sup>21</sup> The former refers to the failure to analyze gender-differentiated data by gender and the latter refers to “a vision of the world in male terms, a reconstruction of the social universe from a male perspective” (p. 19). Eichler argues that overlooking gender produces sexist, and therefore biased, research. Since women dominate the bariatric population to such a great extent, it is critical to understand bariatric surgery in the context of gender. Another point which needs to be made is that while the consumers of bariatric surgery may be overwhelmingly female, the providers are overwhelmingly male. As Fraser (1997) points out, bariatricians (weight loss specialists), bariatric surgeons, and obesity researchers all tend to be men. Any research on bariatric surgery that overlooks the gender dynamic is incomplete and distorted.

Moreover, patients' experiences of obesity surgery are typically recounted from a medical practitioner's standpoint. Medical accounts of surgery tend to focus on the amounts of weight the patient has lost, the health and social benefits accrued by the weight loss, as well as the complications that can occur during and after the surgery. The changes in self and identity that often take place subsequent to a

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<sup>21</sup> See also Eichler (1990).

radical transformation of the body are generally not considered in this body of literature.

For their part, feminists have also ignored fat women. Feminist scholars have been writing on women's relationships with their bodies for decades and have long noted women's weight preoccupations, but they have tended to focus on the consequences of the valorization of thinness, rather than its corollary, the vilification of fat. With the exception of Millman (1980), the victimization of fat women has not received much attention in either the feminist or sociological literatures. As well, cosmetic surgery has been staunchly criticized by feminists who accuse the medical profession of colonizing women's bodies (Morgan 1991). However, bariatric surgery is a normalizing surgical procedure that is performed almost exclusively on women but which has so far evaded the attention of feminist scholars. This dissertation is an attempt to fill these *lacunae*. The findings from this study have the potential to illustrate how women are controlled within a patriarchal society on the basis of appearance. Moreover, since appearance is closely connected with feminine identity, this study facilitates a better understanding of the intimate connection between the gendered body and the self it allegedly represents.

Stigma is another relevant factor in the sociological analysis of obesity. As noted earlier, obesity is a very stigmatizing attribute, particularly for women. Stigma transforms obesity from a physical condition into a social liability. Despite the growing numbers of obese people in Canada and the United States, the obese are consistently stigmatized as deviants who, through their lack of self-discipline, are complicit in their deviant status. As Allon (1982:130) observes, in stigmatization, deviance becomes a label attached to a person by others, rather than being an attribute of the deviant. Insights into the process of stigma and its effects on the stigmatized are helpful both in understanding a person's motivation for having the surgery and in the cases where significant weight loss is achieved, in the possible acquisition of a destigmatized status. Since gender and stigma are both crucial in shaping the experience of morbid obesity and the decision to undergo surgery, the theoretical framework for this analysis draws upon insights from stigma theory and feminist theory.

Given that so little is known about the subjective experience of excess fatness, in-depth interviews informed by feminist research principles were employed to conduct this study. As Eichler (1990, 1997)



observes, qualitative methods are helpful for exploring new topics as they provide participants with the opportunity to speak for themselves and identify issues that are salient to them. While I agree with Davis (1995) that the concept of voice has been overused in the feminist research literature, I nonetheless view this study as a forum that gives a voice to the voiceless. Fat women have been marginalized by society, by researchers and by the mainstream feminist movement and, as a consequence, their stories and experiences have rarely been heard.

In sum, the focus of this qualitative study is to provide a feminist sociological framework of women's lived experiences of bariatric surgery and how this operation changes (or does not change) women's relationships to their bodies, themselves and their relationships with others. Specific questions to be considered in this research include:

1. What factors are involved in a woman's decision to undergo weight loss surgery?
2. How would she describe the surgical experience and recovery period?
3. What, if anything, is different in her life as a consequence of the surgical procedure?
4. How does she perceive her body now? E.g., how would she describe the differences in her body, pre- and postsurgery?
5. What impact, if any, have these changes made on her sense of self and identity?

My interests in this research are motivated by own personal experience of moderate obesity. I had been a fat child and a fat adult until the age of 27 when I lost 30 pounds and maintained this loss for about 10 years. While I have recently regained some weight (a source of great distress to me), I am still a "normal-weight" woman. During my fat years I suffered the humiliation of being called "fatso," was always chosen last to play on sports teams, and experienced the rejection of men who liked me as a friend but who would not consider establishing a romantic relationship with me. Strangers also chastised me when I ate "fattening" food in public. Long before I became an academic who made the stigmatization of obesity her area of research interest, I wondered if the world was so hostile to me, a moderately obese woman, what must life be like for grossly obese women? This is not the main purpose for carrying out this dissertation research, but my findings answer that question very vividly.

## OUTLINE OF THE DISSERTATION

The outline which follows has been included here in order to give an overview of the content of this study and to facilitate the reader's ability to quickly locate matters of particular interest.

**Chapter Two** provides a comprehensive review of the literature on the stigma of obesity. The following are noted: (1) dislike of obese people starts at a young age; (2) obesity stigma pervades all aspects of the individual's life; (3) women are more stigmatized than men; (3) while there is an extensive literature which details the suffering involved in obesity, there is a paucity of information provided by obese people themselves.

**Chapter Three** integrates insights from traditional stigma theory and feminist theory on the politics of women's bodies to explain how and why the stigmatization process occurs, why obesity is so stigmatized and why the stigma is more crucial for women than men. The role of feminine appearance norms and how they function as a mechanism of social control of women is stressed. The role of the mainstream feminist movement in inadvertently perpetuating the marginalization of fat women is also discussed.

**Chapter Four** discusses the research design of the study, including the rationale for choice of population and the methods for selecting those interviewed. It provides information on demographic issues such as age, education, and occupation as well as the participants' presurgical and current weights and type of operation undergone. The processes of interviewing and data analysis are also discussed.

**Chapter Five** gives a chronological overview of the life experiences of the participants before their surgery. The chapter explores the subject of participants' first awareness of overweight as a stigmatizing issue and follows them through relevant events at school and employment. Friendships and romantic relationships are also discussed. Marital issues that have arisen because of the participants' obesity are presented.

**Chapter Six** examines the decision-making process involved in undergoing bariatric surgery. The participants describe how they first became aware of the existence of the surgery and the circumstances involved in making the decision to undergo a surgical procedure. Encounters with medical professionals

are presented, as well as the reaction of significant others to the announcement of the decision to undergo weight loss surgery.

**Chapter Seven** explores the participants' postsurgical experiences, starting from their hospital stay. Two thirds of the sample are pleased with the outcome of the surgery and describe how the transformation in their bodies led to transformation in their lives. The sample members for whom the operation failed to work describe the negative impact the surgery has had on their health and discuss the diverse ways in which they have dealt with surgical failure. The issues of embodiment and enselvement as they relate to bariatric surgery patients are examined in depth.

**Chapter Eight** summarizes the major insights generated by this research and discusses the substantive and theoretical implications of the research. Suggestions for future research are made.

A final point needs to be underscored. The reader will notice that I often refer to obese persons as "fat." My usage of this word is not meant in its usual negative sense; rather, I promote the word "fat" as a neutral adjective, in much the same way as one would describe an individual as tall, blond, etc. I urge others to join me in this effort to empower fat people.

## CHAPTER TWO

### THE STIGMA OF OBESITY: REVIEW OF THE LITERATURE

As noted in Chapter One, obesity is an extremely stigmatized condition in Canada and the United States. The academic literature reviewed in this chapter indicates that fat people are not only negatively stereotyped, but that they also experience stigmatization and rejection from numerous sources. Almost every aspect of a fat person's life, from childhood onwards, is affected by the stigma of obesity. Jackson (1992:165) notes, "being fat is associated with more negative inferences than almost any other physical characteristic."

Revulsion against the obese, popularly known as "fatphobia," constitutes a pervasive, virulent force in both countries (Crandall and Biernat 1990; Nemeth 1994). Indeed, anti-fat hostility is so entrenched and widespread in North American society that Crandall (1994) maintains it is a better method for studying prejudice and discrimination than is racism or sexism.<sup>22</sup> The empirical literature also consistently indicates that fatness is considerably more problematic for white women than it is for white men.

#### **LIVING OBESE: STIGMATIZED AND REJECTED BY CHILDREN, ADOLESCENTS AND ADULTS**

The empirical literature indicates that dislike of fatness starts early. Dyrenforth, Freeman, and Wooley (cited in Dyrenforth, Wooley, and Wooley 1980:34) asked children between the ages of two and five to choose between a very thin rag doll and a very plump one. Of their 63 subjects, 59 of them chose the thin one. Even the obese children who identified with the fat doll, preferred the thin one. When asked to explain their choices, the children who chose the thin doll replied that they "didn't like fat things."

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<sup>22</sup> Crandall (1994) found that the distribution of scores on a racism scale was highly skewed, with most subjects self-reporting low levels of racism. In contrast, on a scale assessing dislike of obese people, scores were normally distributed.

When 45 primary school children who were shown headless photographs of chubby, average and thin children in bathing suits, 86 percent demonstrated an aversion for the chubby child (Lerner and Gellert 1969).

There is an abundance of empirical data which indicates children do not want to associate with overweight children. Goldfield and Chrisler (1995) showed first graders a set of body silhouettes and asked them which child they would most like to be friends with. Twenty-eight out of the 29 children participating in the study indicated they did not want to be friends with the endomorphic child. Richardson et al. (1961) showed ten- and eleven-year old children six line drawings and asked them to rank order the figures in terms of likeability. The figures depicted a physically normal child; a child with crutches and a brace on the left leg; a child sitting in a wheelchair with a blanket covering both legs; a child with the left hand missing; a child with a facial disfigurement on the left side of the mouth, and an obese child. The subjects overwhelmingly ordered the obese child as the least likeable. This study is considered a landmark in the study of attitudes toward obesity and has been replicated numerous times. The overwhelming majority of the replications have maintained this preference order (Allon 1982).<sup>23</sup>

In another landmark study on this issue, Staffieri (1967) asked six- to ten-year-old boys to assign each of 39 adjectives to one of three silhouette drawings depicting an extremely thin, muscular and fat body shape. Almost all of the adjectives assigned to the obese silhouette were derogatory: sloppy, lazy, dirty, stupid, ugly, cheats, lies. The obese body shape was also least frequently described as "best friend" and most frequently described as "gets teased." Girls in that age group also exhibit negative attitudes toward overweight children. Caskey and Felker (1971) found that girls in the first through fifth grades attributed favorable characteristics to an extremely thin silhouette, describing this image as honest, happy, pretty, smart, kind and helpful. In contrast, they rated the fat silhouette as lazy, lonely, sloppy, ugly, mean, dirty and stupid.

British researchers studying children's attitudes to obesity have reported similar findings. Wardle, Volz, and Golding (1995) asked four- to eleven-year-old children to attribute characteristics to six outline

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<sup>23</sup> See also Maddox, Back, and Liederman (1968).

sketches representing a range of body shapes from very thin to very fat. The authors found the children displayed a strong tendency to attribute many negative characteristics to the fat pictures, such as ugly, lazy, selfish, stupid, lies, has few friends, gets teased. In another study, when nine-year-old children were shown silhouettes of thin and overweight males and females, they rated the overweight figures as having significantly fewer friends, being less well liked by their parents, being less content with their appearance and wanting to be thinner (Hill and Silver 1995).

Children not only demonstrate a blatant dislike of obesity, but they also victimize fat people—children and adults alike. Obese adults who were obese as children report having been tormented by their peers (Fuller and Groce 1991; Joanisse and Synnott 1999; Loewy 1998; Millman 1980). Abuse of fat children varies from calling them unflattering names, ostracizing them, and throwing food and other objects at them (Fuller and Groce, 1991; Gimlin 2002; Joanisse and Synnott 1999; Loewy 1998; Neumark-Sztainer, Story, and Faibisch 1998).

Obese adults also report being harassed by children in private homes and public places (Breseman et al. 1999; English 1993; Millman 1980; Myers and Rosen 1999). As one respondent in English's (1993) study recounts:

I dread going to dinner at a home where small children are present...they can say some very embarrassing things. I remember going to dinner at the home of a woman from work, and she had a four-year-old child. The child took one look at me and said, "Mommy, this lady is so fat she's going to eat all our nice dinner and there won't be any for you and I." (P. 230)

A respondent in Millman's (1980:9) study described an encounter in a supermarket where a four-year-old child repeatedly circled her screaming, "You are fat. You are fat. You are fat."

Adolescents also demonstrate an aversion to fat children. Matthews and Westie (1966) presented high school students with a set of pictures similar to the line drawings used in the Richardson et al. (1961) study, and asked them to rank order the pictures in terms of preference. The students were also asked to rate the children on a specially developed social distance scale. The authors found that the students preferred to be at a greater social distance from an obese child than from handicapped children.

Teenagers do not only display antipathy toward fat children, the literature also shows they do not want to date, or even associate with, overweight peers. The fat adolescent girls in Neumark-Sztainer et al.'s (1998) study reported experiencing numerous hurtful incidents at the hands of their schoolmates. Some of Millman's (1980) subjects described experiences of loneliness during their teenage years and difficulty in forming friendships. They attributed this outcome to being shunned by peers and to their own self-consciousness about their overweight condition. All of the college-age women in Fuller and Groce's (1991) study reported experiencing frequent periods of loneliness during adolescence, and they too attribute this outcome to their weight. The college-aged female subjects in Tiggemann and Rothblum's (1988) study reported that their weight interfered with their social activities.

Adolescents not only shun fat teenagers, but they bully them as well. Significant percentages of the obese men and women participating in Rothblum et al.'s (1989) survey reported incidents of school victimization in their junior high school, high school and college years. As Loewy (1998) observes:

Fat children should be admired because being fat in our society takes tremendous strength. For fat children to face teasing, rejection and discrimination on a daily basis and still thrive takes great strength of character. It is amazing that many fat children survive adolescence, given the hatred and meanness directed at them. (P. 20)

Numerous studies have found that adults also hold negative attitudes towards fat people, especially fat women. Some of the findings are that fat men and women are lazier, more self-indulgent, less intelligent, less happy, less self-confident, less self-disciplined, and less attractive than thin people are (DeJong and Kleck 1986; Harris, Walters, and Washull 1991; Tiggemann and Rothblum 1988). The stereotype of an overweight woman tends to be significantly more negative than that of an overweight man (Harris et al. 1991; Tiggemann and Rothblum 1988).

Obese people report being frequently accosted by strangers on a regular, sometimes daily, basis. These incidents range from ostentatious stares, derisive laughter, and name calling (Bovey 1994; Gimlin 2002; Louderback 1970; Millman 1980; Myers and Rosen 1999; Neumark-Sztainer et al. 1998; Poulton 1996). The privacy of fat people is often invaded by sometimes well-meaning friends or strangers who offer unsolicited weight loss advice (Louderback 1970; Neumark-Sztainer et al. 1998).

In some instances, however, the encounters can be even more intrusive and sometimes violent. For instance, a female respondent in our study (Joanisse and Synnott 1999) reported having items removed from shopping carts by strangers in grocery stores on the grounds that they were "too fattening." Slightly over one quarter of the very obese men and 16 percent of the very obese women in Rothblum et al.'s (1989) sample reported having been punched, hit, beaten or threatened with violence on account of their weight. Fourteen percent of the very obese men in the sample and 17 percent of the very obese women reported they had objects thrown at them. Seven percent of the very obese women in the sample reported they had been sexually assaulted because of their weight. The respondents in Myers and Rosen's (1999) study also reported having been assaulted on account of their weight.

#### **STIGMATIZATION AND REJECTION BY FAMILY MEMBERS**

It must be emphasized that the home does not necessarily offer respite from anti-fat hostility; in fact, Millman (1980) notes that the family setting is the first place fat people become aware of their deviance. Obese subjects have reported they have suffered torment at the hands of their family members (Gimlin 2002; Joanisse and Synnott 1999; Millman 1980; Neumark-Sztainer et al. 1998; Rothblum et al. 1990; Stake and Lauer 1987). The women in Millman's (1980) study and in Gimlin's (2002) study reported being harassed by their mothers and sisters, in particular, about their weight. However, fathers of overweight children are often not neutral about their children's overweight status. For instance, many of the women who participated in Hesse-Biber's (1996) study indicated their fathers pressured them constantly to lose weight. One of the female respondents in our study (Joanisse and Synnott 1999) reported having been told by her father as an adolescent that she was too ugly to be a good prostitute. A male respondent spoke of having endured years of verbal abuse from his father about his weight. Wooley, Wooley, and Dyrenforth (1980) report a finding they came upon inadvertently when they approached families in public settings for permission to photograph their children for research purposes. All of the parents of non-obese children readily acquiesced to the request; however, the parents of the obese children all refused to have their children photographed. In the cases when parents had both obese and non-obese children, only the non-obese children were allowed to be photographed. As Millman observes (1980:75),



“[t]o parents, a fat child is an embarrassment, being viewed by society as a poor reflection of the parents themselves. If obesity is an expression of something gone wrong with the child, there must be something wrong with the parents as well, and the way they treated the child.”

### STIGMATIZATION AND REJECTION IN INTERPERSONAL SITUATIONS

The literature shows that obese individuals, particularly white women, have a more difficult time arranging dates and establishing intimate relationships. While there is evidence that both sexes hold negative attitudes toward obese persons, men consistently display more reluctance to be romantically involved with an obese woman. These findings are most salient for white, college-educated males. For example, Vener, Krupka, and Gerard (1982) asked 600 college students to indicate who they would be least inclined to marry, choosing from a list of 15 variants which included an obese person. Obesity ranked as the fifth highest type their subjects would reject as a possible marriage partner. They preferred to marry an embezzler, cocaine user, marijuana user, shoplifter, former mental patient and other stigmatized persons, before they would marry an obese person. The researchers noted that the male participants expressed greater resistance to the possibility of marrying an obese person than did the females.

The young men surveyed in Sobal and Burszty'n's (1998) study indicated they would rather date a woman with anorexia nervosa or bulimia than an obese woman, although they recognized the strain involved in dating a person with an eating disorder. Sitton and Blanchard (1995) placed two personal advertisements in metropolitan newspapers. The text in the advertisement depicted either a woman recovering from a drug addiction or a woman who was 50 pounds overweight. Thirty men responded to the recovering addict, compared to eight for the obese woman. These studies suggest that men prefer to date or marry troubled women rather than becoming involved with a fat woman.

Sobal, Nicolopoulos, and Lee (1995) surveyed 786 high school students and found that only 12 percent of the students had dated someone who was overweight, with women (16 percent) more often dating overweight people than men (8 percent). The majority of the students believed that overweight people had difficulty in attracting dates, but men much more often than women stated that a partner being the “right weight” was very important. The white male college students in Harris et al's (1991) study were

more likely than females and black males to say that a date's weight mattered to them and to report they had refused to date an overweight woman.

Harris (1990) asked college students to complete a questionnaire on love and dating experiences after viewing a picture of a photograph of a male or a female ("Chris") who was either obese or of normal weight. The students were asked to respond to the questionnaire as they thought the stimulus person would. The obese Chris was perceived as less attractive, less likely to be dating, less erotic, and deserving of a fatter, uglier, romantic partner.

Similarly, Regan (1996) presented college students with information about an obese or normal-weight man ("Jim") or an obese or normal-weight woman ("Julie") and then asked them to evaluate that person along several dimensions related to sexuality. Participants believed that an obese man's sexual experiences would be very similar to those of a normal-weight man. However, the obese woman was viewed as less sexually attractive, warm, and responsive than a normal-weight woman.

Fat women themselves report difficulties in establishing and maintaining romantic relationships. A participant in Fuller and Groce's (1991:168) study reported that a boy speaking to his friends about her, told them he wouldn't go out with "that fat-ass." Millman's (1980) subjects complained that men were more likely to view them as asexual, good friends rather than as prospective sexual partners. Similarly, the subjects in Stake and Lauer's (1987) study also reported dating less often and having less date or mate satisfaction than their normal-weight peers. In their two-year longitudinal study of adolescent girls, Halpern et al. (1999) noted a negative association between body fat and dating activity—even when the girls were non-obese. Fat women tend to marry at later ages than their average-weight counterparts and one reason for this finding may be men's reluctance to view fat women as desirable marital partners (Gortmaker et al. 1993).<sup>24</sup>

Spouses of fat people are not necessarily accepting of them, however, as studies have shown excess weight can serve as a source of marital conflict. The married female participants in Millman's (1980) study reported negative comments from their husbands, with some threatening to divorce them if

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<sup>24</sup> See also Sobal (1984a).

they failed to lose weight. A similar trend was noted in our study (Joanisse and Synnott 1999), the exception being that the male respondents also indicated their wives had threatened them with divorce on account of their weight (and in some cases, did so). The women interviewed by Grogan and her colleagues (in Grogan 1999) reported that their husbands made derogatory remarks about their bodies after they had gained weight. These findings indicate that fat people can be stigmatized by their spouses who, despite their intimate involvement with them, apply normative sanctions against fatness.

### SOCIAL PREJUDICE AND DISCRIMINATION IN EDUCATION

Not only are obese people often considered to be unattractive, but they are also perceived as unintelligent (DeJong and Kleck 1986; Harris, Harris, and Bochner 1982). Laziness, of course, is another negative stereotype widely attributed to obese people. Since intelligence and self-discipline are two characteristics necessary for scholastic success, obese students may be seen as lacking these qualities and thus may experience discrimination in educational settings. For example, teachers rated obese children more negatively than average-weight children on characteristics such as attractiveness, energy level, leadership ability, self-esteem, and the ability to be socially outgoing (Loewy 1998). In a study of 599 educators, a picture of an average-weight teenage girl received higher ratings on scholarship, while a picture of an overweight girl was rated highest on risk for personal problems (Loewy 1998).

In their landmark study, Canning and Mayer (1966) found that obese high school students experience differential admission rates to elite colleges. The authors, after examining the scholastic records of more than 1,000 first-year students at two high-ranking colleges in New England, noted that obesity was not prevalent among the student population, particularly among females. Canning and Mayer were able to discern this trend since information regarding height and weight was provided in the students' files. The authors then examined the records of over 1,000 high school students in a middle-class community near the colleges and divided them into obese and non-obese categories. The two groups did not differ significantly in terms of IQ, PSAT, and SAT scores; academic qualifications; absenteeism rates; enrolment in extracurricular activities, and application rates to colleges. The application form did not query an

applicant's weight status, but a personal interview with the institutions' admissions officials was required. Canning and Mayer conclude the lower acceptance rate of obese students could be explained by bias on the part of college admission officials.

Pargman (1969) scrutinized the health records of over 2,000 undergraduate students enrolled at a large, private university in the northeastern United States. He too noted that less than 3 percent of his sample was obese, although the national rate of obesity was 13 percent at the time of his study. A personal interview was not a required feature of the university's admissions process, so Pargman speculates that obese students may receive unenthusiastic letters of reference written by teachers who harbor prejudice against obese people.

Obese students are not only discriminated against at the undergraduate level but are also expected to be less successful in graduate school than their thinner colleagues (Benson et al. 1980). Benson et al. mailed identical cover letters and résumés to 70 health administrators. The letter, ostensibly written by a female college student in her junior year, inquired about assessment of acceptance into graduate school and the chances of finding employment in this field. Enclosed with these were either a photograph of an overweight woman or a normal-weight woman. The researchers noted that the subjects who received a photograph of the overweight applicant were less likely to respond to the inquiry. Those that did reply were pessimistic both about the applicant's chances of admission into graduate school and of finding employment in health administration.

Crandall (1991), in an attempt to explain the paucity of obese students in prestigious educational institutions, hypothesized that parents of overweight children—girls in particular—may be less inclined to invest in their post-secondary education. He distributed questionnaires to undergraduate students at the University of Michigan and the University of Florida. The questionnaires asked for information regarding gender, age, height, weight, parents' education level and socioeconomic status, and the students' source of financial support. The responses revealed that fat college students are substantially less likely to receive financial assistance from their parents, regardless of the parents' educational level and socioeconomic status, race, and number of children. This finding was particularly significant for females. In a follow-up

study, Crandall (1995) found that reluctance to pay for an overweight daughter's education is a matter of parental choice, not financial ability.

Some American colleges also consider obesity as a valid reason for expulsion. In 1985, Salve Regina College in Newport, Rhode Island expelled nursing student Sharon Russell on the grounds that she was morbidly obese and therefore unsuitable to the nursing school's image. The college admitted Russell into their nursing program knowing that she was obese but then started pressuring her to lose weight. Russell was forced to sign a contract requiring her to lose at least two pounds a week and to report for weekly "weigh-ins." Russell maintained a high grade point average and earned high praise from her supervisor who described her as "a professional with good attendance and performance, and as someone he would be happy to hire" (Breseman et al. 1999:178). Despite these achievements, however, she was dismissed from the school when she failed to lose weight (Breseman et al. 1999; *NAAFA Newsletter* 1989).

Salve Regina College is not the only educational institution to barter education for adherence to normative weight standards. In 1977, the administration at Oral Roberts University in Tulsa, Oklahoma instituted the Pounds Off Program, whereby overweight students were placed on compulsory diets. The students who could not or would not adhere to this stipulation were expelled. The program was later extended to non-tenured faculty members who were threatened with termination if they did not lose the prescribed amount of weight. The university later rescinded the Pounds Off Program when it was threatened with loss of federal funding (*NAAFA Newsletter* 1977; *NAAFA Newsletter* 1978).

### **SOCIAL PREJUDICE AND DISCRIMINATION IN EMPLOYMENT**

One of the most ramifying discriminations that obese people face is in the employment sector. Until recently, many jobs had upper-limit weight regulations, even in professions where size and weight are not directly related to satisfactory job performance. In order to work for the cities of Los Angeles, New York and Baltimore in any capacity, an individual had to agree to having an upper weight limit written into his or her contract. These guidelines were applicable to teaching and nursing positions, as well as those of police officers and firefighters (Allon 1982). Teachers who were fired for breaching those weight

guidelines lost their cases in court when they tried to argue that weight is unrelated to effectively transmitting knowledge or maintaining discipline in a classroom (Allon 1982; Louderback 1970).

The airline industry has traditionally enforced narrow height and weight guidelines to which female, but not male, flight attendants were expected to conform if they wanted to be hired and retain their jobs (Lynch 1996). After the negative publicity generated by high-profile lawsuits, airline companies have apparently relaxed these guidelines somewhat in recent years (Lynch 1996). However, according to Breseman et al. (1999), few obese flight attendants are hired, and those recruits who gain weight are threatened with dismissal if they fail to lose weight.

Medical reasons are often cited as justification of the imposition of weight guidelines, even when weight does not interfere with the execution of the appointed tasks (Allon 1982; Lynch 1996; Rothblum et al. 1990). Employers in the private sector may not have official weight requirements written into job descriptions, but overweight candidates are often rejected on the grounds that the potential employer's insurance company will not cover them (Allon 1982). Even when fat people are hired, they may still be denied benefits such as health and life insurance (Rothblum et al. 1990).

Alleged medical concerns aside, there may be more insidious reasons for the reluctance to hire obese employees. Rodin (1992) notes that success in most occupations depends on an individual's appearance as much as his or her abilities. For example, Ross and Ferris (1981) studied accountants and found that the likelihood of becoming a partner in the firm depended more on an individual's attractiveness than the prestige of the graduate school he or she had attended or even if the individual held a graduate degree. Since obesity is considered so unappealing and is associated with many negative traits, it is somewhat predictable that researchers have detected a prevailing stereotype that overweight employees are less desirable, even if they possess the same skills as their thin counterparts.

Shakespeare's Julius Caesar may not have trusted "lean and hungry" men, but such men—and women—in today's corporate world personify ambition and discipline, and its attendant reward, success. A fat person, on the other hand, is often perceived to embody laziness, lack of ambition and discipline and thus would be detrimental to a company's image. Larkin and Pines (1979) asked undergraduate college students about their perceptions of the employability of obese people. The majority of their respondents

indicated that they believed overweight individuals are an impediment to an employer on the grounds that they are lazy, incompetent, indecisive, unproductive and unsuccessful. These opinions were maintained even after the students viewed a video which demonstrated no difference in the competence of the normal-weight and overweight candidates as they completed physical and mental tasks in a simulated work setting.

Rothblum, Miller, and Garbutt (1988) asked college students to rate résumés of female job applicants for two different jobs, a sales position or a position involving “working with people.” The résumés included either a picture of an obese or normal-weight woman, or a written description of an obese or normal-weight woman. When subjects received written descriptions of the women, the obese woman was evaluated significantly more negatively on supervisory potential, self-discipline, professional appearance, personal hygiene and ability to perform a physically demanding job, particularly if the application was for a sales position. Similarly, Pingitore et al. (1994) conducted a mock employment interview study in which the “applicants” were either normal-weight and moderately obese women. The researchers found that bias existed for the obese women to a considerably greater extent than for the normal-weight women.

College students have also indicated an aversion to the possibility of working with an obese colleague. In a study conducted by Jasper and Klassen (1990a) undergraduate students read a description of a fictitious employee in a personnel file. Among other questions, students were asked to indicate how much they would like to work with the person. The students who had read about an obese person indicated greater reluctance to work with that person, in comparison to the students who had read the description of a non-obese person. In a related study, Jasper and Klassen (1990b) reported that subjects described potential obese co-workers as sloppy, messy, lazy, unambitious, unhealthy and insecure.

The prejudice displayed by college students appears to translate into discrimination in actual employment contexts. Roe and Eickwort (1976) surveyed 81 employers from a variety of sectors about their willingness to hire obese women. Sixteen percent of their respondents reported an unwillingness to hire obese women under any circumstances and an additional 44 percent would not hire them under certain circumstances. They also indicated a preference for hiring an active alcoholic over a fat person.

Even when fat people are hired, they may still experience differential treatment. Rothblum et al. (1990) mailed questionnaires to members of a fat rights lobby group asking them about any job-related discrimination they may have experienced. The 500 questionnaires which were returned indicated a strong relationship between respondent weight and the experience of discrimination. Over 40 percent of the men and 60 percent of the women stated that they had not been hired for a job because of their weight. Over 30 percent indicated that they had been denied promotions or raises. Nearly all had been urged to lose weight. The heavier the respondent, the more likely he or she was to have encountered size-related discrimination in the work force.

Whether or not obesity adversely affects income, however, is unclear, especially for men. In early 1974, a study conducted by the Robert Half Association (a prominent personnel agency specializing in the placement of accountants) was published in *The New York Times* ("Pay of Fat Executives is Found Leaner"). Half chose 1,000 files at random from each of his branch offices in 15 American cities. The files contained information such as the executive's weight, salary, and employment record. After comparing his clients' weights to standardized weight tables, Half calculated that fewer than 10 percent of those in the highest income bracket were more than 10 pounds overweight. Half estimated that the overweight executives were penalized \$1,000 in salary for each excess pound. The employment records indicated that they were also less likely to be promoted. Half maintained that his agency frequently received requests for executives "on the thinner side." Frieze, Olson, and Good (1990) examined salary data provided by over 1,000 male and female business school graduates and noted a strong relationship between weight, height and income. The subjects who were at least 20 percent overweight earned \$4,000 less per year than their thinner colleagues. Being short and overweight compounded the problem: A short, fat man could expect to earn \$8,200 less per year than a tall, thin man.

Contrary to these findings, however, some researchers have noted the opposite effect: Obesity can actually serve as a bonus for men. McLean and Moon (1980) investigated the possibility of obesity acting as a wage depressant among mature men (aged between 51 and 65) in both blue and white-collar occupations. In both sectors, the men's salaries increased slightly as their weight increased. McLean and Moon suggest that large stature in mature men may be equated with power and authority. When Register



and Williams (1990) studied the possible negative consequences on young people's earnings, the obese men in the sample out-earned their non-obese counterparts. One possible reason for this finding is that the obese males in the sample had significantly more experience than the non-obese males and were more likely to be employed in capital-intensive industries.

Overweight women, however, appear to suffer economic penalties. For example, Register and Williams (1990) noted a 12 percent wage differential between young obese women and their normal-weight colleagues. In their longitudinal survey, Gortmaker et al. (1993) noted that the annual incomes of twenty-three-year-old obese women were \$6,710 less than their thin cohort. No statistically significant relationship between obesity and income was found among the men.

The same trend appears to exist in Britain. In their longitudinal survey of 12,537 men and women, Sargent and Blanchflower (1994) also noted an inverse relationship between obesity at 16 years of age and earnings at age 23 for females. The women who had been overweight at the age of 16 earned between 7.4 to 11.4 percent less than their average-weight cohort, even when parental social class and IQ were controlled. Interestingly, the inverse relationship between obesity at 16 years of age remained as strong, even if the woman had lost weight by the age of 23. However, there was no relationship between obesity and earnings in males.

The respondents in Rothblum et al.'s (1990) study who were very obese tended to be employed in low-prestige jobs, but none reported any suspicion of receiving lower salaries than their co-workers. However, their respondents were all recruited from a fat rights activist group, so they may be more likely to protest if they suspected they were earning less than an average-weight colleague.<sup>25</sup>

As Breseman et al. (1999:177-78) note: "[I]n summary, it is clear obese people are treated differently in actual and hypothetical employment situations and, relative to thinner people, have fewer chances to take advantages of opportunities for which they are equally qualified." It may also be safely concluded that obese women are discriminated against to a greater extent than obese men.

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<sup>25</sup> Gimlin (2002) noted that the NAAFA women she interviewed tended to be either unemployed or underemployed, given their education and skills.

### Legal Issues Concerning Employment-Related Size Discrimination

Weight is not a protected category in civil rights legislation in either Canada or the United States. In Canada, the obese do not constitute a recognized group according to the 1982 Canadian Charter of Rights and Freedoms. Thus, an obese Canadian who suspects he or she has been discriminated against has few avenues of legal redress. The option is to claim discrimination on the basis of a handicap. The same situation exists for residents of the province of Quebec, where the Quebec Charter of Human Rights and Freedoms is in effect.

In the United States, Michigan is the only state that specifically prohibits size discrimination and this legal protection is provided only in the area of employment (Breseman et al. 1999). Obese people who want to sue for discrimination are forced to resort to the 1973 Rehabilitation Act or the 1990 American Disabilities Act (ADA), which protect Americans from discrimination due to actual or perceived handicap.

However, the courts do not consistently view morbid obesity as a handicap that merits legal protection, as three highly publicized cases in the US attest. In *Gimello v. Agency Rent-A-Car Systems Inc.* (1991), the court agreed Joseph Gimello was the victim of discrimination on the basis of a handicap when he was fired from his job as an office manager. Gimello, who was 5 feet 8 inches and weighed 270 pounds, had received bonuses, commendations, and letters of praise from superiors who had never met him in person. When Gimello applied for a promotion and had a face-to-face meeting with his superiors, they allegedly called him a "fat slob" who, if promoted, would hire other "fat slob." Gimello was subsequently fired from his position because of his weight. After a protracted legal battle, a judge agreed Gimello's obesity was a handicap and that he had been discriminated against because of it. She ordered Agency Rent-A-Car to pay Gimello six years of back pay, \$10,000 in punitive damages and \$2,876 to cover expenses incurred in seeking new employment (Breseman et al. 1999; Carter 1989).

In *Cook v. Rhode Island* (1993), Bonnie Cook who was 5 feet 2 inches tall and weighed 320 pounds, re-applied for a job as an institutional attendant at a hospital for the mentally disabled. Cook had previously held the same position and had an unblemished work record. She had also passed the required pre-employment medical exam. However, the hospital rejected her application on the grounds that her size would impede her ability to evacuate patients safely in the event of an emergency. The hospital also

expressed concern that Cook's morbid obesity put her at risk of developing serious illnesses which could then lead to frequent absences and to worker's compensations claims. Cook filed a lawsuit claiming perceived disability, and the court found in her favor (Breseman et al. 1999; Lynch 1996).

However, the outcome of the case involving *Cassista v. Community Foods Inc.* (1993), was different. The plaintiff, Toni Linda Cassista, was 5 feet 4 inches and weighed 305 pounds. Cassista claimed that Community Foods Inc., a health food collective, in its refusal to hire her for various positions involving manual labor, cited concern that her weight would impede her ability to meet the job requirements. Cassista maintained she had proved she was in good health and that she could perform the duties required of her and subsequently filed suit in the California State Court. Cassista alleged she was denied employment because Community Foods considered her weight a physical disability. The jury returned a verdict in favor of Community Foods, but the California Court of Appeals reversed the trial court's decision. The Supreme Court of California eventually reviewed the case but unanimously ruled against Cassista, determining that she had failed to prove her weight was the consequence of a physiological disorder and therefore did not qualify for definition as a handicap (Breseman et al. 1999; Lynch 1996; Poulton 1996). According to legal scholar Dennis Lynch (1996:221), the decision of the California Supreme Court in *Cassista v. Community Foods, Inc.* "seems to reflect the majority view of the courts in the area of obesity as a handicap."

An example of similar reasoning in Canada is the case of a thirty-one-year-old Saskatchewan woman. In 1989, Sandra Davison, who was 5 feet 4 inches and weighed 280 pounds, was refused employment as an aide in a nursing home due to her weight, although she was qualified for the job. Prior to being laid off as a result of government cutbacks, Davison had worked for seven years previously at the same job and her weight did not impede her performance. She became embroiled in a four-year battle with the nursing home but ultimately lost her case when the Saskatchewan courts ruled that since her weight was not a disability caused by an illness, she had no grounds for complaint (Kelman 1993; Poulton 1996:136-137).

Weight-related lawsuits are not numerous in either Canada or the United States. This may be explained by the onerous burden of proof of obesity as a handicap that impairs daily functioning, added to

the fact that many fat people do not consider themselves handicapped (Allon 1982; Poulton 1996). Allon (1979, 1982) further points out that many severely obese individuals may not consider themselves handicapped, but have internalized others' feelings of disdain towards them and accept their discriminatory treatment as appropriate and just. Therefore, in the event of employment discrimination, they may not be inclined to seek legal restitution.

### **SOCIAL PREJUDICE AND DISCRIMINATION IN MEDICAL CARE**

Obesity is an extremely medicalized condition in North America, and therefore various health care professionals are often consulted by overweight persons for assistance in treating their condition. Although the ethos of medical treatment rests on neutrality and objectivity, research conducted on the attitudes of health care practitioners indicates that they too share the cultural aversion to fat people. Hilde Bruch (1957:318), a psychiatrist and eating disorders pioneer, has even stated that “[m]any contemporary American physicians, even those who specialize in the treatment of obesity, consider their fat patients a somewhat lower type of humanity.” Empirical research supports this observation. Physicians in various specialties surveyed by Maddox and Liederman (1969) overwhelmingly described their fat patients as weak-willed, ugly, and awkward. When Adams et al. (1993) surveyed gynecologists to determine their feelings about performing pelvic examinations on obese women, they noted a negative correlation between a patient’s weight and the physician’s willingness to perform this procedure. Adams et al. suggest that one out of six physicians is reluctant to carry out pelvic examinations on obese women.

Obese people have complained to researchers about the victimization they have suffered at the hands of their physicians. The subjects in Rand and MacGregor’s (1991) study reported disrespectful remarks from their doctors such as “How many chairs did you break in my waiting room?” The participants in Rothblum et al.’s (1990) study revealed that they were verbally abused by their doctors, with one woman reporting that she was advised by her doctor to take a gun and shoot herself. Our research supports these findings (Joanisse and Synnott 1999). One of our participants was called a “lump of fat” by her gynecologist. Another young woman was warned by her male doctor that fatness in women was not attractive to men. Almost all of the male participants reported having been openly referred to as fat slobs

by their doctors. When one man protested this treatment and tried to invoke the doctor's Hippocratic oath, the doctor informed him that he did not have to like him in order to treat him and abruptly ushered him out of his office. Canadian author, journalist and fat rights activist, Terry Poulton, describes a humiliating pelvic examination during which her gynecologist treated her roughly and complained about having to examine her "through all this upholstery" (Poulton 1994:96).

A particularly egregious example of the gross insensitivity that can be displayed by some doctors towards their obese patients is recounted by Packer (1994), who interviewed 118 women who were more than 30 percent overweight. One of the women told her that when she was brought to a hospital for semen samples after having been raped, the attending doctor chastised her for her overweight condition.

Patients also complain that doctors routinely rebuke them about their weight even when the consultation is not weight related (Burgard and Lyons 1994; Joannisse and Synnott 1999; Poulton 1996). One of the women interviewed by Burgard and Lyons (1994) related an incident whereby she was scolded about being overweight by her doctor when she went to pick up her glasses.

Not surprisingly, medical students also express negative attitudes toward obese patients. Breyspraak et al. (1977) presented medical students with either an audiotape or a videotape of an obese or average-weight female patient who was complaining to her doctor that she was feeling ill and was also experiencing irritability and nervousness. The same woman appeared in both the videotapes. She disguised herself as obese with the aid of padding and special make-up. The medical students who watched the video of the "obese" woman rated her more negatively on 10 out of 14 adjectives, in comparison to the students who watched the non-obese videotape or heard the audiotape. For example, she was considered more nervous, depressed and emotional, incompetent, insincere, not straightforward and not likeable.

Blumberg and Mellis (1985) surveyed medical students at the beginning of their clerkship in psychiatry and asked them to rate non-obese, moderately obese and morbidly obese patients. The students rated the moderately obese patients as more ugly, awkward, sad, unsuccessful, difficult to manage and lacking in self-control than they did the non-obese patients. Morbidly obese patients fared even worse: they were rated as more unpleasant, worthless, bad, and awful than the moderately obese. The students were surveyed again when they had completed their clerkship in psychiatry and their responses indicated

they retained their extremely negative attitudes toward obese patients. Those medical students who had contact with morbidly obese patients during their two-month clerkship did not report a change in their attitudes towards them.

Other studies on nurses reveal similar findings. Nurses in both Canada and the United States report feelings of revulsion toward their obese patients and a reluctance to care for them (Bagley et al. 1989; Maroney and Golub 1992). The prevailing attitudes in Maroney and Golub's (1992) study held that obesity can be prevented by sufficient self-control, hospitalized obese adults should be on diets, and providing care for obese patients is exhausting. Nearly two-thirds of school nurses in Price et al.'s (1987) study labeled obese children as lazy and sad.

Obese individuals may also turn to mental health practitioners such as counselors and therapists in order to cope with the social rejection that often accompanies obesity. However, as Young and Powell (1985) have discovered, mental health professionals also subscribe to the widely prevailing negative stereotypes regarding the obese. These authors found that mental health workers are more likely to assign psychopathological symptoms to their obese patients and that their clinical judgement is affected by their client's overweight status. Agell and Rothblum (1991), in their study of psychotherapists' attitudes towards their obese patients, found that they are negatively influenced by a patient's weight to some extent.

Nutritionists specializing in weight-loss programs were surveyed by Maiman et al. (1979) about their attitudes toward obesity and beliefs about its etiology. Seventy-five percent of the sample believed that obese people are self-indulgent, that they eat as compensation for disappointments, and that they suffer from family and emotional problems. It should be noted that only 13 percent of the sample reported having received any specialized training in the treatment of obesity.

In a study of registered dietitians and dietetics students, both groups were found to hold slightly negative attitudes toward obesity, with those who reported lower body weights being slightly more negative than those whose weights were higher (Oberrieder et al. 1995). The 439 registered dietitians who participated in a study conducted by McArthur and Ross (1997) indicated they hold ambivalent attitudes toward their overweight clients. They were also inclined to believe overweight was a consequence of emotional problems.

## OTHER TYPES OF SOCIAL AND PHYSICAL DISCRIMINATION

*Social Discrimination in Housing.* Karris (1977) found that some landlords in Portland, Maine prefer not to have obese male tenants, even if they themselves are obese. A small percentage of the very obese respondents in Rothblum et al.'s (1989) survey on size-related discrimination reported they had been denied the rental or purchase of a dwelling on account of their weight. The reasons commonly cited by landlords were fears that a very fat tenant would break furniture or toilets. One landlord expressed concern that the floors in his apartment would collapse under the weight of an obese tenant.

*Physical Discrimination in Public Transportation and Seating Facilities.* Traveling on public transportation can be an arduous experience for the morbidly obese. The formed plastic seats on mass transportation systems such as buses and subways are flimsy and uncomfortable (Allon 1982). Theater and stadium seating is typically narrow, since it is designed to accommodate as many spectators as possible. Booth seating in fast food restaurants can prove awkward, as can turnstile-restricted access (Allon 1982; Rand and MacGregor 1990). Seatbelts in some car models are often too short to accommodate the girth of the morbidly obese, although seatbelt extendors are available. Morbidly obese airline passengers often require two airplane seats as a result of their size.

*Social Discrimination by Clothing Retailers and Fashion Designers.* Obtaining well-cut, fashionable clothing in large or extra-large sizes is virtually impossible (Allon 1982). Although specialty clothing stores catering to the "plus-sized" exist, these are few in number and the clothing is expensive (Breseman et al. 1999). Designer clothing is rarely available in sizes larger than 12. The paucity of stores catering to obese women is puzzling considering that "approximately 31 percent of all American women nationwide are size 16 or larger...Furthermore, at least 45 percent of such women are 24 to 35 years old, making them the most powerful clothes-purchasing segment of the U.S. population" (Breseman et al. 1999:180-181). According to Daria (cited in Breseman et al. 1999:181), popular American designers such as Calvin Klein, Ralph Lauren, Donna Karan and Anne Klein are reluctant to design clothing for large women because it apparently would be an affront for a slender woman "who supposedly works hard to maintain a good figure" to be confronted by an obese woman wearing the same outfit.

It also appears that fat women's purchasing power is not highly regarded, as Pauley (1988) noted in her study of salespersons' response time toward obese and non-obese customers. The overweight customers had to wait longer for service than did the non-obese customers. Obese women have also complained of snide treatment by female sales clerks (Allon 1982; English 1993).

### **REPRESENTATION (OR LACK OF) THE OBESE IN THE MEDIA**

Over half of the American population may be overweight, but this figure is not represented in American television shows, particularly in the case of women. In their content analysis of the 30 most popular American television shows of the 1970s, Wooley and Wooley (1979) noted only one appearance of an overweight woman in 131 continuing characters, and two single appearances. Wooley and Wooley also found that heavier women were more likely to portray characters with low-status roles, such as servants or housewives.

Thirty years later, little has changed. Thompson and Heinberg (1999) estimate that fewer than 10 percent of female television characters are overweight, and it would appear that even this low percentage might be optimistic. Silverstein et al. (1986) examined the body size of characters on the most popular television shows in the mid-1980s and found that 69 percent of female characters received the thinnest possible ratings, while only 5 percent of the female characters were rated as heavy. In Fouts and Burggraf's (2000) content analysis of 18 situation comedies, the researchers found that 76 percent of the female characters were underweight, with 19 percent and 5 percent being average and above-average weight, respectively.

Not only are overweight people under-represented in the mass media, they are also blatantly ridiculed on a regular basis (Allon 1982; Bovey 1994; Goodman 1995; Poulton 1996). For example, comedians frequently parody fat celebrities such as Oprah Winfrey, Luciano Pavarotti, Rita MacNeil, Elizabeth Taylor and Bill Clinton in their routines. In fact, almost all popular television comedians, e.g., David Letterman, Jay Leno, Joan Rivers, and the troupe of Saturday Night Live and the Royal Canadian Air Farce rely on fat jokes as fodder for their acts.



Fouts and Burggraf (2000) also noted that 14 percent of the central female characters featured in situation comedies received negative comments from male characters about their weight or bodies. Furthermore, there was a strong positive correlation between a female character's weight and the frequency of negative comments she received from male characters. Negative comments were also significantly associated with audience reactions; that is, 90 percent of negative comments were followed by audience reactions such as laughter, murmurs, and giggles. The greater the number of derogatory comments the character received, the more frequent were the audience reactions. While the popular mid-1990s situation comedy, *Roseanne*, featured a strong-minded fat woman surrounded by loving family and friends, the actress and the character she played were frequently criticized as a loud, oafish shrew by critics and television personalities.<sup>26</sup> Large women are negatively portrayed in drama shows as well (Kilbourne 1994).

Fat people are the butt of jokes in the print media as well. The long-running comic strips "Beetle Bailey," "B.C.," and "The Wizard of Id" routinely demean fat people, particularly fat women (Goodman 1995; Poulton 1996). The bodies of female federal politicians such as Kim Campbell and Suzanne Tremblay have been caricatured by Canadian newspaper cartoonists. Overweight people are also consistently described in derogatory terms such as "blimps," "porky," and "tubby" in headlines, articles and editorials (Goodman 1995:64).

The content of women's magazines may not often be so blatantly fatphobic, yet they subtly denigrate overweight women by excluding them from their articles, features and advertising. These magazines relentlessly propound the salience of attractiveness for women and then present the attractive woman as the one who is thin (Rothblum 1994). In a comprehensive review of the models featured in women's magazine advertising between 1950 and 1984, Gagnard (1986) found that thin models were featured as the most attractive and successful of all body types. Silverstein, Peterson, and Purdue (1986) note models and popular actresses featured in the magazines *Ladies Home Journal* and *Vogue* have steadily gotten thinner, particularly since the 1950s. Guillen and Barr (1994) noted the same trend in *Seventeen* magazine, known as the "best friend" of high school girls in the United States.

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<sup>26</sup> Roseanne has since had bariatric and cosmetic surgery.

Even educational materials are propounding a slender ideal for young women. A study of illustrations of boys and girls in third-grade textbooks showed that in each decade since 1900 and 1980, depictions of girls became thinner (Davis and Oswalt 1992). There was no significant trend for the depiction of boys.

### **FAT AS A WOMAN'S PROBLEM**

Obesity may be a stigmatizing condition for both men and women, but empirical data clearly indicate that fat women are penalized to a much greater extent than are fat men. In *Such a Pretty Face*, Millman's (1980) benchmark study on American women's personal experiences of fatness, she notes:

And it is especially the case that an overweight woman is assumed to have a personal problem. She is stereotypically viewed as unfeminine, in flight from sexuality, antisocial, out of control, hostile, aggressive....In the case of women, being fat is considered such an obvious default or rebellion against being feminine that it is treated as a very significant, representative, and threatening characteristic of the individual....the overweight individual, especially if she is a woman, probably suffers more from the social and psychological stigma attached to obesity than she does from the actual physical condition. (P. xi)

Why are fat women more persecuted than fat men for an identical physical condition? Obesity is associated with a number of negative stereotypes such as laziness and self-indulgence, as well as ugliness. The latter is of more significance to women because the social desirability of women is still irrevocably paired with their appearance. More than a generation after the feminist movement, women are still expected to parley an aesthetically pleasing appearance for social, economic and marital rewards (Wolf 1991). As was pointed out in the previous chapter, female attractiveness in Western societies is equated with thinness. Fat women are clearly violating an established cultural norm and are punished for their transgression. While women are judged on their appearance rather than their accomplishments, the social worth of men depends more heavily on quantifiable criteria such as education, occupation, and financial worth (Rodin et al. 1984).

### **The Relationship Between Women's Weight and Social Mobility**

Men place greater emphasis on an attractive appearance in a partner to a greater extent than women do. Etkoff (1999:61) cites a study of 37 cultures which asked men and women about the

importance of attractiveness in a partner. In 34 of the cultures included in the study, men indicated they valued a pleasing appearance in a partner much more than women did. Women did not care more about the appearance of their partners than the men did in any of the cultures studied.

While women may not be particularly concerned about men's appearance, there is some evidence which indicates they are concerned about their financial status. Harrison and Saeed (1977) examined 800 advertisements placed in the "personals" columns of newspapers and magazines in the United States. They found that women were more likely to seek older, financially secure men. Men, on the other hand, sought younger women who were thin and attractive. Smith, Waldorf, and Trembath (1990) noted a similar pattern when they examined 564 personal ads placed by heterosexual men and women in a singles' magazine. The findings of content analyses of personals columns indicate women advertise their physical and sexual attractiveness and men advertise their financial and occupational attractiveness.<sup>27</sup>

Rothblum (1994:67) explains this trend by pointing out that women are socialized to regard men as material providers, while men are socialized to regard women as sexual providers. As a result, marriage in many cases may not be founded on romantic love but may involve barter between a woman's youth and beauty and a man's money and status. Social mobility for women has traditionally been achieved by marrying men from higher socioeconomic classes, and attractiveness in women definitely facilitates their entry into the higher echelons of the marriage market. Among working-class women, attractiveness is an important predictor of marrying higher-class men, while among middle-class women, education takes precedence over attractiveness (Elder 1969). A study by Udry and Eckland (1984) found that the most attractive girls in high school are more than 10 times as likely to get married to higher-status males as the least attractive. These researchers also noted that a man's appearance in high school—or at any age—is not a useful predictor of his likelihood to marry or the financial status of his future wife. Men's prestige depends to a greater extent on the attractiveness of their female partners than on their own physical attractiveness. Sigall and Landy (1973) found that when a man is paired with a beautiful woman, he elicits a favorable impression. When he is paired with an unattractive woman, however, he is viewed negatively.

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<sup>27</sup> See also Deaux and Hanna (1984).

The man's own appearance does not appear to be relevant. Sigall and Landy refer to the status one gains by association with an attractive woman as the "rub-off" effect. Bar-Tal and Saxe (cited in Bar-Tal and Saxe 1976) found that an unattractive male married to an attractive female garnered favorable ratings from subjects, while the ratings of an unattractive female were unaffected by her husband's appearance.

Empirical research indicates that attractive women tend to "marry up." Since thinness is a prerequisite for attractiveness in Western culture, it is not surprising to discover that thin women marry up as well. In a study of 1,017 husband-wife pairs Garn et al. (1989a), noted that men with high educational attainment were married to "lean" women. In another study, Garn et al. (1989b) also found that the spouses of men with high incomes tend to be thin. Other researchers have noted this trend. For instance, the white underweight women (BMI <19) in Averett and Korenmen's (1999) large-scale, longitudinal survey were married to men who had the highest annual incomes, in contrast to the spouses of women in the study who were average weight, overweight and obese. Sobal and Stunkard (1989), who reviewed 144 studies of the relationship between socioeconomic status and weight, found a strong inverse correlation between a woman's weight and her social and economic status in virtually all industrialized countries. In contrast, the relationship is equally as strong in the *opposite* direction in developing countries.<sup>28</sup> In developed countries, the relationship between status and weight is less consistent for men.

While female slenderness may be associated with upward mobility, female obesity, on the other hand, is associated with downward social mobility. In a classic study, known as the Midtown Manhattan Study, Moore, Stunkard, and Srole (1962) noted that obesity was seven times more frequent among women of the lower socioeconomic class. About 30 percent of women in the lowest socioeconomic category were obese, compared with 4 percent in the highest group. The same relationship did exist among men, but to a lesser extent. In a follow-up study conducted in 1965, the subjects' incomes were compared with those of their parents when the subjects were eight years old. The obese women in the sample were significantly

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<sup>28</sup> See "Cross-Cultural Comparisons" Section on page 44 for greater detail on the relationship between socioeconomic status and weight in non-industrialized countries.

likely to be downwardly mobile, while the upwardly mobile women were thin. Among men, the same relationships were noted, although these were less striking (Goldblatt et al. 1965).<sup>29</sup>

One reason why obese women may be downwardly mobile is their tendency to marry men with less education and lower incomes than themselves.<sup>30</sup> Numerous studies have consistently discerned an inverse linear relationship between women's obesity and the educational attainment and income of their husbands (Averett and Korenmen 1999; Garn et al. 1977; Garn et al. 1989a, 1989b; Garn and Ryan 1981; Rimm and Rimm 1974).

Recent large-scale studies illustrate the extent to which a woman's life chances can be greatly compromised by obesity. For example, Gortmaker et al. (1993) obtained information on the physical, social and economic characteristics of over 10,000 male and female adolescents who participated in a national survey in the United States. Seven years later, 80 percent of the respondents were contacted and asked the same questions. The female subjects who had been obese as adolescents had fewer years of educational attainment than their non-obese cohort, earned \$6,710 less, and were 10 percent more likely to have income below the poverty level. They were also less likely to have married. Of the obese women who were married, their spouses' earnings were one quarter lower than the spouses of women of average weight. This pattern prevailed regardless of the respondent's original socioeconomic status and was significantly more marked for women. It must be pointed out that these findings pertained particularly to white women; little difference in socioeconomic difference was found between obese African American women and those of normal weight. Another longitudinal survey carried out by Averett and Korenman (1999) replicated Gortman et al.'s results and suggest that lower probability of marriage and lower earnings of husbands among those obese women who do marry account for the income differences between obese white women and their thinner counterparts.

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<sup>29</sup> The nature of the relationship between obesity and class mobility is complex; it seems likely that being obese may contribute to downward mobility, and in turn, membership in a lower class contributes to continued high weight. See Sobal (1991) and Stunkard and Sorensen (1993). However, Rothblum (1992, 1994) argues that obesity is a determinant of low socioeconomic status in women. See page 43 for a detailed description of her rationale.

<sup>30</sup> White, college-educated men consistently demonstrate an aversion to the possibility of dating or marrying a fat woman (Harris 1994; Harris et al. 1991; Sobal and Bursztyjn 1998; Sobal et al. 1995). Presumably this distaste acts as a barrier to the upward mobility of overweight women.

Fatness not only decreases a woman's marriageability to a higher-status male, the literature has also demonstrated it functions as an impediment to her obtaining admission to a prestigious school and to a well-remunerating job. Rothblum challenges the conventional assumption that socioeconomic status functions as the independent variable in the relationship between weight and social mobility (Stunkard and Sorensen 1993). Rather, Rothblum contends obesity leads to poverty in women (1992, 1994).<sup>31</sup> She cites the evidence indicating the lower acceptance rate of obese women into prestigious colleges and the decreased likelihood of attaining the high-prestige, high-paying jobs commonly accorded to those who attend these institutions. When fat people are hired, they often do not receive promotions. Moreover, fat women are much more likely than thin women to marry men from a lower socioeconomic background. Since fatness has a tendency to be intergenerationally transmitted, the children of overweight mothers are more likely to remain in the lower socioeconomic brackets.<sup>32</sup>

#### Lesbians and Weight Standards

Although lesbians do not strive to make themselves desirable to men, there is evidence which suggests that they too are influenced by cultural pressures to be thin. According to Brand, Rothblum, and Solomon (1992), fictional lesbian heroines tend to be described as slim and diet ads are frequently featured in lesbian media. Fat lesbians also appear to experience discrimination by other lesbians. The lesbian respondent in Millman's (1980) study complained about not receiving attention in lesbian bars. As well, lesbian contributors to Schoenfelder and Wieser's (1983) anthology of women and fatness indicated that their partners were constantly threatening to terminate the relationship if they did not lose weight.

Brand et al. (1992) investigated weight, preoccupation with weight, dieting behavior and eating disorders among lesbians and gays and compared those variables to those of heterosexual women and men. Although they found lesbians and heterosexual men to be less preoccupied with their weight than were heterosexual women and gay men, the authors nevertheless concluded that "gender is a more salient factor than sexual orientation on most variables" (p. 253). Dworkin (1988) argues that all women, regardless of

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<sup>31</sup> See also Sargent and Blanchflower (1994).

<sup>32</sup> See also Sobal (1995a).

sexual orientation, are socialized to consider their appearance as a primary aspect of their lives and thus adhere to traditional standards for social acceptance.

### CROSS-CULTURAL COMPARISONS

Cross-cultural research about weight and preferred body shape indicates that obesity as a stigmatized status is not universal. Researchers studying cross-cultural differences in the meaning of thinness and fatness note fatness is despised and thinness is valorized in developed nations where the food supply is secure (Brown and Jasper 1993; Brown and Konner 1987; Bruch 1973; Rothblum 1990). However, in developing countries where deaths due to malnutrition and starvation are common, obesity is associated with wealth and prestige for it is evidence of access to scarce resources (Brown and Konner 1987; Cassidy 1991). In these countries, thinness is typically seen as a sign of malnutrition, poverty and infectious disease (Rothblum 1990).

Brown and Konner (1987) found that 81 percent of the 58 traditional societies which have data about values and fatness view high levels of fatness as a sign of health and viability, and fatter individuals are more likely to attain positions of power and prestige. By contrast, people who are thin are viewed more negatively and not granted access to social positions available to their fatter counterparts. In their literature review of the relationship between obesity and socioeconomic status in 144 countries, Sobal and Stunkard (1989) noted that, in non-industrialized countries, obesity in men is more prevalent in the higher social classes and is viewed as an indicator of high status. Corpulence in men living in developing countries or in traditional societies is a manifestation of their wealth, physical strength and social power (Cassidy 1991). Cassidy also observes, that in much of West Africa and the Caribbean today, it is a compliment to call a man "fat," for it recognizes his physical strength, and social and economic success (p. 196).

Research conducted among adults in Latin America, Puerto Rico and among children in China and the Philippines shows that an increased body weight is associated with an increased standard of living and health (Furnham and Alibhai 1983). Researchers studying African populations also note that, in those countries, obesity is viewed positively. Hooper and Garner (1986) in their study of Zimbabwean

schoolgirls found that the black African and inter-racial girls had a more positive view of obesity than the white African girls. Ugandan university students rated fat male and female figures as happy, healthy, confident and attractive, in contrast to British students who indicated the opposite opinions (Furnham and Baguma 1994). These findings were replicated by Cogan et al. (1996) who compared Ghanaian and American students' attitudes to high body weight. When queried about their own weight concerns, both the male and female Ghanaian students expressed a desire to gain weight.

Mexico, despite its proximity to the United States, does not appear to share the latter's widespread aversion to obesity. Crandall and Martinez (1996) compared American and Mexican students' attitudes towards overweight people. The Mexicans were less likely than the Americans to indicate dislike of overweight persons and to fear becoming fat themselves. They were also less likely to endorse the belief that weight is under an individual's control.

Societies that experience chronic food shortages and high infant mortality rates value plumpness in women and associate it with sexuality and fertility. For example, the traditional societies examined by Brown and Konner (1987) also indicated they prefer "plumpness" as an ideal of feminine beauty. In some parts of Africa, chiefs send their pubescent daughters to fattening huts before they are offered for marriage (Brink 1989; Brown and Konner 1987; Cassidy 1991; Powdermaker 1960). In Jamaica, large women are considered nurturant, fertile, and sexually attractive (Sobo 1994). The Western Samoan women surveyed by Wilkinson, Ben-Tovim, and Walker (1994) pronounced themselves attractive, healthy and strong, although they were clinically overweight by Western standards.

However, there is some empirical evidence which suggests that when a person moves from a culture where plumpness is valued to one where slenderness is preferred, this may lead to a shift in body weight preference. Asian women (of Indian origin) living in Kenya and Asian women who had emigrated from Kenya to Britain were asked to rate line drawings of women of different body weights. The Asian women who were living in Kenya gave more positive ratings to line drawings of heavy women than the women who emigrated to Britain (Furnham and Alibhai 1983). The authors suggest that the women who had emigrated had absorbed the British cultural prejudice against overweight.



### Race, Ethnicity and Body Satisfaction

Both British and American studies have suggested that black, Asian and Hispanic women are likely to report higher desired body weight, larger desired body shapes and fewer weight concerns than white women (Abrams, Allen, and Gray 1993; Harris 1994; Wardie et al. 1993). Black and Hispanic women, on average, have higher levels of body fat than white women, but are more likely to report being satisfied with their weights (Cash and Roy 1999; Rand and Kuldau 1990). Harris et al. (1991) report that both male and female African Americans were more positive about overweight in women than were white Americans. African American men were more likely than white American men to want to date an overweight woman and to consider an overweight woman sexually attractive. Hebl and Heatherton (1998) asked black and white female undergraduate students to rate photographs of thin, average, and large black and white female models along six dimensions: attractiveness, intelligence, job success, relationship success, happiness, and popularity. Both black and white women rated the targets lower on the dimension of attractiveness, but only the white women rated large white targets lower in all the other dimensions. The black subjects rated the large black targets positively and even rated them as more popular than the average and thin targets.

Studies undertaken in both the United States and Britain have found that black girls report less dieting behavior than white girls. For instance, Neff et al. (1997) investigated body size perceptions and weight management practices in both black and white adolescent girls, aged 14 to 18. They found that significantly more white girls (41 percent) than black girls (28 percent) considered themselves overweight. White girls were six times more likely to use diet pills or exercise as a way to manage their weight. The authors concluded that white adolescent girls are significantly more likely to consider themselves overweight and are more likely to engage in unhealthy weight management behaviors, compared with black girls of the same age.

British researchers have reported similar findings. Wardle and Marsland (1990) found that fewer Afro-Caribbean and Asian-British girls than white girls wanted to lose weight. Wardle et al. (1993) studied body image and dieting concerns in a sample of 274 white and Asian British women aged 14 to 22. The Asian women were less likely to describe themselves as too fat, less dissatisfied with their body size, less

likely to want to lose weight and less likely to diet. Some of these differences were the result of generally lower body weight in the Asian group. However, when the researchers controlled for the effects of body size, they found that white women rated their stomach, thighs and buttocks significantly larger than those of Asian women of the same size. The authors concluded that white women felt larger than Asian women of the same size. Wardle et al. suggest that these results may demonstrate cultural differences between the two groups, where body shape may be a less emotive issue for the Asian group and/or obesity may not be such a stigma as in the white group.

Less research has been done on the relationship between race, ethnicity and body image in Canada, particularly among Canadian Natives. Gittelsohn et al. (1996), however, investigated body shape perceptions of Ojibway-Cree men and women living in Northern Ontario and found that both genders in their sample chose larger body shape ideals than those reported for white groups.

### **INDIVIDUAL AND SOCIETAL CONSEQUENCES OF OBESITY STIGMA**

Obese individuals are discriminated against with respect to education, employment, health care, transportation and seating facilities in restaurants. Their families and spouses malign them. Obese women, particularly, have difficulty establishing and maintaining romantic relationships. They are also ascribed negative character traits such as lazy, stupid and incompetent. What are the personal consequences of being fat in a society that so overtly hates fat people and expresses it with relative impunity? The medical, psychological and sociological literatures demonstrate that obesity stigma has a wide-ranging negative impact on the lives of fat people. Obesity stigma has such pernicious power that it even affects non-obese individuals. Numerous polls consistently show that large numbers of the American population are terrified of even the possibility of becoming fat.

### **Impact of Obesity Stigma on Physical and Psychological Health of Obese People**

Fat prejudice is often disguised as concern for the fat person's health (Millman 1980). The medical profession has also legitimated its mistreatment of fat people on the grounds that the condition is a proliferating public health menace which can only be resolved through drastic measures (Burgard and Lyons 1994; Cogan and Ernsberger 1999; Fraser 1997). However, fat prejudice does not promote health in

fat people; rather, it has the opposite effect. Given the level of hostility expressed by doctors toward their fat patients, it is not surprising to discover that fat people would rather avoid seeking medical care altogether. As Burgard and Lyons (1994:214) observe, “[w]hen a physician, who is expected to provide expertise and offer comfort, offers criticism instead, it can be emotionally devastating—even life threatening.” Burgard and Lyons relate the incident of a woman who had undergone a mastectomy. The woman knew she was at risk for cancer but would not undergo Pap smears after having been told by a gynecologist that “she was too fat to have a proper exam” (p. 215). In the ten years before the subjects in Rand and MacGregor’s (1990) study underwent weight loss surgery, many had not had Pap tests, breast examinations or regular prenatal care. In Bovey’s (1994) study of over 200 obese women, they too reported avoiding health care out of fear of doctors hectoring them about their weight.

Close to 13 percent of the 310 female hospital employees surveyed by Olson, Schumaker, and Yawn (1994) reported delaying or canceling doctor’s appointments because they knew they would be weighed. The authors found that BMI alone correlated with delayed medical care. Other variables such as age, education, occupation, or reason for most recent visit did not influence the findings to a significant degree. Similarly, after controlling for age, race, income, education, smoking, and health insurance status, Fontaine et al. (1998) found that women with BMI >35 were more likely to delay clinical breast examinations, gynecological examinations and Pap smears. The authors speculate that these women are reluctant to undress before a doctor and have their bodies manipulated.

Another point about health needs to be emphasized. Fat people are victims of emotional stress almost their entire lives. According to Schroeder (1992:97), “[t]he emotional stress of being fat, in the United States, is not unlike that experienced by soldiers who spend long periods in a combat zone....but at least soldiers can be...sent home.” Constant stress, of course, has physical and psychological ramifications. For instance, African Americans have considerably higher blood pressure than whites and some researchers suggest that this discrepancy may not be entirely due to genetics but may be a consequence of racism (Schroeder, 1992:96). Similarly, Polivy and Herman (1983) cite evidence which indicates that elevated blood pressure and major depression in obese people may be caused, not by obesity *per se*, but by being the target of widespread societal prejudice and discrimination.

Obesity stigmatization is not only damaging to obese people's physical health, it is also damaging to their psychological and emotional health as well. For example, obese individuals, particularly white obese women, tend to have lower self-esteem than their non-obese counterparts (Averett and Korenman 1999; Crandall and Biernat 1990; Crocker, Cornwell, and Major 1993; Quinn and Crocker 1998).

Negative body image is also common in obese individuals (Friedman and Brownell 1995; Stunkard and Wadden 1992; Wadden and Stunkard 1985). Some researchers have suggested that the frequent weight-related teasing experienced by many obese children is associated with body image disparagement in obese individuals (Fabian and Thompson 1989; Grilo et al. 1994). Myers and Rosen (1999) found a positive correlation between the number of stigmatizing situations, and the presence of mental health symptoms, negative body image and lower self-esteem in their obese respondents.

Weight-related teasing can have drastic consequences, as the suicides of three young people dramatically illustrate. Brian Head, a fifteen-year-old Florida boy, brought a gun to school in 1994 after having been taunted for years about being overweight. Declaring, "I can't take it anymore," he shot himself to death in his classroom ("Student Kills Himself in Class" 1994). Twelve-year-old Samuel Graham, also living in Florida, hanged himself from a tree in his backyard in anticipation of the abuse he would face at the hands of his classmates on the first day of school ("He Dreaded Teasing" 1996).

Weight-related suicides do not only occur in the United States. Kelly Yeomans of Derby, England was verbally abused by her schoolmates on a regular basis on account of her weight. Her victimization also included having salt thrown in her food and her clothes thrown in the garbage. An already difficult situation was exacerbated in the fall of 1997, when groups of neighborhood children gathered to scream invective about her weight and pelt her house with food for several consecutive nights. After that incident Yeomans told her parents that she "couldn't take it anymore" and fatally overdosed on sleeping pills days later (Lederer 1997).

The above stories of these three fat teenagers illustrate the pain of obesity stigmatization and the havoc it can wreak on young people's lives. Obesity stigmatization is indeed a source of constant psychological distress, but interestingly, suicide rates are lower for obese people than they are for the general population (Ciliska 1993). As well, the prevalence of psychopathology is no greater in obese than

non-obese samples (Friedman and Brownell 1995; Stunkard and Wadden 1992; Wadden and Stunkard 1985, 1987). Friedman and Brownell (1995:3) in their comprehensive examination of the relationship between obesity and psychopathology, note that, "the effects of being obese vary across individuals. Obesity may create serious psychosocial problems in some individuals, mild problems in others, and perhaps no distress at all in others."<sup>33</sup> Myers and Rosen (1999) note that while obesity stigmatization is a common occurrence for obese individuals, coping techniques vary. They range from maladaptive strategies such as crying, self-criticism, and avoidance of distressing situations to problem solving efforts, social support, positive self-talk, and confrontation.

In our own research on coping techniques of obesity stigma (Joanisse and Synnott 1999), we noted that most of our sample members did not accept their victimization passively. Some sample members viewed their size positively, noting that they stand out in people's minds. Both men and women occasionally used their large bodies to intimidate others. Finally, a small number indicated they were better people as a result of being fat because they were empathetic to other "deviants."

### **THE SIZE ACCEPTANCE MOVEMENT**

Currently, there is only one major advocacy group in North America for fat people.<sup>34</sup> The National Association to Advance Fat Acceptance (NAAFA), founded in 1969, is dedicated to eliminating weight discrimination in employment, education and public transportation. Full access to adequate medical care is another major concern. The ethos of the organization is that fat people must be accepted as they are and what essentially needs to be changed are the condemning social attitudes toward obesity (Gimlin 2002; Millman 1980; Sobal 1999). NAAFA uses the word "fat" purely as an adjective and insists that the term has been made pejorative by a society not accepting of larger people (Millman 1980:91). Fatness is not a requirement for membership, but the organization promotes self-acceptance among its members and stresses that fat can be beautiful (Gimlin 2002; Millman 1980; Sobal 1999).

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<sup>33</sup> See also Quinn and Crocker (1998).

<sup>34</sup> See also Sobal (1995, 1999).

NAAFA publishes a bimonthly newsletter discussing relevant concerns to fat people such as fraudulent dieting schemes, outcomes of weight-related lawsuits, clothing outlets which carry large sizes, etc. A conference is held yearly, as are numerous social events. The organization not only provides an environment where obesity is acceptable and even desirable, it is also organized as a political force (Breseman et al. 1999; Gimlin 2002; Sobal 1999). NAAFA members hold public demonstrations, engage in letter-writing campaigns, and hold press conferences in order to call attention to actions and policies that are discriminatory or offensive to fat people (Sobal 1999).

The association is made up of approximately 5,000 members, including 100 in Canada (Nemeth 1994; Sobal 1999). These are low numbers, considering that NAAFA has been in existence for over 30 years and that fat people dominate the American population. The leadership of the organization suggests NAAFA's ongoing recruitment difficulties lie in the fact that most fat people are ashamed of their condition and are reluctant to ally themselves with an organization that promotes "fat pride" (*NAAFA Newsletter* 1996).

### **FEAR OF FATNESS IN ADULTS AND CHILDREN: AN EPIDEMIC**

Fat pride may indeed be a difficult state to achieve. It may even be considered an oxymoron by most people, fat or thin. Poll after poll conducted in the United States indicates the possibility of personal fatness is viewed with great apprehension. For example, when 500 people living in San Francisco were asked what their greatest fear was, 190 of them replied "getting fat" (Boyd 1981). Thirty-eight percent of the respondents in a national poll indicated they dreaded fatness more than dying (Sternhell 1985). Cowley (1990) cites a poll which queried 200 couples about genetic conditions that could influence them to abort a fetus if these conditions were known in advance. Six percent indicated they would abort a child likely to get Alzheimer's in old age, while 11 percent would abort a child prone to fatness to "save a child from obesity."

Gaesser (1996) recounts a study in which over half of the participating females between the ages of 18 and 25 reported they would prefer to be run over by a truck than to be morbidly obese. Two-thirds of them would choose to be mean or stupid. Children also cite possible fatness as one of their worst fears.

When reporters on a television magazine show asked children what would be the worst thing that could ever happen to them, most replied, "getting fat" (Fraser 1997:47).

Some populations express a fervent desire to avoid obesity altogether or at least never to experience it again. Children with juvenile diabetes were asked if they would prefer to remain diabetic and thin or to become healthy and obese. Most of the children preferred staying diabetic and thin (Rodin et al. 1984). Rand and MacGregor (1990) surveyed 47 people who had lost over 100 pounds after undergoing intestinal bypass surgery and found that virtually all said they would rather be blind, deaf, or have a limb amputated than be obese again. None would change places with a morbidly obese millionaire.

Negative attitudes toward obesity are held not only by thin people but also by obese individuals themselves. This feature seems to be particularly salient when compared to other frequently stigmatized groups (Allon 1982; Crandall and Biernat 1990; Quinn and Crocker 1998). Cahnman (1968) contends that obese people consistently experience rejection from so many sources that they come to believe their derogation is just. Similarly, although many stigmatized individuals protect their self-esteem by attributing criticism and rejection to others' prejudices, many obese individuals fail to make such attributions (Crocker et al. 1993; Crocker and Major 1989; Quinn and Crocker 1998).

### CONCLUDING REMARKS

The academic literature shows that fat people, particularly fat women, live in a hostile social and cultural climate. Hatred of fat starts early and is well established by adulthood. Obese individuals are stigmatized by numerous sources and these multiple rejections have a detrimental impact on nearly every aspect of their lives. Since substantial numbers of the Canadian and American population are fat, it can be reasonably inferred that many people suffer from obesity stigma. It is notable that research into this topic rarely queries fat people themselves about their experiences of stigma; rather, data on the stigmatization of obesity are usually gathered by asking college populations to evaluate an obese person's desirability as a potential partner, employee, colleague, etc. While these studies are useful in providing us with information about the extent of the stigmatization of fat people, it does not tell us what are the consequences and implications of stigma for the individual who must bear this devalued status.

It is also evident that the mere possibility of fatness inspires terror for numerous populations. Thus, if individuals are not suffering from being fat, they are suffering from the fear of becoming fat. The succeeding chapters will demonstrate that the widespread fear of fatness, in tandem with rejection of fat people, has provided capitalist and patriarchal institutions with a powerful means of social control over large numbers of the population.

While it is popular to speak of the importance of weight control, the preceding literature review would suggest that weight controls us. If we are not suffering the consequences of being fat, we worry about the consequences of becoming fat. Especially, if we are white women living in Western society.



## CHAPTER THREE

### THEORIZING THE STIGMA OF OBESITY

The studies cited in the previous chapter indicate that obesity is a highly stigmatizing condition. What is stigma and what does it mean to be stigmatized? The principal theorist on stigma is Erving Goffman, and his work on stigma will be described in this chapter. However, Goffman did not address the stigmatization of obesity; Werner J. Cahnman and Natalie Allon developed this issue.

The literature review also strongly indicates that fat women are considerably more likely to be stigmatized than fat men. Accordingly, this chapter includes the contribution of feminist theory to our understanding of the social significance of women's body size. Feminist theorization on female embodiment expands the concept of fat stigma further by locating it in the context of patriarchal control of women's bodies. I integrate several themes from Goffman's stigma theory and feminist theory to provide a multi-faceted explanation not only as to why fatness is so loathed, but to show how weight serves as a significant social control mechanism of women.

#### ERVING GOFFMAN

Erving Goffman (1963) argues:

While the stranger is present before us, evidence can arise of his possessing an attribute that makes him different from others in the category of persons available for him to be, and of a less desirable kind....He is thus reduced in our minds from a whole and usual person to a tainted, discounted one. (Pp. 2-3)

In *Stigma: Notes on the Management of Spoiled Identity* (1963), Goffman discusses the situation of people who, for various reasons, are devalued by wider society. He defines stigma rather broadly as "an attribute that is deeply discrediting" (p. 3). Goffman works from the assumption that human beings need to categorize each other on the basis of visible characteristics and claims that people become stigmatized when they have certain characteristics that set them apart from others. The concept is an important one, according to Goffman, because it often has an impact on individual relationships. Like most of Goffman's

work, *Stigma* is not an empirical investigation, but is written in essay format. His sources consist largely of autobiographies and case studies, and he draws primarily on the plight of the physically challenged and the blind.

Goffman identifies three types of stigma (p. 4): (1) *Bodily abominations* which include various physical deformities, as well as conditions such as blindness, deafness, and muteness. (2) *Characterological flaws* such as a weak will, unnatural passions, and dishonesty. These are manifested in aberrations such as homosexuality, substance abuse, criminality, and mental illness. (3) *Tribal stigma*, which alludes to membership in disadvantaged or devalued racial, ethnic, or religious groups. The stigma can subsume any other qualities the person may possess: "an individual who might have been received easily in ordinary social intercourse possesses a trait that can obtrude itself upon attention and turn those of us whom he [sic] meets away from him, breaking the claim that his [sic] other attributes have on us" (p. 5).

Goffman refers to the nonstigmatized as "normals" and predicts they will condemn and reject the stigmatized. Not only is the stigmatizing condition deemed unacceptable, but normals have a tendency to "impute a wide range of imperfections on the basis of the original one" (p. 5). The best that can be hoped for is a reluctant acceptance on the part of normals. An already difficult situation is exacerbated by the fact that the stigmatized individual is often viewed as less than human and is more likely to suffer discrimination from a variety of sources which could reduce his or her life chances (p. 5). Goffman further points out that, whenever the stigmatized are believed to be the cause of their condition, the irrational, prejudicial attitudes are amplified.

For stigmatization to occur, the discrediting attribute must be known by others with whom interaction takes place. Some stigmatizing attributes such as criminality, homosexuality or previous incarceration in a mental institution are not readily apparent and stigmatization may therefore not result. Goffman refers to these types of stigmas as "discreditable." Persons with discreditable traits fear that their secret will be revealed and will take steps to protect themselves from exposure. Attempts at concealment

of the discreditable self is referred to as "passing" (p. 42). The semblance of normality is so advantageous that Goffman assumes that all persons in a position to pass will inevitably do so (p. 74).

Those whose stigma is not visible have a distinct advantage over those whose stigma is easily discerned; in fact, Goffman contends that "visibility is a crucial factor" (p. 48). Attributes such as skin color and physical disability provide visible evidence of stigma, so their bearer can be immediately discredited. The more obtrusive the stigma, the more likely it will interfere in the individual's social interactions. The stigmatized person's actions are constantly viewed through the lens of his or her otherness and any minor infractions will be interpreted in the context of the blemish. As an example, Goffman cites the reluctance of many former mental patients to engage in disputes with spouses or employers, out of fear they will be regarded as uncontrollable. As well, the bearer of the discredited attribute is more subject to invasions of privacy such as stares from children (p. 16). Thus, stigma resides not in the stigmatizing condition itself, but in others' reactions to that condition.

The visibility of some stigmas precludes the option of passing, but some discredited traits can be "covered" (p. 102). This can be done in the literal sense, such as wearing dark glasses to conceal a facial disfiguration. Another type of covering involves the public restriction of the disabilities identified with the stigma. A visually impaired person who can only read a book by bringing it very close to the eyes may avoid reading around others (pp. 103-4). Some disabilities such as deafness may be camouflaged by deliberately choosing to limit conversations with people with clear voices or to hiccup, cough or choke in order to divert a questioner's attention.

Encounters with normals are fraught with anxiety; those with a discredited attribute will worry about the resulting tension and will ultimately try to control it. He or she will feel self-conscious, constantly worrying about normals' impressions; whereas, those with a discreditable attribute worry about exposure and engage in information control. In either case, Goffman assumes that these interactions will always leave the stigmatized person with a profound sense of shame.

Besides suffering exclusion or unfair treatment from others as a result of the perception that they are inferior in some aspect, the stigmatized often come to accept the derogatory view of themselves. "Those who have dealings with him [sic] fail to accord him the respect and regard which the uncontaminated aspects of his social identity have led them to anticipate extending; and have led him to anticipate receiving; he echoes this denial by finding that some of his attributes warrant it" (pp. 8-9). This acceptance can often lead to feelings of self-disparagement and self-loathing.

Goffman does allow for the possibility that some stigmas can be reversible or overcome with surgical intervention. If these options do not exist, then the individual can either become proficient in an activity that is commonly viewed as impossible to achieve for someone with a disability or eschew both these avenues and flout convention altogether by behaving in an unorthodox manner. What is important to remember is that, according to Goffman, a person who manages to erase a flaw does not acquire the status of normal; rather, he or she will be known as someone who once had a blemish but corrected it.

Of course, not all aberrations provoke rejection and disgrace. Some conditions such as physical handicaps or disabilities can elicit positive responses such as sympathy or concern to a condition that is an accident of fate beyond the person's control.

Goffman's treatment of stigma is illuminating insofar as it provides a glimpse into the agony experienced by those who are viewed as flawed, but his presentation of the significant commonalities shared by stigma bearers tends to obscure the differences between types of stigmas and the problems they pose for the individuals. For instance, baldness does not arouse the same types of reactions as do physical deformities. Goffman's insights into stigma do not sufficiently explain as to why certain stigmas are more problematic than others.

Since Goffman wrote his classic text, the specific conditions that elicited the negative reactions towards the deviant conditions he described have changed considerably. There is now widespread sympathy for the physically deformed and the mentally ill, with substantial efforts being made to integrate them into the larger society. Divorce is now commonplace. Homosexuals have become an organized

political force and vociferously demand the same rights accorded to heterosexuals. Prostitutes and convicts are considered retrievable by many, and greater sensitivity is displayed to their situation. Most of the groups that Goffman described as stigmatized a generation ago are now offered legal protection and it is recognized, at least in principle, that these people have a right to full participation in society. Fat people, however, continue to be vilified and derided and their ill treatment is not condemned. Thus, Goffman's theory alone is not a sufficient explanation as to why some stigmas decrease in importance over time, while others intensify.

#### Goffman's Omission of the Stigma of Obesity

Goffman refers to the subject of obesity stigma only very peripherally. He notes the existence of support groups for overweight people and cites the "fraternity fat boy" as an example of an in-group deviant (p. 142). Other than these vague remarks, he does not mention obesity at all. Perhaps he did not view the stigma of obesity to be as severe as the others he described, or he simply may have been unaware of the extent to which it exists. Moreover, the prevalence of obesity and the research on anti-fat attitudes occurred decades after Goffman's work. Cahnman (1968) defends Goffman's exclusion of the obese on the grounds that Goffman lacked autobiographical material from fat people--a consequence Cahnman attributes to fat people's acceptance that their derogation is justifiable. More likely Goffman's omission can be explained by his openly-expressed feeling that a stigma that is immediately evident to everyone at all times is not worthy of any special interest (p. 73). Finally, even if Goffman had addressed obesity, his focus on commonalities would probably render him oblivious to the fact that fat discrimination is not gender neutral.

#### THE STIGMA OF OBESITY

Other researchers, while paying homage to Goffman, have expanded upon his ideas and have subsequently provided a more precise explanation of why fat hostility is so pervasive in U.S. and Canadian society. There is no doubt that obesity fits Goffman's criteria for a stigmatizing condition. Actually, obese persons are *doubly* stigmatized: Overweight is an abomination of the body that elicits immediate negative assessment from others on the basis of its aesthetically displeasing qualities. Moreover, since it is

presumed to be a consequence of a lack of willpower, obesity is emblematic of a characterological stigma (Allon 1982; DeJong 1980, 1993; DeJong and Kleck 1986). Management of the obesity stigma is exceedingly difficult because the blemish is so visible. Attempts to disguise excess weight are relatively futile, as loose clothing can accomplish only very little by way of camouflage. The best and only means of stigma management available to the obese is shedding the weight and entering the world of normals as a "thin" fat person.

Cahnman added to Goffman's work in a (1968) article entitled "The Stigma of Obesity." This publication is considered a benchmark work in the study of obesity stigma because Cahnman was the first sociologist to note that obesity is stigmatizing and that obese individuals are routinely derogated. His article is often cited and he does offer some useful insights. For one, Cahnman is more precise than Goffman in his definition of stigma which he describes as "the rejection and disgrace that are connected with what is viewed as physical deformity and behavioral aberration" (p. 293). For another, Cahnman points out that the obese are *triple* disadvantaged: (1) they are discriminated against; (2) they are made to feel that they deserve such discrimination; and (3) they come to accept their treatment as just (p. 294).

Cahnman focuses his empirical investigation on young obese people, ages 10 through 25, because of his concerns that youth are particularly vulnerable at those ages due to the uncertainty of their social status as well as the conflicting nature of their emotions. Cahnman also posits that the marginalization of fat adolescents can have lifetime ramifications.

Cahnman suggests that the negative attitudes expressed toward the overweight arise from the belief that it is caused by self-indulgence. The thrust of Cahnman's article is to argue against the common supposition of medical professionals and others that obesity is a moral defect. Cahnman recommends that the typical, psychogenic outlook of obesity with its tendency to regard it as an idiosyncratic pathology should be replaced with the broader sociogenic view. Focusing on sociogenic factors allows the entire "situational field" of the obese person to be examined, a field that is marked by stigma (p. 293).

Later researchers agree with Cahnman's suggestion that obesity is so widely stigmatized because it is viewed as a self-inflicted condition, the consequence of indulgence, laziness, and lack of self-control (Crandall 1994; DeJong 1980, 1993; DeJong and Kleck 1986; Maddox, Back, and Liederman 1968;

Millman 1980). DeJong and Kleck (1986:74) observe that individuals possessing "a characterological stigma are often explicitly derogated, whereas those who are physically deviant are not." DeJong (1980) attributes this difference to commonly held assumptions that those who possess a characterological stigma are seen as bearing at least some responsibility for acquiring it, whereas physical attributes are seen as determined by forces beyond an individual's control. DeJong and Kleck (1986) note that obese people are more likely to be classified as those who have a characterological stigma than those who are physically deviant. The character of the obese person is impugned by the characteristics imputed to obesity, namely, that its bearer is lazy, gluttonous, immoral and self-indulgent. It bears mentioning that these are traits despised by a society that was founded on Puritan principles which valued abstinence and self-control (Crandall 1994; Freedman 1986; Rothblum 1992; Stearns 1997). Crandall (1994) and Crandall and Martinez (1995) also argue that the individualistic ideology predominant in the United States which holds individuals responsible for their life outcomes is also a factor in the perpetuation and maintenance of anti-fat attitudes.

Thus, the obese are seen as rightfully precluded from full social acceptance because they are complicit in their own victimization. Unlike other attributes such as gender, skin color, or age, body weight is viewed as a mutable condition, and therefore within an individual's power to change. It is widely believed the obese have a relatively easy option to escape their deviant status: They have only to muster sufficient willpower to control their appetites or to become more physically active.

One sociologist who has made a considerable contribution to the study of the stigmatization of obesity is Natalie Allon. Allon was a prominent obesity researcher in the 1970s. Her areas of focus included obesity stigma, the problems of young obese people, and in particular, group dieting (1973a,b; 1975; 1976; 1979; 1982).<sup>35</sup> Allon appears to have been the first sociologist to note that fat women are more stigmatized than fat men and that fat hatred functions as a method of social control (1973a).

She was influenced by Goffman and Cahnman and believed that more damage, physical and emotional, was done by the stigmatization of obesity than by the problems caused by the condition itself.

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<sup>35</sup> For a detailed overview of Natalie Allon's contributions to the sociology of obesity, see Sobal (1984b).

Allon (1973a) classified the stigmatization of obesity in four core areas: (1) in religion, as a sin; (2) in medicine, as a disease; (3) in crime, as a misdemeanor or felony; and (4) in aesthetics, as ugliness. Obesity is sinful in that it is regarded as immoral because the condition is believed to originate from an inability to delay gratification. This behavior flouts the Puritan ethic of self-control on which the United States was founded. Overweight people are stigmatized for their self-indulgence and are seen as deserving of retribution. Allon notes the religious overtones involved in popular weight loss organizations. The members confess their dieting sins, listen to testimonials attesting to the goodness of the organization, and redeem themselves by vowing to faithfully follow the diet plan.

Obesity is viewed as pathology by the medical community; unlike other medical conditions, however, excess weight is considered to be self-inflicted and therefore deserving of rebuke and castigation. The low success rate for long-term cure is dismissed as patient non-compliance. After reviewing the medical literature on the health consequences of obesity, Allon concludes that the social problems resulting from the stigmatization of fatness are much more severe than the physiological and psychological problems actually associated with obesity. She notes that the medical community is as likely to be as harsh and judgmental as the general population and wonders if a lifetime of persecution could actually be a catalyst for obesity-related conditions such as heart disease, high blood pressure, and depression and anxiety.

Crime is the third theme in the stigmatization of obesity. Fat people have committed the double offense of overeating and shamelessly displaying the fruit of their spoils; thus, they have committed two crimes for which they must be appropriately punished. No sympathy should be accorded to fat "criminals": They have the choice of controlling their urges and have chosen not to. The crime of fatness results in the suspension of privileges such as eating an ice cream cone in public. Harsher sanctions include prejudice and discrimination in education, employment, as well as everyday life.

Lastly, Allon discusses current cultural standards of beauty which equate obesity with ugliness. She points out that in other cultures and in earlier historical periods, obesity was an indicator of wealth and



sexual attractiveness. She discusses the inverse relationship between socioeconomic status and weight and notes that in societies where food is plentiful, obesity is reviled.<sup>36</sup>

While Allon's work is an important contribution to the relevance of gender, the feminist literature offers further insights as to why the stigma of fatness is such a gendered phenomenon.

### **FEMINIST THEORY: FAT STIGMA AS A GENDERED PHENOMENON**

Feminist theorists and researchers identify the particularly acute stigmatization of fat women as a significant source of oppression for women (MacInnis 1993; Mayer 1983; McKinley 1999; Millman 1980; Rothblum 1994; Wolf 1991). The insights of feminism further elucidate the phenomenon of anti-fat attitudes by pointing out that women's bodies in patriarchal culture are inferiorized by definition; therefore, since fatness is so despised, fat women's bodies are inferiorized even more.

While the topic of women's bodies has resulted in a proliferation of feminist theorizing and research over the last two decades (Bordo 1993; Gimlin 2002; Grogan 1999; Millman 1980; Spitzack 1990; Weitz 1998), these works should not be viewed as a cohesive body of knowledge.<sup>37</sup> The approaches within this field are disparate, but they tend to focus on the importance of attractiveness for women, their preoccupation with weight, and their profound dissatisfaction with their bodies. The only sociological, explicitly feminist, work to study women's subjective experience of obesity is Marcia Millman's *Such a Pretty Face* (1980). Millman, a medical sociologist, conducted extensive interviews with over 50 participants, the majority of whom were white, middle-class women living in urban environments. Millman's objective was to glean insight about the social and psychological meanings of obesity and why fatness is so stigmatized. In the course of her research, she also profiled three weight-related groups. As participant-observer she attended meetings of NAAFA and Overeaters Anonymous, as well as spending a summer at a children's diet camp.

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<sup>36</sup> Unfortunately, Allon's theorizing and research about obesity was cut short in 1980 when she became incapacitated following surgery for injuries sustained in a car accident. She died in 2001.

<sup>37</sup> Numerous scholars have addressed the relationship between the body, culture and society. See Featherstone (1991); Frank (1991); Giddens (1991); Shilling (1993); Synnott (1993); Turner (1984, 1991). Since this research is a feminist analysis, and in view of space limitations, I have chosen to focus entirely on the feminist literature on women and weight issues in my discussion of why fatness is so stigmatized.

Millman identifies some common themes amongst her sample members: lack of control, isolation and exclusion, normalcy versus deviation, poor self-image, desexualization versus heightened sexuality, and disembodiment. Millman notes that her sample members engaged in frequent before/after transformation fantasies and appeared to believe all their problems originated from their fatness. Throughout her study, Millman stresses the role of sexism in the suffering experienced by fat women in America. Other feminist scholars have taken up this theme, which is commonly referred to as “politics of the body.”

In an appendix entitled “Fat Men: A Different Story,” Millman describes her findings from interviews she conducted with 22 fat men. She found that the male experience of being fat is vastly different from the female. Her male participants, some of whom weighed more than 100 pounds above their ideal weight, were less introspective about their weight and were less inclined to connect it with psychological or emotional problems. They also confronted anti-fat attitudes with belligerence. Moreover, they did not think obesity affected their relationships, careers, or masculinity. In short, they were less perturbed about their fat.

### **The Social Construction of Women’s Bodies**

Why does fatness appear to imprison women to a greater extent than men? Feminists note attractiveness is an essential element of femininity (Brownmiller 1984; Chapkis 1986; Rodin et al. 1984). As has been pointed out in the preceding chapters of this dissertation, moreover, for white, middle-class, heterosexual women living in advanced capitalist societies, attractiveness is now largely defined by thinness (Bordo 1993; Freedman 1986; Rodin et al. 1984; Rothblum 1992). Thinness is merely the latest in a long history of feminine appearance norms. Feminists point out that women’s bodies are objectified and evaluated in a way that men’s bodies are not. Women’s bodies have always been subjected to cultural ideals of beauty; dominant aesthetic preferences for beauty may vary across time and between cultures, but the commonality that links them is the view that the female body is an object to be molded, adulterated, and generally improved upon. As Brownmiller (1984:33) notes, “nearly every civilization has sought to impose a uniform shape upon the female body, a feminine esthetic that usually denies solidity by rearranging,

accentuating or drastically reducing some portion of the female anatomy or some natural expression of flesh.”

One explanation why women are judged by their bodies and why their bodies are more regulated is the dualism between mind and body that has dominated Western thought since antiquity. Women are associated with the bestial body, ruled by drives, instincts, emotions, while men are associated with the exalted mind, governed by rationality and logic (Bordo 1993; Chernin 1981; Hesse-Biber 1996; Spelman 1982). Mind-body dualism has shaped cultural perceptions of masculinity and femininity (Hesse-Biber 1996). This strongly emphasized connection between women and the body has sustained the inferiorization of the feminine (Spelman 1982). This gendered duality also gave rise to a long tradition of misogyny in Christian theology and Western philosophy. Early religious men and philosophers were contemptuous of the body and of women’s bodies in particular (Callaghan 1994; Hesse-Biber 1996; Synnott 1993; Turner 1984; Wooley 1994). Holy men not only despised women’s unruly bodies but they feared their sexuality as well. Women were portrayed as dangerous, immoral temptresses who distracted men from the pursuit of rationality and therefore needed to be contained (Bordo 1993; Callaghan 1994; Hesse-Biber 1996).<sup>38</sup> Restrictive appearance norms represent just one example of the containment of women’s bodies and ultimately women themselves. As Bordo (1993:143) observes, “the social manipulation of the female body [has] emerged as an absolutely central strategy in the maintenance of power relations between the sexes over the past hundred years.”

### The Sexual Politics of Body Size

It is notable that female slenderness is fashionable during the periods of history when women challenge traditional gender roles (see Introduction). First and second wave feminists embraced the thin ideal as a symbol of strength, control, and emancipation (Bordo 1993; Seid 1989). However, the correlation between slenderness and greater social and political freedoms for women is now interpreted by numerous feminists as a symbolic reduction of women’s power: When women metaphorically take up

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<sup>38</sup> There are many different explanations about the social forces which encouraged social structural arrangements where men had social control over women, including, for example, men’s desire to ascertain paternity because of the development of surplus value (Engels 1972) and men’s desire to control women’s productive capacity (Coontz and Henderson 1986).

more room by demanding equal rights, they are confronted by cultural demands to reduce their physical size (Bordo 1993; Chernin 1981; Freedman 1986; Hesse-Biber 1991; Kilbourne 1994; Orbach 1978, 1983, 1986; Rothblum 1994).<sup>39</sup> As Hesse-Biber (1991) observes:

Ironically, when women are demanding “more space” in terms of equality of opportunity, there is a cultural demand that they “should shrink.”... Thinness may be considered a sign of conforming to a constricting feminine image, whereas greater weight may convey a strong, powerful image. (P. 178)

This is not a trivial point because large body size has a powerful symbolic significance. Physical characteristics of dominance, such as height and weight, include increased size and use of space (Frieze et al. 1978, cited in Rothblum 1994:71). Freedman (1986:152) points out, “[b]ig people are hard to ignore; their movements have impact, and by throwing their weight around, they can make a dent in the world.” If a large body size can be equated with an increased physical presence conveying strength, maturity and capability, a diminutive body size is a lesser physical presence and also depicts a person as child-like, passive and helpless (Bartky 1990; Chernin 1981; Freedman 1986; Kilbourne 1994; Rothblum 1994). It bears pointing out that the attributes ascribed to body size are not gender neutral but are essential elements of masculine and feminine norms. As Brownmiller (1984:28) observes, masculinity is characterized by concepts of “powerful” and “large,” whereas femininity is characterized by concepts of “small” and “weak.” If women were not circumscribed by an ideal which constricts their body size, they too could be conceived of as “powerful” and “large” and enjoy the benefits associated with these characteristics.

Numerous feminists suggest the rise of the thin ideal and the increased attention to women’s appearance is part of a backlash phenomenon intended to neutralize the social, political, and economic gains of the feminist movement by keeping women focused on their bodies (Bordo 1993; Chernin 1981; Faludi 1991; Rothblum 1994; Wolf 1991). Wolf (1991:196) describes the thin ideal as a “political solution...something serious being done to us to safeguard political power.” According to this argument, whenever the Western political climate eases restrictions for an aspect of women’s behavior (e.g., the right to vote, sexual freedom provided by oral contraception and legalized abortion, greater participation in the labor force), other aspects of women’s appearance or behavior are restricted accordingly. For example,

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<sup>39</sup> See also Stearns (1997).

Bordo (1993:162) notes that in the second half of the nineteenth century when feminists were calling for universal suffrage and health reform, the “S-curve” figure, requiring an ever-tighter corset, became the fashion.

The argument that the thin ideal is a “political solution” may seem implausible at first glance, but there is compelling evidence which documents how patriarchy<sup>40</sup> and other institutions of social control have benefited in various tangible ways by what Chernin (1981) calls the “tyranny of slenderness.” As noted in the Introduction, the ideal body as represented by models, actresses, and beauty pageant contestants is virtually unattainable for most women. Despite this, they are still expected to closely approximate it and are rewarded for their conformity. Feminists note the high costs—physical, psychological, and financial—involved in the pursuit of a body which is inimical to female biology. The effort of endlessly striving and failing to change their body shape has had a negative impact on women’s mental and physical health. National surveys consistently show that women feel an astonishing degree of antipathy, if not hatred, towards their bodies (Brownell 1991; Cash 1990; Hesse-Biber 1996; Wooley 1994). Numerous significant consequences arise from women’s chronic, pervasive body hatred. Even women whose bodies approximate the cultural ideal are alienated from their bodies and lack a sense of body ownership (Chernin 1981; Wooley 1994). Women living in the United States—arguably the most socially, politically, economically, and technologically advanced country in the world—feel worse about their bodies than do women living anywhere else (Faludi 1991). Canadian women may not be spared this fate either, as the National Eating Disorders Centre estimates that as many as 90 percent of Canadian women are dissatisfied with their bodies (Sheinin 1990). Bordo (1993) argues the source of women’s chronic body hatred is political:

In this historical era, when the parameters defining women’s “place” have indeed been challenged, it is disturbing that we are spending so much of our time and energy obsessed, depressed, and engaging in attempts at anxious transformation (most frequently reduction) of our bodies. It is hard to escape the recognition... that a political battle is being waged over the energies and resources of the female body, a battle in which at least some feminist agendas for women’s empowerment are being defeated (or, at a minimum, assaulted by backlash). (P. 66)

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<sup>40</sup> For the purposes of this study, patriarchy is defined as “a system of interrelated social structures, and practices in which men dominate, oppress and exploit women” (Walby 1990:20).

McKinley (1999) and Wolf (1991) argue that patriarchy benefits from encouraging women to pursue a virtually impossible beauty standard because the torment involved distracts women from further confronting the political sources of their oppression and demanding change. Women who are exercising compulsively and experiencing constant hunger will have considerably less energy than women who are not engaging in these pursuits, even though dominant discourse maintains these are “healthy” and “empowering” activities (Kilbourne 1994; McKinley 1999; Wolf 1991). Wooley (1994:44) further points out the pursuit of ideal weight focuses women’s attention inward and isolates individual women, thereby “destroying the possibility of the political power that comes from collective subjectivity.” The possibility of a cohesive feminist movement working towards collective solutions to women’s oppression is further eroded by the intense competition that an unattainable beauty standard fosters (Kilbourne 1999; McKinley 1999; Wolf 1991). Extreme thinness is so rare and so cherished, that women are pitted against their bodies and also against each other.

Moreover, the sense of control and empowerment offered by slenderness is spurious at best. Bartky (1990), Kilbourne (1994) and McKinley (1999) point out that the only form of control that is unreservedly available to women is *self-control*.<sup>41</sup> Despite recent inroads into previously male-dominated spheres, women in Canada and the United States continue to be denied access to valuable societal resources. But one area in which they are required to demonstrate control and competence is their physical appearance. This is not only problematic because it reduces women to their bodies, but controlling body weight ultimately does not challenge gender inequality. Thinness in women does not change their subordinate status. A never-ending quest for individual self-improvement does not serve as a catalyst for societal change.

Capitalism obviously benefits greatly from the creation and marketing of women’s collective bodily dissatisfaction. In order to attain the ultra-slender ideal, women purchase weight-loss products and spend enormous amounts of time and energy on their bodies. Women’s chronic insecurities about their appearance enrich the coffers of capitalist enterprises such as the \$33-billion weight loss industry (Fraser

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<sup>41</sup> See also Chapkis (1986).

1997), the \$130-billion advertising industry (Kilbourne 1994), the \$20-billion cosmetics industry and the \$300-million cosmetic surgery industry (Wolf 1991). As long as women view their bodies as objects in continual need of self-improvement, they will always be profitable. If women were to accept their bodies and renounce these pursuits, capitalism would suffer a serious blow.

#### Appearance Norms and the Social Control of Women: The Historical Context

We can better understand the extent to which the ultra-slender body ideal is constricting for women by examining the historical context of appearance norms. Various feminists maintain the thin ideal is analogous to earlier restrictive appearance norms such as foot binding and corseting (Brownmiller 1984; Chernin 1981; Rothblum 1994; Wooley, Wooley, and Dyrenforth 1979). Brownmiller (1984) points out that feminine appearance norms tend to exaggerate the smallness of a female feature that is usually smaller in comparison to a male (e.g., size of feet, circumference of waist). Rothblum (1994:58) adds that appearance norms have always acted as a strategy of social control of women. She observes that these norms have been constructed as the design of women themselves, but without conformity to those norms, women have been prevented from functioning in society. She also charges that the medical profession endorses the current beauty norm of the time as health promoting, even when evidence proves otherwise.

For one thousand years, the feet of young upper-class girls living in China were bound by their mothers in order to bend the toes under the sole. This practice broke and deformed the bones in the feet and reduced them to about one-third of their normal size (Fallon 1990). The tiny feet were considered the epitome of beauty and femininity (Hesse-Biber 1996). Women with bound feet could not walk and had to be carried; however, this immobility enhanced their desirability (Fallon 1990). Upper-class women who did not conform to this practice could not marry, and a woman's only value lay in her marriageability (Daly 1990; Fallon 1990; Hesse-Biber 1996). The practice of foot binding eventually spread to the lower classes who wanted to marry into a higher-class family. Since peasant families needed their daughters' labor power, they could not afford to bind their feet (Hesse-Biber 1996).<sup>42</sup>

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<sup>42</sup> Even prostitutes and concubines had to have their feet bound in order to make themselves attractive to men (Freedman 1986).

Chinese men reaped numerous advantages from the custom of foot binding. The small foot was extremely eroticized by men, and fondling and sucking it was a part of sexual foreplay (Brownmiller 1984; Fallon 1990; Hesse-Biber 1996). Since a foot-bound wife could not work outside the home, she was overt evidence of a man's superior economic status (Fallon 1990). Her extreme dependence also elevated his masculinity (Freedman 1986). Women whose feet were bound had less opportunity to have extramarital affairs since they could not leave the home without assistance (Fallon 1990; Hesse-Biber 1996). Hesse-Biber (1996) cites a doctor who endorsed foot binding on the grounds that it helped create an ideal female figure:

Foot binding had a physical influence on a woman's body. When the foot-bound woman went walking, the lower part of her body was in a state of tension. This caused the skin and flesh of her legs and also the skin and flesh of her vagina to become tighter. The woman's buttocks, as a result of walking, became larger and more attractive sexually to the male. (P. 22)

While Chinese men characterized foot binding as a procedure performed by women on women (Daly 1990), there is no doubt that this practice lasted so long because it reinforced the patriarchal structure of Chinese society.

During the Victorian era, the hourglass figure was the feminine ideal for women living in America and England. In order to achieve it, upper-class women wore a whalebone corset (and later steel) which compressed the waist into a circumference between 14 to 18 inches (Hesse-Biber 1996). The small waist exaggerated the woman's breasts and hips and emphasized her maternal role (Fraser 1997; Hesse-Biber 1996). The corset induced a severe, upright posture and limited, feminized motions, both of which were associated with moral rectitude (Brownmiller 1984). The corseted woman also represented her husband's economic success (Fraser 1997; Hesse-Biber 1996). Women who did not wear the corset were labeled "loose" (i.e., immoral) (Brownmiller 1984; Hesse-Biber 1996).

Doctors endorsed the corset because they believed women were such weak creatures that they needed foundational garments to help them stay upright (Brownmiller 1984; Fallon 1990). The corset was also believed to support women's spines, muscles, and breasts. However, corseting had serious health consequences for women: Applying up to 80 pounds on the abdomen, it made breathing difficult, caused fainting spells, distortion of the internal organs, permanent liver damage, and still births, among many other



problems (Bennett and Gurin 1982; Brownmiller 1984; Fraser 1997; Freedman 1986; Hesse-Biber 1996; Rodin 1992; Rothblum 1994).

When feminine appearance norms are examined in a historical and sociocultural context, it is evident that there are indeed commonalities between thinness and earlier body alteration practices. For one, in the early twenty-first century, the female feature that is being made smaller is body size. However, whereas earlier restrictive norms required the external control of women's bodies, control is now achieved through internal means, or what Fraser (1997) calls "the inner corset." Moreover, as in earlier cultural ideals, low body weight became fashionable in the upper classes and filtered down to the lower classes (Fallon 1990). Thin women have increased chances for upward mobility and serve as symbolic evidence of their husbands' economic success (See Chapter 2). Maintaining a low body weight has also been buoyed by medical discourse which has promoted thinness as healthy since the early twentieth century (McKinley 1999; Seid 1989). The pursuit of the modern appearance norm is also extremely damaging to women's bodies and psyches, although this fact often goes unrecognized. Finally, as in earlier times, women who do not approximate the current body ideal have difficulty functioning normally in society.

#### **Foucauldian Feminism: The Female Body as Site of Control and Domination**

Considerable feminist scholarship utilizes historian Michel Foucault's (1979) analysis of the development of modern forms of power to theorize a different type of politics of the body (Balsamo 1996; Bartky 1990; Bordo 1993; Spitzack 1990).<sup>43</sup> In *Discipline and Punish*, Foucault identifies the body as the primary site of the expression and reproduction of power relationships. He argues that modern bodies are subjected to pervasive, continual, and minute disciplinary practices that attempt to closely regulate their movements, therefore rendering them docile: "[a] body is docile that may be subjected, used, transformed, and improved" (p. 136). Control of the body was once imposed by institutions such as the army, schools, and factories. However, over time, control of the body has become more internal through self-imposed body practices. These self-imposed body practices are the result of individuals behaving as though they are constantly being watched, a sense which when internalized, leads to a state of permanent self-policing.

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<sup>43</sup> See also Walden (1985).

While accepting the insights of Foucault's analyses and appropriating his docile body thesis among other Foucauldian concepts, feminist scholars point out that he ignores gender (Balsamo 1996; Bartky 1990; Bordo 1993). For example, Bartky (1990) chides Foucault for overlooking the fact that women's bodies are expected to be more docile than those of men's and that they are subjected to more disciplinary practices. Similarly, Bordo (1993:27) argues that contemporary disciplines of diet and exercise "train the female body in docility and obedience to cultural demands while at the same time [these practices often are] experienced [by women] in terms of power and control" (p. 27).

Bartky (1990) identifies three categories of disciplinary practices that produce the docile female body: "those that aim to produce a body of a certain size and general configuration; those that bring forth from this body a specific repertoire of gestures, postures, and movements; and those that are directed toward the display of this body as an ornamented surface." Dieting and exercise undertaken in pursuit of the ideal female body are examples of Bartky's first category of disciplinary practices. There are no formal disciplinarians who enforce food restriction and exercising, nor are there ritual punishments for women who will not conform. Yet women's eating and exercising behaviors are policed, by others and by themselves (Germov and Williams 1999; Hesse-Biber 1996; Spitzack 1990). The research on fat discrimination attests that women who do not appear to be disciplining their bodies are indeed punished for their insubordination. Bartky also notes that the disciplinary practices through which the docile bodies of women are created benefit men and patriarchy in various ways. Women are under great pressure to make themselves sexually attractive to men. Since women appear to be voluntarily inflicting these disciplines on themselves rather than at the behest of men, "men get off scot-free" (p. 80). While traditional patriarchal authority has eroded, it has been replaced by a more subtle form of masculine domination which is just as invasive in its regulation of women's bodies.

### The Threat of Fat Women

To return to the question that I asked earlier, Why are fat women penalized so much?, the short answer is they do not meet the dominant culture's standard of attractiveness. But fat women also represent a threat to the established gender order: They subvert patriarchy and the forces that support it. Fat women obviously do not conform to the cultural norms of femininity: Seemingly not bound by an inner corset,

they are not small, delicate or frail. They transgress gender boundaries by intruding in spaces reserved for men, and their largeness threatens men's masculinity. They feed themselves, not the capitalist system that thrives on women's body insecurities. They seem to be uncaring of their pathologized status by the medical profession and are outside its sphere of control. Perhaps the most threatening aspect of women's fatness is the manifestation that men are not in control of their bodies. As McKinley (1999) argues:

A fat [woman's] body, especially when the woman refuses to apologize for her size, can also embody protest against the control and limitations of the female gender role....Rather than arguing that fatness can be attractive or sexual or healthy, when a fat woman refuses to watch her body and refuses to apologize for her nonconformity to ideal weight, she challenges constructions of the ideal women as bodies, as contained, and as subject to male approval. (Pp. 110-111)

In *Fat is a Feminist Issue* (1978, 1983), Susie Orbach, a feminist social worker and therapist, theorizes that women become fat as a means of signaling their discontent with rampant sexism. She proposes that obesity is solely caused by compulsive overeating and that this particular eating habit is a way of asserting control in a world that otherwise renders women powerless. Because fat is so repellent, large women are viewed as sexually unattractive and lose their power to allure men. However, fatness accords women a power of a different kind. Men are more likely to take them seriously in a work environment and are less inclined to treat them as sexual objects. Whereas thinness is constricting, fatness is liberating—the ultimate “screw you” (p. 9). According to Orbach, a large woman has substance, strength and physical presence. She is viewed as a productive worker, while her thinner, (presumably) sexier counterparts must struggle with stereotypical attitudes and behaviors. According to Orbach, the most useful benefit of largeness is the protection it offers from unwanted masculine attention. Large women may be neutered by their fat but they are insulated from sexual predation and are therefore valued for themselves rather than the marketability of their bodies.

There are some difficulties with many of the assumptions Orbach makes. For example, one unanswered question is, If there are so many advantages to being fat, why are more fat women not saying “screw you?” Or to rephrase the question more politely, why are fat women not commonly regarded as positive role models for feminists? One reason may be that very few fat women feel empowered by their fatness. Orbach may be aware of this, as this book was originally touted as a no-effort weight-loss method

(the sub-title of the book is *The Anti-Diet Guide to Permanent Weight Loss*, a point that is never mentioned in the feminist literature.) Orbach is wrong to assume that fat women are more highly valued as employees than their thinner counterparts. There is absolutely no substantiation for this claim; on the contrary, the literature strenuously refutes that hypothesis. Rather than being regarded as productive, obese workers are consistently viewed as lazy and worthless. As for the suggestion that men regard fat women for themselves rather than their bodies, that too is erroneous. Most men evince an abhorrence of fat women and simply ignore them altogether. The truth is that fatness—and fat hatred—serves as a formidable force in reducing women's life chances in every aspect of their lives.

Orbach's thesis is problematic in other areas. For instance, her reasoning about the etiology of obesity is flawed and simplistic. According to Orbach, the sole cause of overweight is compulsive overeating. If the cause of compulsive overeating can be identified, then weight loss should occur. Although this proposition sounds logical, it is not, because it assumes that overeating is the single root cause of obesity. As the literature cited in Appendix B illustrates, obesity is a puzzling phenomenon, involving multiple bases. Orbach appears to subscribe to the popular myth that weight is within one's control—either in gaining it or losing it. Her argument that women become fat as a way of rebelling against their inferior position in patriarchal society ignores male fatness. If fatness in women serves as an expression of protest and as a shield from sexual predation, how then is male fatness to be explained? Are they protesting against repressive social structures? Are they protecting themselves from predatory women? Fatness in men appears to be an issue Orbach has not considered.

Finally, while it is obvious Orbach's intent is to provide support to women who compulsively overeat, but she does leave the reader wondering if there are so many advantages to being fat, why would a woman want to lose weight? Orbach's work was originally heralded as empowering the fat woman, but I argue that by showing a grotesque misunderstanding of the challenges the fat woman faces, Orbach ultimately disempowers her.<sup>44</sup>

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<sup>44</sup> See Diamond (1985) for a trenchant critique of Orbach's work.

### Feminism and Fat Stigmatization

The feminist movement has also not empowered fat women. Feminist scholars have written voluminously on the excessive valorization of female thinness in Western culture and its devastating consequences for women, yet they have virtually ignored the problems of fat women. Mayer (1983), McKinley (1999), Millman (1980), and Rothblum (1994) accuse the mainstream feminist movement of failing to support fat women. Fat may be a woman's problem but it is not a mainstream feminist concern. This is somewhat puzzling, as the valorization of thinness is constructed on the hatred of fat. Feminist ambivalence about fatness is reflected in the paucity of feminist research on women's subjective experiences of fatness and the profound effects excess weight can have on women's lives. Only Millman (1980) and Orbach (1978, 1983) have studied fat women's problems in depth, and Orbach has since focused her attention on women with eating disorders.

I suggest there are several reasons for the feminist inattention to the gendered phenomenon of fat stigma. For one, the mainstream media has traditionally caricatured feminists who do not conform to normative beauty standards as unfeminine and therefore "ugly" (Rothblum 1994; Wolf 1991). Moreover, large women may not be viewed as embodying the ideals espoused by liberal feminism; e.g., activity over passivity, control over one's life, freedom to make choices, etc. (Seid 1989). Seid describes a letter to the editor of *Ms.* in protest of an article which argued that fat women could be fit and healthy. The letter writer argued that this position was anti-feminist on the grounds that:

[it] implies that obese women have no power to change; that they are victims of their fate. These are the ideas that have stifled women's progress for ages. It's time that these terribly overweight women realize that there is a healthier alternative: a choice. Isn't the opportunity to choose the essence of feminism? (P. 249)

Women—feminists or not—simply do not support fat women, even if they themselves are fat. Studies show that women, including obese women, are even harsher than men in their derogation of obese people (DeJong 1993; DeJong and Kleck 1986; Jackson 1992). The fat women interviewed by Cordell and Ronai (1999) indicated they feel superior to women who are fatter than them. Feminist scholars who write on women's troubled relationships with their bodies are themselves affected by fat stigma. For instance, Marcia Millman (1980:xii) writes in the preface to *Such a Pretty Face*, "...I have at times felt tremendously

frustrated and foiled at being unable to lose twenty pounds. And although I am tough and take pleasure in a good fight with a formidable opponent, on occasion I have actually dissolved into tears when someone suggested that I should be on a diet.” Millman goes on to describe the dilemma facing her as an overweight feminist: Her life would be definitely easier if she lost weight, but then she would have the burden of feeling she capitulated to an “arbitrary and oppressive standard of normal weight and of what is acceptable and attractive in a woman” (p. xii). Similarly, despite her critique of ideals of the slender female body, feminist philosopher Susan Bordo (1993) reveals that she lost 25 pounds after enrolling in a commercial weight loss program. Bordo notes that while the weight loss brought her benefits (which she does not specify), it also left her feeling ambivalent and regretful that she could no longer provide an alternative role model for her students as a large woman who was confident and happy (pp. 30-31). In another forum (Fraser 1997:48), Bordo explains her decision to lose weight as an indication of the extent to which women, including feminist intellectuals, are enmeshed in the diet culture.

While the thin ideal has often been condemned by feminists as a means of social control of women, it is fat stigma that serves as the actual mechanism of the social control of women’s bodies. The vilification of fat women ensures that women—even feminists—understand the consequences of not watching their bodies. If they relax their eternal self-vigilance, they too could end up suffering the perilous fate of very large women: unlovely, unloved, unwanted, unemployable. The persecution of fat women not only serves as a punishment to them for transgressing cultural rules but further enforces women’s conformity to the hegemonic body ideal by reminding them what could happen to *them* if they were to let their bodies “get out of control.”

### CONCLUDING REMARKS

Both the feminist literature and the traditional literature on stigma provide insights into the stigma of obesity. Goffman and other social scientists have detailed the social processes which create the stigmatized status. The mark or sign of deviance initiates a drastic inference process that engulfs impressions of the deviant person and sets up barriers to interaction. Stigmatization is more likely to be acute when the deviant person is viewed as the creator of his or her problem and is therefore responsible for

addressing it. Since obesity is widely viewed as a self-inflicted condition, obese people are stigmatized by multiple sources. They are also perceived as being out of control in a society whose value system places great emphasis on the control of desires and impulses.

Obesity stigma, however, is a gendered process. The feminist contribution to the discussion of fat stigma has been considerable in drawing attention to the patriarchal and capitalist context of the social construction of the female body. The situating of fat hatred in the broader realm of gender politics has enhanced our understanding that fat women are not only stigmatized but oppressed.

The theoretical ideas from the stigma literature and the feminist literature will be integrated in my analysis of the experiences of very fat women who sought to manage the stigma of obesity by undergoing surgery. The stigma literature helps me to understand the lived experience of stigma and its implications on these women's lives, as well as on their identities. The feminist literature provides a framework for exploring the implications of gender for stigma in the case of women undergoing bariatric surgery.

The next chapter delineates the methodology used in conducting this research.

## CHAPTER FOUR

### METHODOLOGY

In this chapter I discuss the process of data collection employed in this study of women's experiences of weight loss surgery. I begin by describing my rationale for choosing a qualitative approach for the study of this topic. Since this is not only a qualitative study of weight loss surgery, but also a feminist analysis, I illustrate how my research was guided by feminist methodological principles. I then discuss my sampling recruitment techniques, characteristics of the sample, and data analysis. The generalizability, validity and reliability of my findings are also discussed. I conclude with my reflections on the research process.

#### **THE RATIONALE FOR A QUALITATIVE STUDY OF WEIGHT LOSS SURGERY**

As discussed in the Introduction to this dissertation, weight loss surgery has been researched almost exclusively from a medical perspective, primarily concentrating on refinement of surgical technique. This literature abounds with studies in which surgeons analyze the medical outcome of bariatric surgical procedures, but they do not discuss, in any depth, the emotional and social implications of the surgery for their patients. For instance, how do their patients feel about undergoing the rigors of weight loss surgery? How do they adjust to weight loss, or to an unsuccessful result? In fact, the analyses seem to focus on patients who have lost weight, under-representing women who have not (Powers and Rosemurgy 1989).<sup>45</sup>

Moreover, current research in the medical literature on patients' experience of bariatric surgery overwhelmingly employs research techniques consistent with quantitative methods such as questionnaires or structured interviews. The emphasis is typically on the amount of weight lost and its correlation with

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<sup>45</sup> Powers and Rosemurgy (1989) note the dropout rate in follow-up studies of bariatric surgery is high, about 30 to 40 percent. Hall et al. (1990) and MacLean, Rhode, and Forse (1990) suggest patients lost to follow-up have failed to lose significant amounts of weight. See also Appendix C.



subsequent improvements in the physical and mental health of the patient, as well as the occurrence of side effects. These research strategies are particularly useful for hypothesis testing; however, a strength of qualitative research is that it allows a rich exploration of issues that may have been previously overlooked (Eichler 1990, 1997). Since very little research exists which attempts to understand the personal experience of weight loss surgery from the point of view of the patient herself or himself, qualitative research methods are useful in a study of this topic.

The surgeons are positioned as the experts in the field of bariatric surgery on the basis of their knowledge of the surgical technique involved, as well as the respect traditionally accorded to members of the medical profession. They are depicted as the sole purveyors of knowledge of bariatric surgery, and it is this knowledge that is widely disseminated in medical journals. These tendencies reflect the audience for which medical researchers are primarily writing. The medical profession may be more interested in the medical aspect of the surgery, yet there is more to this surgery than the desirability of one technique over another or even the amount of weight lost. There is a social process involved in the experience of bariatric surgery, and sociologists can contribute to a more complete knowledge about weight loss surgery by providing an in-depth examination of the machinations of these processes. Sociologists can do this by giving the patients the opportunity to reflect on their knowledge about their motivations for undergoing the surgery and to understand their experiences of the surgery, both positive and negative. The sociologist's contribution is not only to give patients a voice but to recognize that bariatric patients have their own expertise, their own knowledge: They, after all, have undergone the operation. They have an intimate understanding of what is involved in the surgery and the impact it has on their bodies and their lives. They too are experts on the basis of their experiential knowledge, and their voices need to be integrated into our understanding of weight loss surgery.

On the basis of these concerns, I chose a qualitative approach to facilitate a holistic analysis of the subjective experiences and meanings of women who have undergone weight loss surgery (Maynard 1994; Taylor and Bogdan 1998). A further strength of a qualitative approach is the possibility it offers of gathering rich, detailed data that are not limited by preconceived concepts and categories (Singleton, Straits, and Straits 1993; Taylor and Bogdan 1998). Women who undergo bariatric surgery often have had

a broad range of embodiment experiences throughout their lives and therefore cannot be easily slotted into pre-specified categories. Maynard (1994) suggests that feelings and perceptions about the body have more affinity with research which employs relatively open-ended strategies. Finally, qualitative research is particularly well suited for exploring new topics of study (Eichler 1990; Rubin and Rubin 1995; Taylor and Bogdan 1998), and little is known about the subjective experience of bariatric surgery and its long-term aftermath.

### FEMINIST RESEARCH PRINCIPLES

This research endeavor is not only informed by feminist theory; it is also guided by feminist research principles. Although there is no singular definition of precisely what feature characterizes feminist social research, according to Maynard and Purvis (1994:6), “[i]t has generally been regarded as an axiomatic feature of feminist social research that it is grounded in women’s experiences.”<sup>46</sup> Feminist philosopher Sandra Harding (1987:2-3) distinguishes among method, methodology and epistemology. *Method* refers to techniques or specific sets of research practices for gathering research material. *Methodology* is a theory and analysis of the research process. *Epistemology* is a theory of knowledge which addresses central questions such as: who can be a knower, what can be known, and what constitutes and validates knowledge.

Harding (1987:6-9) argues that if a methodology is to be feminist, it must have three characteristics: (1) It utilizes new empirical and theoretical resources which incorporate women’s experiences. (2) The research problem is viewed as inseparable from the purpose and consequences of the research and analysis; researchers cannot divorce themselves from the purpose of the research and analysis. (3) The researcher is placed in the same plane as the research participant: “[t]hat is, the class, race, culture, and gender assumptions, beliefs, and behaviors of the researcher her/himself must be placed within the frame of the picture that she/he attempts to paint” (p. 9). The substantive findings themselves include the beliefs, attitudes, as well as the behaviors of the researcher.

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<sup>46</sup> See also Cook and Fonow (1990); Fonow and Cook (1991); Harding (1987); Maynard (1994); Reinharz (1992); Smith (1987); Taylor and Bogdan (1998).

### FEMINIST INTERVIEW RESEARCH

Since my objective was to give bariatric surgery recipients an opportunity to recount their surgical stories in detail, the optimal research strategy was to conduct in-depth interviews. The in-depth interview context provides the researcher the opportunity to clarify responses, probe fruitful topics more deeply and explore motives and feelings (Reinharz 1992; Rubin and Rubin 1995; Taylor and Bogdan 1998). The way in which a response is made (tone of voice, facial expression, hesitation, etc.), can further provide information that a written response conceals (Bell 1993; Singleton et al. 1993).

An argument consistent with Harding's characteristics of feminist methodology is the view that feminist methodology is not an entity separate from other methodologies, but rather the application of feminist principles to the research enterprise (Ollenburger and Moore 1992:59). Data collection employing in-depth interviews has long been a hallmark of feminist research primarily because of the open forum it provides for participants to describe their experience in detail (DeVault 1999; Jayaratne and Stewart 1991; Maynard 1994; Reinharz 1992). As Reinharz (1992:19) explains:

...interviewing offers researchers access to people's ideas, thoughts, and memories in their own words, rather than in the words of the researcher. This asset is particularly important for the study of women because in this way learning from women is an antidote to centuries of ignoring women's ideas altogether or having men speak for women.

Maynard (1994:15) notes that interview research has been of enormous appeal to feminist researchers, but points out "they have not adopted this strategy blindly." She makes the point that feminists have modified every existing research technique, and interviewing is no exception. Oakley's (1981) study of the transition to motherhood for 55 women was a groundbreaking work in feminist methodology and was instrumental in the feminist modification of traditional data collecting process which advocated detachment from the interviewee and to avoid answering questions posed by the interviewee. Oakley's work on motherhood led to a modification in the paradigm used for interviewing; specifically, she challenged the notion that it was inappropriate for the interviewer to answer questions asked by the interviewee. Instead, she found that when asking women about their children, breastfeeding, birthing, etc., interviewees would frequently ask her about her own experiences, as well as ask her for information. Oakley found that, in terms of establishing rapport but also on ethical grounds, she needed to show a

willingness to answer those questions in turn. She decided to abandon the textbook recommendations and answered the women's questions as completely and as honestly as she could. Consequently, she became an important source of information and reassurance about the unknowns and anxieties related to childbirth. As a result of these interview experiences, Oakley developed a feminist paradigm for interviewing by treating the interview as a non-hierarchical interactional exchange.

Oakley's interview paradigm, countering the then traditional positivist approach, has proved to be very influential for both feminist and non-feminist researchers (Nielsen 1990; Reinharz 1992; Rubin and Rubin 1995). Although there is no consensus about the particulars and the practical details involved in a feminist interview, feminist researchers agree there should be no hierarchical separation between the interviewer and the interviewee (Cook and Fonow 1990; Harding 1987; Kirby and McKenna 1989; Reinharz 1992; Rubin and Rubin 1995).<sup>47</sup> Instead, feminist researchers have argued for the establishment of a genuine, rather than instrumental, relationship between the interviewer and the participant. This, in turn, encourages a non-exploitative relationship, where the research participant is not treated as a passive source of data. A non-exploitative relationship between researcher and participant extends to providing information and assistance to the participant if it is requested (Cook and Fonow 1990; DeVault 1999; Oakley 1981; Reinharz 1992).

Reinharz (1992:22) suggests that "[u]sing unconventional terms such as "participant" instead of "subject" is a signal that the researcher is operating in a feminist framework that includes the power to name or rename." Moreover, referring to individuals who are being researched as "participants" rather than as "subjects" empowers them and recognizes them as active and agentic, rather than static and passive.

Another distinguishing feature of feminist interview research is the liberal inclusion of the researcher's personal experience in the research, concomitant with the conviction that including the researcher's experience in the process does not taint or bias the data; rather, it enriches it (DeVault 1999; Kirby and McKenna 1989; Maynard 1994; Reinharz 1992; Stanley and Wise 1993). Maynard (1994:16)

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<sup>47</sup> Even though feminist researchers endorse the principle that trust is necessary between the interviewer and the interviewee, and that trust is fostered through researcher self-disclosure, Reinharz (1992:34) points out that "there is no single feminist perspective on researcher-interviewee relations and self-disclosure. Rather, there is openness to numerous possible meanings of these phenomena."

maintains, “rather than being seen as a source of bias, the personal involvement of the interviewer is an important element in establishing trust and thus obtaining good quality information.” Stanley and Wise (1993) argue that the researcher is also a subject in her research and that her history is part of the process which “understanding” and “conclusions” are reached. Many feminist researchers describe how their research interests stem from, and are a part of their own lives, thereby merging the “public” and “private” (Kirby and McKenna 1989; Reinharz 1992:258, 259).

In the Introduction to this dissertation, I have indicated that my research interest stems from my experience (and tribulations) as a moderately obese woman. The connection between the research project and the researcher’s experiential self frequently takes the form of “starting with one’s own experience” (Reinharz 1992; Smith 1979, 1987). “Starting with one’s own experience” serves as a guideline to the researcher that she is starting from the standpoint of women. Dorothy Smith (1979), a major advocate of writing sociology from the standpoint of women, begins with her experience when doing research:

The work of inquiry in which I am engaged proceeds by taking this experience of mine, this experience of other women...and asking how it is organized, how it is determined, what the social relations are which generate it. (P. 135)

DeVault (1999:39) adds, “[f]rom this beginning, the inquiry points toward an analysis of the social context for experience, the relations of ruling that organize daily life and connect all members of a society in systematic interactions.”

Personal experience can provide the researcher with a good vantage point from which to develop questions and the source for finding participants. This “insider knowledge” can also provide a researcher with unique insights not available to those who have not shared this experience. For instance, my own experience of fatness made me aware that family members can also be victimizers and this inspired me to ask questions about how fatness affects family dynamics. Battling my weight for most of my life has made me extraordinarily sensitive to the fact that weight loss is not just a matter of will power, as is often perceived by both medical professionals and laypeople alike. More than anything, my having been fat makes me sensitive to the indignities faced by fat people and to the recognition that fat people genuinely constitute a victimized group.

## APPLICATION OF FEMINIST INTERVIEW PRINCIPLES TO THE STUDY OF BARIATRIC PATIENTS

I employed a semi-structured, open-ended interview format to allow my participants to provide detailed accounts of their decisions to undergo bariatric surgery and their embodiment experiences both before and after the surgery. Reinharz (1992:281) defines semi-structured interviewing as “a research approach whereby the researcher plans to ask questions about a given topic but allows the data-gathering conversation itself to determine how the information is obtained.” According to Raymond (cited in Reinharz 1992:18), “[t]he use of semi-structured interviews has become the principal means by which feminists have sought to achieve the active involvement of their respondents in the construction of data about their lives” (italics omitted).

The interview format also contained some elements of a life-history interview (Rubin and Rubin 1995; Taylor and Bogdan 1998), in that I wanted to talk to my participants about their experiences of fatness as far back as they could remember. The questions were left open-ended to lend a conversational tone to the interview and to provide the participants with the opportunity to relate their accounts in detail and in the way that they chose. Open-ended questions also permit the researcher to probe with follow-up questions.

It may be legitimately argued that an unstructured interviewing style gives a participant more space and range to recount her experience. However, I was wary of incorporating tangential information into my data set and wanted to remain focused on the participants’ experiences of morbid obesity and their decision to resolve it by undergoing weight loss surgery.

The interview schedule (please refer to Appendix D) was designed to ask the participants about their life histories, as it related to their weight and their surgery. The interview was divided into five major sections. After obtaining pertinent demographic information, I asked the participants to chronicle their lives before their surgery, going back to the time they first became aware they were overweight. This section of the interview covered issues such as stigmatization, discrimination, relationships with others, quality of encounters with medical professionals, health status, and previous attempts to lose weight, etc. I also asked about their feelings about their body and how it impacted on their sense of self and identity prior

to their operation. The second section of the interview addressed the decision-making process involved in undergoing the surgery, support from spouses, friends and family, the relationship with the surgeon and the experience of the surgery. The third section of the interview was concerned with the postoperative course; i.e., complications, weight loss, need for reversal or for another surgery, etc. The fourth section examined the participants' feelings about the results of the operation and how it impacted on their personal and professional lives. I also asked how their post-surgical bodies made a difference on their sense of self and identity. The final section of the interview was concerned with attitudes toward morbidly obese people, attitudes toward the fat acceptance movement and the role of surgical support groups in both the preoperative and postoperative phases. I concluded the interview by asking what recommendations the participant would suggest to a woman who is considering undergoing weight loss surgery. Before I turned off the tape recorder, I asked if the interviewee had anything else to add before the interview ended.

Previous research I had conducted on the stigma of obesity (Joanisse and Synnott 1999) made me sensitive to the fact that recounting stories of victimization can be very traumatizing for people who experience stigmatization and rejection from many sources, sometimes on a daily basis. If an interviewee were to become extremely distressed in response to an interview question, my intention was to turn off the tape recorder and offer to resume the interview at a later date or ask if she would prefer withdrawing from the study. I had the names of two therapists to whom I could refer participants who felt the interview process overwhelmed them, although I did not seriously anticipate that this would happen.

Feminists writing on research methodology emphasize it is inappropriate for researchers to "take the research and run" (Kirby and McKenna 1989:69). Interviewees who have taken the time to participate in the research and, in the case of interview research, answer questions of a highly personal nature should not be left stranded once the interview process is complete. Research participants deserve to know the eventual outcome of their contribution to the study. Feminist researchers advocate the precept of "returning the research" to their participants as one way of reducing the inequality often characterizing the relationship between the researcher and the researched and to reduce the possibility of exploitation of research participants (Patai 1991:146). The question remains however, at what stage should the research be returned to the researched? Patai appears to advocate involving the participants in all stages of the research

project. Kirby and McKenna (1989) also suggest that participants should be invited to comment on drafts. However, the notion of involving the participants at all levels of data analysis can be problematic for various reasons (Patai 1991:147). One of the reasons includes lack of interest on the part of the research participants in further involvement in the project. For example, Patai (1991) describes Liz Kennedy's experience of conducting research in a lesbian community. Kennedy was surprised and disappointed that her subjects often did not express interest in her follow-up communications or failed altogether to respond. She concluded that they simply did not share her intense involvement with the project. Although Patai is a strong believer in returning the research, she counsels researchers to "guard against foisting onto others a demand or a wish for reinforcement in our work and our concerns" (p. 147).

I agree that returning transcripts to participants allows them to exert control over the researcher's interpretations. However, in the context of my own research, it was simply not feasible for me to provide transcripts and drafts to my participants for commentary and feedback. I was also concerned that an attempt to involve interviewees in the data analysis might be viewed as an intrusion to participants who may be only interested in giving up to two hours of their time, at most, to this research. Further, while I was determined to maintain an equal relationship during the interview, during the data analysis phase, my conclusions are my own and I alone am responsible for them. I resolved this issue by offering my participants a summary of the research findings.

### The Interview Process

I interviewed 30 women, 15 Canadians and 15 Americans, about their experiences of bariatric surgery.<sup>48</sup> The interviews were from one and one half-hours to two hours in length. Eleven of the interviews were conducted in person. These took place in a variety of settings: the participants' homes, restaurants, hotel rooms, and in my own home. The rest of the interviews were conducted by telephone. Five of the interviews were conducted in French and then translated into English. I tape recorded and fully transcribed the interviews. The transcripts were later coded for analysis.

Rubin and Rubin (1995) point out that telephone interviews are impersonal and deprive the

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<sup>48</sup> The recruitment process is discussed in the next section.



interviewer of important non-verbal cues, such as facial expression and body language. Rubin and Rubin, as do numerous other qualitative researchers, maintain the interviewee's non-verbal language is as important as his or her words. Oddly, though, Rubin and Rubin bolster their argument about the significance of body language by describing how the *interviewer's* body language can influence the interview process. For instance, the first author describes an interview where he leaned forward to show "real interest" in what his informant was saying and sat back when he wanted to minimize discussion of the topic (p. 141). I would argue that this example illustrates how the interviewer's body language can act as a distraction and a muzzle to the interviewee and inadvertently (or deliberately) dominate the interview process. Interviewer interest or disinterest in the topic of discussion, however subtle, is yet another way of establishing the interviewer's power over the interviewee by determining what gets discussed and what does not. An interviewee who is aware of the interviewer's disinterest will likely become uncomfortable about pursuing a particular subject, even if important information has not yet been revealed.

The interviewer's body language at least cannot distract the interviewee when the interview takes place on the telephone. I do not discount the importance of non-verbal cues, but I do point out that there are non-verbal cues other than body language which can serve as indicators to an interviewer. Oral cues such as long pauses, sharp intakes of breath, or rambling can indicate that the interviewee is feeling strong emotion about a particular subject. Inflections and intonations in the person's speech can also guide the interviewer. To summarize, I argue that the information obtained during a telephone interview is not necessarily inferior to that obtained from a face-to-face interview.

Babbie (2001) points out that one advantage of telephone interviews is their relative cost and time efficiency. Given the time and financial constraints that I faced, telephone interviewing was both time and cost effective. Had I had to conduct all my interviews in person, I would have ended up with a much smaller, more homogeneous sample.

Another advantage of telephone interviewing is the privacy it affords to the interviewee. Several women told me candidly that they would not have granted me the interview in person, mostly because of reasons of confidentiality. The great majority of the sample were very discreet about their surgery; for instance, very few interviewees had told anybody outside their immediate families and close friends that

they had had surgery. Some women had been asked by their surgeons to describe their successes with weight loss surgery on talk shows, but they refused to do so because they would lose their anonymity. However, they wanted other women to know about this surgery and their experiences with it; thus, a telephone interview provided them with the ideal forum to disseminate their information. Finally, telephone interviews have the advantage of being very convenient for both the researcher and the participant, as neither has to displace herself. My participants and I could talk in comfort and privacy while husbands were absent, children were sleeping, or after the end of a working day.

I achieved a high level of rapport with virtually all the interviewees. In some instances, I had exchanged numerous e-mails with the women and had therefore established a relationship, however fragile, with them. As well, I had spoken to various women on the telephone before the actual date of the interview itself, so we were not entirely unknown to each other. A substantial level of intimacy was developed during the interview even with the women with whom I had not established a prior relationship. The interviews proceeded smoothly, with nobody refusing to answer any questions. While there were some women who were not loquacious and tended to answer questions in a "yes" or "no" fashion, probing and asking for further elaboration or clarification drew them out. In most cases the conversation continued after the "official" interview had ended. I attribute the rapport I had with my participants to our shared interest in fatness and to my interviewing style, which was friendly and conversational in tone. I was also careful to never interrupt my participants as they were speaking. Besides being rude, interrupting participants during an interview gives the interaction a hierarchical, question-and-answer tone, with the interviewer asserting power over the interviewee. Interruptions also usurp an interviewee's space, thereby robbing them of the chance to describe an experience or opinion they feel is relevant. I sometimes redirected the conversation if I felt it was going in tangential directions, but I never interrupted the participants while they were speaking. This may seem to be a trifling point, but women are frequently interrupted by others, and an interview cannot truly be a non-hierarchical exchange if one person interrupts the other.

In both the telephone and interview contexts, I did not immediately launch into the interview as soon as I met the participant or when she answered the telephone. I engaged the participants in small talk,

and after I felt that a suitable level of comfort had been achieved, I asked if they were ready to begin the interview. Only then did I turn on the tape recorder. I resolved the issue of informed consent with the telephone interviewees by reading the consent form to them and then asking them if they had any questions for me before we proceeded with the actual interview. I then obtained their home addresses and sent the Letter of Information and the Consent Form to them, requesting them to sign the form and return it to me in the enclosed self-addressed, stamped envelope. All participants complied with this request. (Please refer to Appendix E and F for a copy of the Letter of Information and the Consent Form, respectively).

In keeping with the feminist policy of researcher self-disclosure, I answered the women's questions about my own weight, dieting attempts, feelings about my body, etc., honestly and unselfconsciously. Again, in accordance with feminist research principles of giving assistance to participants if requested, I provided what information about obesity that I could. Some women asked me to send them articles from medical journals which explained why weight regain is so common after dieting, and I complied with this request. One woman wanted to read empirical findings on the stigmatization of obesity, and I sent her a copy of Breseman et al.'s (1999) comprehensive review of the literature on the stigmatization of obesity.

While I am satisfied with the information I obtained from the telephone interviews, I have to concede that the personal interviews afforded me insights and privileges that telephone conversations alone, as in-depth and informative as they were, simply could not achieve. Meeting 11 interviewees in person gave me the opportunity to see for myself the tremendous changes—both positive and negative—that occurred in these women's bodies as a consequence of the surgery. Many showed me "before" photographs. As well, three of the women showed me their surgical scars. Interviews held in the participants' homes also gave me the opportunity to observe their dynamics with other family members. One participant, in particular, was especially welcoming of the opportunity to recount her surgical experience. She showed me around the area where she lived and when we reached her home, her family members actually clapped when she introduced me and explained the reason why I was there. Her husband shook my hand, saying that his wife had wanted to recount her surgical story for years but had nobody

outside her family to tell. This incident impressed upon me how important it is for researchers to hear marginalized women's stories from their own perspectives.

The women were assured of confidentiality by being identified under a pseudonym. They were asked to choose the pseudonyms themselves; I felt that being identified under a self-selected pseudonym would personalize the research experience for the participants and could give them a stronger sense of connection to the data. In the few instances where the women had no preferences, I assigned a pseudonym to them. I asked each of the sample members if they would like to receive a summary of my findings and all indicated they would. Virtually all participants told me this research was important and that I should write a book on this topic.

### SAMPLE RECRUITMENT

My original intent was to interview approximately 16 participants who had undergone bariatric surgery, preferably two years prior to the data collection phase to ensure that an adequate period of time had elapsed for them to reflect on the consequences of the surgery. My strategy was to get a few names and to use a snowball technique to expand the sample. A modest sample size was thought to be realistic because I was under the impression that bariatric surgery was only rarely performed in southern Ontario. A series of scathing articles had been written in the local newspaper about the experiences of two women who had had devastating outcomes from the surgery (Barlow 1998a; 1998b; 1998c; "Weight Loss Surgery Patient Dies" 1998). The author of one of those articles reported that only three surgeons in the "Golden Horseshoe" area performed bariatric surgery and I concluded that I could cull only a very small sample, locally.

In the fall of 1998, an acquaintance who is a family doctor practicing in a medium-sized city in Quebec, expressed great interest in my research topic. He offered to help me by mentioning my research to three female patients who had undergone weight loss surgery. They indicated to him that they would grant me an interview and gave him permission to provide me with their home phone numbers. After speaking to them on the telephone, I traveled to their locale in the summer of 1999 to further explore the possibility that

they might be participants in a study on this topic. Two of these women provided me with one contact each: a sister and a close friend. I also spoke to these two women during that same trip.

A relative from Quebec gave me the names of another sister dyad whose parents had lived next door to her when she grew up in a suburban city, 20 kilometers south of Montreal. She knew that both women had undergone weight loss surgery and were very forthcoming about their experiences with this surgery. She gave me their telephone numbers and when I called them, both indicated they would give me an interview whenever I was next in their area.

After this initial success, however, I experienced some difficulties; namely, getting more people to speak to me about their surgical experience. Four women I knew had a friend or a relative who had undergone weight loss surgery and they offered to ask them if they would like to participate in my research. These women categorically refused to give me an interview. My friends felt that their refusal was based on the fact that the surgery was not successful for these women and that they were perhaps too embarrassed to talk about an experience they perceived as a failure. One of these women, however, appeared to have had a successful surgery. But she refused to be interviewed because her husband did not know that she had once been morbidly obese, and she feared that he would somehow find out about this were she to participate in interview research. She was assured of complete confidentiality but remained resolute in her decision not to be interviewed.

Despite my mention of my research to almost every person I met for the next two years, I was unable to recruit any more participants. Advertisements I placed on bulletin boards in grocery stores and pharmacies in suburban southern Ontario cities were met with no response. My committee was reluctant to persuade me to place advertisements in the local papers on the grounds that this is a costly endeavor which often yields few participants.

One committee member referred me to a psychiatrist who had facilitated a bariatric surgical support group for women at a hospital in a major southern Ontario city. While the psychiatrist expressed an interest in the research, she informed me the hospital which had sponsored the support group had stopped performing the surgery many years before and the group had stopped meeting since then. As a

result, she had lost touch with many of the women in the group. She did, however, agree to mention my research to any of those women who might happen to contact her.

I did not approach bariatric surgeons to ask them if they would agree to act as a source of participants for several reasons. I had sent some e-mail inquiries to two surgeons practicing in southern Ontario but did not receive a response from either of them. It is possible that those surgeons were concerned about patient privacy and confidentiality. In addition, bariatric surgery patients typically consult their surgeons once before the procedure and possibly once or twice afterwards. They are then followed up by their family physicians. Surgeons whose patients do not experience protracted difficulties after the surgery likely close those patients' files. As a consequence, bariatric surgeons may only be a potential source of contacts who are in the immediate aftermath stage of the surgery.

Finally, I had not placed an invitation to participate on the Internet, as I literally had no idea where to start. As well, my original intention was to meet with the participants in person; therefore, they had to live within driving distance of where I live in southern Ontario. After some discussion with my committee, it was decided that since I was having such difficulty recruiting local participants, increasing my sample size could only be achieved by expanding my geographic perimeter. This, in turn, could best be done by placing an invitation to participate on the Internet. To do so, however, required substantial changes in my research design. When I first conceived of this research project, I had assumed that my prospective participants would all be Canadians, probably living in central Canada, and that I would interview them in person. Recruitment through the Internet would surely catch the attention of Americans, particularly since bariatric surgery is popular in the United States. However, my committee and I agreed that interviewing Americans provided an opportunity to diversify the sample and to determine to what extent the experience was similar or different, depending on which country the participant lived.

The expansion of my geographic reach also meant that I had to modify my intention of interviewing all my participants in person. In view of my diminutive financial resources and the inherent logistical difficulties involved in interviewing people who live across the United States, it was obvious that many of the interviews would have to take place on the telephone. One of my committee members asked an academic contact at NAAFA to place an ad on their Web site describing my research and inviting

NAAFA members to participate. Luckily, the contact person responded to this request very promptly, placing an invitation to participate notice two days later (March 19, 2001). (Please refer to Appendix G for a copy of the invitation to participate.) This proved to be a turning point in my recruitment efforts, as several NAAFA members, all of whom were Americans, contacted me.<sup>49</sup> I responded to their inquiries by providing some background information about my research and the previous work I had done on the stigma of obesity. I also emphasized that I would be assuming the expense of the long-distance call. For those who did not provide me with a phone number in their initial e-mail, I encouraged them to engage in further e-mail correspondence with me if they were not comfortable immediately giving out their home phone number to a stranger. They all provided their phone numbers in their next e-mail response. Ultimately, I was able to recruit seven sample members through the ad placed on the NAAFA Web site.<sup>50</sup>

One NAAFA member spontaneously forwarded the original invitation to participate to two on-line surgical support groups of which she was a member. The invitation was further disseminated among other on-line surgical support groups in the United States. As a result, I found myself flooded with e-mail and telephone calls from American women during the months of April and May 2001. Three snowball contacts were also generated from the women who contacted me as a result of the Internet posting.

After conducting interviews with 15 American women, I decided to close the study to Americans and focus my efforts on recruiting more Canadians. One American woman had a Canadian friend who had undergone the surgery who lived close to me. This woman agreed to take part in my research, but this still left me with twice as many Americans as Canadians.

One American interviewee told me that the largest on-line obesity surgery support group in the U.S. (OSSG) had a wide network in Canada as well. Although I was concerned about having a preponderance of sample members generated from surgical support groups, I decided that this forum at least represented the best opportunity to reach Canadian women who had undergone bariatric surgery. On

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<sup>49</sup> This was not particularly surprising, as NAAFA has only about 100 Canadian members (Nemeth 1994).

<sup>50</sup> The invitation to participate was forwarded to another size acceptance group based in the United States and some members offered to get involved. However, I had already declared a moratorium on more American subjects. As well, I had some concerns about the homogeneity of my sample and did not want to focus my efforts primarily on size acceptance groups.

April 23, 2001 I posted an invitation for participants on this support group's OSSG-Canada Web site (see Appendix H). This invitation yielded six participants, all of whom lived in southern Ontario. I had been under the impression that this Web site was accessed by women all over Canada but later found out that OSSG participation is minutely splintered along various axes: region, province, city, type of surgery, hospital where surgery was performed, etc. Apparently, OSSG participants who surf or post on the "Canadian" site, are predominantly from Ontario. I interviewed those six respondents in April and May 2001. I also traveled to Quebec in April 2001 to interview the seven participants living there. By mid-May I had a sample of 29 people, 15 Americans and 14 Canadians and was satisfied with this number.

Although I closed the study at this point, the psychiatrist who I had approached in March 2001 contacted me in June to tell me that she had recently seen one of the women who belonged to the support group she used to facilitate, and the woman was very enthusiastic about participating. Since the psychiatrist had gone to so much trouble on my behalf, and considering that her patient was anxious to recount her surgical story, I felt it was important to interview her. It also meant that I would have an equal number of participants from Canada and the US. The recruitment sources are summarized in Table 4.1.

**Table 4.1—Network of Contacts**

<b>Recruitment Sources</b>	<b>Number</b>
NAAFA	7
Internet Surgery Support Group(s)	12
Snowball	5
Personal Contacts	2
Physician Referrals	4
<b>Total</b>	<b>30</b>

Unfortunately, I was not able to interview everybody who contacted me. For one, many people had not yet had the surgery and so did not qualify for participation. Other people had the surgery only a very short time before the interview (e.g., two weeks or one month) and therefore did not meet the criteria for participation. Many participants offered to give me the names of people they knew who had had the surgery, but I had to turn these offers down because of deadline and financial pressures. I also had to take the rigors of transcribing into consideration and simply had to declare a moratorium at some point.



For a number of reasons, women who were fewer than two years postoperative participated in the study. This turned out to provide an interesting opportunity to compare those women who had the surgery most recently to women who had the surgery a number of years ago.

### CHARACTERISTICS OF THE SAMPLE

Of the Canadian sample members, seven lived in Quebec and the rest in southern Ontario. Every geographic region in the United States is represented.<sup>51</sup> Their ages ranged from 22 to 61, with the average age being 43.4 years: three women were in the 20-30 age range; 10 women were in the 31-40 age range; eight women were in the 41-50 age range; seven women were in the 51-60 age range; two were over 60. All were white, of European descent. There were two sister dyads in the sample. The participants' sexual orientation was not asked, but I was able to reconstruct from their narratives that all were heterosexual. Fifteen of the sample members were married; three of these participants were married for the second time. Three were co-habiting with a male partner. Seven were single and living alone. Three were divorced. Two were separated. Demographic information is presented in Table 4.2.

The participants were drawn from a broad range of sociological groupings, but the majority of the sample was clustered in female-dominated occupations. On the basis of the information provided on the participant's or her spouse's educational and occupational level, I determined most of the sample were of working class status. Nine women had finished high school; two did not. Eighteen had one or more years of post-secondary education. One held an advanced degree. One woman was a homemaker who had never participated in the paid labor force. One woman had retired early from the paid labor force. Three women were living on social assistance.

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<sup>51</sup> One of the women included in the American sample, although currently living in the United States, was actually born and raised in New Zealand and underwent surgery there.

Table 4.2--Demographic Information

Participant's Name	Age	Marital Status	Country of Residence
Barbara	59	Married	United States
Casey	38	Single	Canada
Catherine	33	Married	United States
Celeste	61	Married	United States
Cinzia	36	Co-habiting	Canada
Cynthia	25	Married	Canada
Doris	61	Separated	Canada
Elaine	28	Married	United States
Filomena	42	Married	United States
Fiona	36	Married	Canada
Gisèle	48	Co-habiting	Canada
Isabella	56	Married	United States
Jeanne	59	Separated	Canada
Jennifer	31	Married	United States
Joanne	35	Divorced	Canada
Juanita	47	Single	United States
Julie	35	Single (engaged)	United States
Lara	46	Married	Canada
Marcia	45	Single	United States
Marianne	47	Single	United States
Nadine	31	Married	Canada
Nicole	51	Married	Canada
Renate	39	Married	United States
Rosemary	44	Married	United States
Sherri	51	Single	United States
Suzanne	55	Divorced	Canada
Trudy	48	Single	Canada
Valerie	22	Married	Canada
Wanda	39	Co-habiting	United States
Yolande	54	Divorced	Canada

The participants' preoperative weights ranged from 238 pounds to 500 pounds, with the average being 337 pounds. The median preoperative weight was 318 pounds. Their current weights ranged from 136 pounds to 600 pounds, with the average being 254 pounds. The median current weight was 214 pounds. The participants' weight histories are summarized in Table 4.3.

Table 4.3--Participants' Pre-Surgical and Current Weights

Participant's Name	Preoperative Weight (pounds)	Lowest Weight Obtained (pounds)	Postoperative Weight loss (pounds)	Current Weight (pounds)
Barbara	265	185	80	185
Casey	306	236	70	236
Catherine	328	220	108	220
Celeste (*)	243	140	103	219
Cinzia	280	148	132	148
Cynthia	260	175	85	175
Doris (*)	330	230	100	300
Elaine	348	162	186	168
Filomena	293	203	90	203
Fiona	320	220	100	220
Gisèle (*)	300	138	162	265
Isabella	460	196	264	196
Jeanne (*)	387	154	233	230
Jennifer	470	320	150	340
Joanne	350	180	170	205
Juanita (*)	280	186	94	292
Julie	392	140	252	192
Lara	240	136	104	140
Marcia (*)	376	286	90	313
Marianne (*)	455	295	160	350
Nadine	250	130	120	155
Nicole	314	149	165	149
Renate (*)	500	400	100	496
Rosemary	315	212	103	212
Sherri	456	280	176	280
Suzanne (*)	250	150	100	405
Trudy	345	270	75	270
Valerie	310	239	71	239
Wanda (*)	404	254	150	600
Yolande	287	180	107	180

\*These women's current weights are not commensurate with the amount of weight lost because their surgeries were unsuccessful. In those cases, the "weight loss" column refers to the weight lost after their surgery.

The participants underwent surgery as long ago as 23 years, or as recently as five months prior to the interview. Seven surgical procedures were represented in the sample. Thirteen participants underwent vertical banded gastroplasty (VBG). Nine of them underwent Roux-en-Y gastric bypass (RNY). Three had a duodenal switch (DS). Two had a jejunioileal bypass (JIB). One had an adjustable gastric band (AGB). One underwent horizontal banded gastroplasty (HBG) and one had a silastic ring vertical gastroplasty (SRVG). The surgical procedures are presented in Table 4.4.

**Table 4.4--Surgical Procedures**

Surgical Procedure	Number of Participants
VBG	13
RNY	9
DS	3
JIB	2
AGB	1
HBG	1
SRVG	1

Four of the sample members are "re-ops"; that is, they underwent bariatric surgery more than once. Two of the women had the same procedure repeated, while one woman had two different procedures. Finally, the fourth woman in this group had three weight loss operations: the first two were the same procedure; the third was different. This information is presented in Table 4.5.

**Table 4.5--Participants Who Underwent Multiple Procedures**

Name of Participant	Procedures
Yolande	VBG (x 2); RNY
Sherri	VBG (x 2)
Valerie	VBG (x 2)
Julie	AGB; DS

#### **DATA ANALYSIS: INTERPRETING THE STORIES**

I fully transcribed the interviews myself to preserve my participants' words and to maintain their confidentiality. Although transcription can be an arduous process, it afforded me the opportunity to become very familiar with my data set. As DeVault (1999:74) observes, "[t]ranscription...is typically

viewed as a mechanical task, ... [but] many researchers do acknowledge that the transcription process can afford rich insight." I considered the transcription phase to be an integral part of the process of data analysis.

The transcripts were coded and analyzed using a grounded theory approach (Glaser and Strauss 1967; Strauss and Corbin 1990). Grounded theory is a qualitative approach that generates theory from data. That is, according to Strauss and Corbin (1990), grounded theory is not generated *a priori* and then subsequently tested. Rather, it is:

... inductively derived from the study of the phenomenon it represents. That is, it is discovered, developed, and provisionally verified through systematic data collection and analysis of data pertaining to that phenomenon. Therefore, data collection, analysis, and theory stand in reciprocal relationship with each other. One does not begin with a theory, then prove it. Rather, one begins with an area of study and what is relevant to that area is allowed to emerge. (P. 23)

The resulting theory is an explanation of categories, their properties, and the relationships among them leading to an evolutionary body of knowledge that is "grounded" in systematically analyzed data (Glaser and Strauss 1967; Strauss and Corbin 1990).<sup>52</sup>

At the heart of grounded theory analysis is the coding process. In grounded theory codes are developed from the analysis of the data as it is collected. Coding involves breaking down the data into concepts, categories of concepts, assigning properties to categories, dimensions of properties along a continuum, and breaking properties into dimensions (Strauss and Corbin 1990:61). Strauss and Corbin distinguish among three types of coding: *open*, *axial*, and *selective*.

Open coding is the initial process in the data analysis generating grounded theory. Strauss and Corbin define open coding as "the process of breaking down, examining, comparing, conceptualizing, and categorizing data" (p. 61). During this phase, each line or sentence is coded to label incidents or events represented by the data. The next step in the procedure is to categorize these codes by grouping them around phenomena discovered in the data which are particularly relevant to the research question. Categories and sub-categories are created through the use of constant comparison and questioning of the data. As a result of coding the interview transcripts line by line, I was able to identify over 40 categories

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<sup>52</sup> See also Charmaz (1995) and Strauss (1987).

and sub-categories in my data. These included stigmatization; relationships with significant others; body image—internal vs. external; body politics; and the notion of temporality (locating oneself in time).

During the axial coding phase, the categories found in open coding are further refined and differentiated. If open coding involves the breaking up of the data set into discrete parts, axial coding puts “data back together in new ways by making connections between categories and its subcategories” (p. 97). This is done by means of a coding model denoting causal conditions, context, intervening conditions, action/interactional strategies and consequences. Axial coding represents the delineation of hypothetical relationships between categories and sub-categories; the objective is to uncover the connections between categories. For example, during the axial coding phase of my data analysis, I noted that the gender of the referring doctor had an impact on body politics.

Selective coding is the process of selecting the core categories identified in the analysis and then relating it in a systematic way to the other categories uncovered in the research (p. 116). The aim of selective coding is to elaborate the core category around which the other developed categories can be grouped and by which they are integrated. During the process a story and story line will start to be developed around the principal phenomena uncovered by the research. Two core categories were identified in this dissertation: (1) the burdens morbid obesity placed on the participants and (2) the transformative effect—both positive and negative—of bariatric surgery. These categories are intertwined in my findings chapters.

Strauss and Corbin recommend the use of memoing, or writing memos or notes throughout the data collection and analysis process. Memos document the findings in a grounded theory investigation. They are useful for organizing a researcher’s ideas and facilitating the development of themes. Strauss and Corbin (p. 197) distinguish among three kinds of memos: *code notes*, *theoretical notes*, and *operational notes*. Code notes identify the code labels and their meanings. Theoretical notes cover a variety of topics such as the dimensions and meanings of concepts, relationships among concepts, theoretical propositions, and so on. Operational notes deal primarily with methodological issues.

I kept detailed theoretical and operational notes throughout the study. My theoretical notes contained ruminations on possible coding categories, core categories, emergent patterns and relationships,

differences and similarities among the accounts, and so on. The operational notes referred to information about the participant and the interview context such as the time the interview took place, the flow of the conversation, my reactions to the interview, etc. After reading the operational notes on two interviews that took place after 10 p.m., I decided that these indicated I was simply too tired to conduct my best interviews at that time. In order to avoid this problem in future interviews, I scheduled interviews at 9 p.m. at the latest or on the weekends.

I also recorded, as part of both the theoretical and operational notes, the type of interaction I had with each participant, the extent to which the interview digressed and how I brought it back to the topic at hand. I looked for particularly fruitful probes, and thought about questions I should have asked, questions that could be helpful in another similar interview situation, and many other notations of a similar nature. The theoretical and operational notes form the substance of this chapter and the three subsequent data findings chapters.

#### **CRITERIA OF MEASUREMENT QUALITY: GENERALIZABILITY, VALIDITY AND RELIABILITY OF FINDINGS**

The limitations of this study should be noted. Since the findings of this research are based on a small, nonrandom sample, I cannot assume that my sample represents all women who have had bariatric surgery. However, there was some triangulation in my sample: with English-Canadians, French-Canadians and Americans participating in this research, I have three quite distinct sample points. Therefore, I am able to test the generalizability of my findings by incorporating women from different geographic locations. This allows me to rule out that there may be something specific to a certain region or group of doctors within a region that makes the experience of the women unique to that location.

Validity is concerned with the degree to which the item measures or describes what it is purported to measure or describe (Johnson 1988). This may seem like a straightforward concept, but measuring the extent of validity can be complicated, and there are several variations of validity (Babbie 2001; Kirk and Miller 1986). In particular, my research has face validity (also known as “apparent” validity). I.e., the research instrument is valid “on its face.” The participants described experiences that they themselves

underwent; their recollections were not based on hearsay. The interview questions were carefully thought out on the basis of my own expertise and on the basis of my exhaustive literature review on this topic. Since the questions were open ended, the participants were given the opportunity to describe and explain the meanings of concepts that were important to them.

Reliability refers to “the extent to which a measurement procedure yields the same answer however and whenever it is carried out” (Kirk and Miller 1986:19). According to Wragg (cited in Bell 1993:64-65), the reliability of interview data can be assessed by asking, “[w]ould two interviewers using the schedule or procedure get a similar results [sic]? Would an interviewer obtain a similar picture using the procedures on different occasions?” In discussions about the assessment of qualitative research, validity is emphasized more than reliability (Kirk and Miller 1986; Kvale 1996; Taylor and Bogdan 1998). While qualitative research has frequently been criticized for its lack of reliability (Hammersley 1992), qualitative researchers reply that it is simply not possible or desirable to produce meaningful qualitative studies that can be easily replicated (Hammersley 1992; Taylor and Bogdan 1998).

I am certain that if I were to interview the same sample on another occasion, using the same interview schedule, I would achieve similar results. However, if another researcher were to use the same interview guide, the achievement of comparable results is not assured. The women in this sample may not have spoken so openly to a male researcher. Nor may they have been as forthright with a researcher who did not identify herself as having weight issues of her own. Additionally, I think that the endorsement of my research by a senior NAAFA member had an influence on NAAFA members to come forward and tell me about their experiences. A researcher who does not have this endorsement may be viewed with greater suspicion and hostility by NAAFA members.<sup>53</sup> Taylor and Bogdan (1998) point out that how a researcher feels about the topic may influence what she or he hears; therefore, somebody who has a strong bias towards or against the surgery may interpret responses differently than I did. A qualitative interview does

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<sup>53</sup> Gimlin (2002) notes that it is difficult for an average-sized or thin woman to conduct ethnography in a NAAFA setting because members—predominantly women—often treat thin women with overt hostility. NAAFA is also vociferous in its condemnation of weight loss surgery (*NAAFA Workbook* 1995).



not merely follow a question-and-answer format; the dynamic between the interviewer and interviewee is an integral part of the research process and has to be taken into consideration.

Due to the methodological limitations noted above, this research should be regarded primarily as a catalyst for further study. I appeal to other researchers to study this neglected topic.

### REFLECTIONS ON THE RESEARCH PROCESS

As Maynard (1994:16) notes, "feminist research is characterized by a concern to record the subjective experiences of doing research." I did not view the process of interviewing women who have undergone obesity surgery as just a mechanical process of data collection to be treated as a means to an end. The data collection phase of this dissertation work affected me not only as a feminist researcher but also furthered the realization that the stigmatization of morbidly obese women has ominous implications for all women.

I felt varying emotions as I talked with my participants. These ranged from sympathy for what they had endured before and after their surgery; outrage over the shabby treatment they received from numerous sources; happiness for their pleasure over their new-found bodies and selves and the opportunities they felt were now open to them; admiration for the dignity with which the women whose surgeries were not successful acquitted themselves. Most of all, I felt profound gratitude for their generosity in not only giving me their time but also giving me unrestricted access to an extremely intimate aspect of their lives.

Feminists maintain that coping with stress should be recognized as one of the challenges of interview research (Reinharz 1992:36). This point is relevant for my own interview experience because as enjoyable as the interview process was, it did contain some stressful moments. For instance, two of the interviewees with whom I met personally live in poverty. One woman, who had been estranged from her husband for many years, lived in what can only be called squalor and this was distressing to witness. While the other participant was at least somewhat better off, she was also living on an extremely low income since her estranged husband refused to pay spousal support. He threatened her that if she pursued him for support, he would seize the house she inherited from her parents. The house was the only asset this

woman owned and she expressed great fear that she “would end up on the street.” She was so depressed by her circumstances that she talked openly about committing suicide by starving herself to death. She added that this was easy to do, as the amount of money she receives from welfare does not permit her to eat adequately. This admission troubled me deeply at the time and continues to do so now. I am comforted by the knowledge that she is under the care of a competent mental health professional but worry about her fate.

Although I have been conducting research on obesity stigma for a number of years, the virulence toward obese people never fails to disturb me. In particular, weight-related abuse inflicted by parents bothers me most of all. It is beyond my comprehension how a parent could not realize that teasing a child about her weight or admonishing her to avoid certain activities because she is too fat could have a negative effect on her self-esteem. It would appear that lack of parental acceptance also disturbs participants as well. I noted that when the participants did cry during the recollection of a particular humiliating incident, it almost always involved a parent’s cruelty about their weight when they were children. Although I came to expect that the participant would recount incidents of parental unkindness, it was still distressing to hear each time.

This research experience also resulted in some personal epiphanies about my own view of my body and my sense of place in body politics. Any person who has managed to maintain a substantial weight loss over a prolonged period of time knows that the secret to maintained weight loss is never to get complacent. This constant vigilance may facilitate weight loss maintenance, but it also inculcates obsession with weight. It is also conducive to a fragile sense of self, as the person in this position often fears that her status as slender person is merely temporary. Morbidly obese women represent the fear of every woman who struggles with her weight: *See what happens if you don’t watch yourself.* I have to admit that this thought tormented me a great deal during the six months I spent talking with women who have experienced morbid obesity. *What would I do if this were to ever happen to me?* The members of my sample women have suffered—and, in some cases, continue to suffer—greatly because of their extreme overweight. The (mis)treatment of morbidly obese women has broad implications for women in general, as it ensures that *all* women understand the consequences of letting their bodies “get out of control.” If they do not maintain their eternal self-vigilance, they too could end up suffering the perilous fate of very large

women. After conducting this research I am inclined to think Carol Sternhell (1985:66) is correct when she describes fat women as "...our culture's last undefeated heretics, our greatest collective nightmare made all-too-solid flesh." Sternhell goes on to conclude that "*Everything in this world, for women, boils down to body size*" (italics in original). Unfortunately, she may be right in that observation, as well.

#### **OUTLINE OF DATA FINDINGS CHAPTERS**

In Chapter 5, the women chronicle their lives before their surgery and make the case that morbid obesity was an unbearable situation for them. Chapter 6 describes how they came to decide to undergo the operation and the process involved in gaining access to this surgery. Chapter 7 provides details about the surgical experience and presents their assessment of the results of the surgery and its impact—whether positive or negative—on their lives.

## CHAPTER FIVE

### BEFORE THE SURGERY: THE LIVED EXPERIENCE OF MORBID OBESITY

This chapter presents my participants' historical accounts of their lives prior to their surgery, starting from their earliest childhood recollections through to their adult experiences. They recount their weight histories, their perceptions about how they came to be morbidly obese, and the impact of their weight on their relationships with their peers, family members and spouses. Their accounts indicate that their body size has had a profound impact not only on their relationships, but on their job experiences, their health and their quality of life. These narratives thus illustrate the extent to which fatness--especially extreme fatness--is stigmatizing in our society.

#### WEIGHT HISTORIES

The participants' weight histories vary considerably. Four of them were morbidly obese in childhood. Marcia weighed 236 pounds when she was 11 years old. Doris weighed 160 pounds by the age of 10. Wanda remembers weighing 135 pounds when she was eight years old. Jennifer weighed at least 100 pounds above her ideal weight by the time she was 12 years old.

Five women indicated they had been obese their whole lives, although they did not become morbidly obese until adulthood. Three of the women in this category noted that their pregnancies in their mid-twenties exacerbated their weight problems.

Fourteen described themselves as "chunky," "a little chubby" or "slightly overweight" as children.<sup>54</sup> However, once they reached adolescence, they gained substantial amounts of weight and became clinically obese.<sup>55</sup>

Five women reported they were "quite thin" as children until they too reached puberty and subsequently gained a massive amount of weight that steadily spiraled upward.

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<sup>54</sup> By clinical standards, however, these women were actually obese.

<sup>55</sup> It must be pointed out, however, that these women did not spend their entire adolescence being overweight or obese. Almost all had "thin periods" during their teenage years as a consequence of strenuous dieting.

Two of the sample members said they had been thin their whole lives until they became pregnant in their mid- to late twenties. According to Barbara, "I gained weight after my pregnancies. As I grew older, my weight kept creeping up and never really stabilized." Suzanne had also been very thin until she became pregnant, but she recounts a different story than Barbara. She describes herself as weighing 118 pounds and wearing a size 8 up until her second pregnancy, when she was twenty-five. Suzanne had actually become underweight after her second pregnancy, and her doctor recommended a "tonic" to stimulate her appetite. Suzanne describes the regimen and its effect on her weight:

In the morning, I had to have eggnog with one ounce of brandy. Before each meal I had to have a bottle of Porters. Porters is like a beer, a dark beer. It was a certainty it stimulated the appetite. I started to eat and then I gained weight. It was then that—I had just had my second child, I was 25 years old—I started putting on weight. It just started going up and up.

Four of the sample members appear to have gained weight in response to a specific traumatic event in their lives, a phenomenon Bruch (1973) refers to as "reactive obesity":

Doris: Up until I was six years of age, I was very thin. And at that time, my doctor suggested that my mom and dad get me tonics to make me eat, because I didn't want to eat. When I was six years of age, several major events took place in my life. I don't know whether one or all of these had anything to do with the mental obsession with food. What happened was: Number one, I started school. That's a big deal in any kid's life. We did not have kindergarten at the school where I went. I started in Grade 1 and I was six years of age. Number two, I was told in that year just before I started school that I was adopted. I had had no idea of that. The third thing that happened was that I had tonsil surgery that year and after I got out of the tonsil surgery—I had tonsils and adenoids removed—after I got out of the surgery and got better, I could never stop eating. And the other thing that happened, I was molested at the school by the janitor. I never told anyone and it never bothered me, or at least I thought it did not bother me. I don't know what if any or all of those things may have triggered the mental obsession I have with food. I know that it was after the tonsil surgery that I couldn't stop eating.

Celeste: I was a very thin child. When I was 6½, one of my siblings died and so I started overeating. And so by the time I was 10, I was a little bit chubby but not that bad.

Nicole: Up until the age of 10, I was quite thin. Then I went to a convent boarding school for two years because my mother was very, very sick. I started to gain weight there. My younger sister was with me. As the eldest of the children, I always felt responsible for them. Obviously, in a convent, you have to eat what they give you. There were a lot of things she didn't like, and so she wouldn't be scolded by the nuns, I ate my food and hers too. That was my way of protecting my sister. When we left two years later, I continued to gain weight and I never stopped. It was as though my stomach had gotten bigger.

Isabella, Julie, and Celeste also experienced reactive obesity in their adult lives. Each of these women was already severely obese, but then a traumatic event occurred, and each became depressed as a consequence. A massive weight gain further aggravated an already difficult situation. Bruch (1973) suggests that those who respond to events by overeating do so because food is a comfort to them and a reminder to them that life still holds pleasure and meaning. Their words vividly illustrate how one can metaphorically eat one's emotions:

Isabella: I hung around 400 pounds until 1992. I was real active in my son's school. Then, in 1992, he graduated and went on to high school. That was when I took to my bedroom. I hardly ever left the house. I had to quit work. It really seems fuzzy between 1992 and 1997. I was diagnosed with depression in January of 1993. I was put on Zoloft. I got up to 460 pounds. It just seemed that when I stopped volunteering at my son's school, that I lost all meaning to my life.

Celeste: My second child turned out to be very ill: She had cystic fibrosis. That was the start of a ten-year odyssey of frantic fear during which time my weight just ballooned.

Julie: The last 100 pounds were pure depression. It was right after my father died in 1997. I gained those 100 pounds in 10 months.

It must be emphasized that virtually all sample members indicated that there was an extensive history of obesity in their families. Some participants described both their parents as obese or morbidly obese; most had one obese parent. Most participants also reported having at least one sibling who was obese. This finding is not surprising, as familial studies have consistently demonstrated that body weight is highly correlated among first-degree relatives (Hill et al. 2000:335). Fifty percent of children born to two obese parents will themselves be overweight (Angel et al. 1989).

Rosemary was the exceptional participant who did not have a longstanding history of severe obesity before her surgery. Nor was there any history of obesity on either side of her family. She was very slender, wearing a size 6, until she became pregnant at age 25. She gained 65 pounds from her pregnancy and lost that weight over a period of two years. When Rosemary was in her early thirties, she saw her weight creep up slightly but she always managed to diet down to her preferred, i.e., "natural" size. However, by the age of 37, she was no longer able to control her weight through dieting, and instead, started gaining weight after following weight loss regimens. She weighed 260 pounds at the age of 40 and three years later, she reached her preoperative weight of 315 pounds. Rosemary insisted her eating

patterns did not change extensively and that her unchecked weight gain could only be due to an undiagnosed metabolic disorder. She experienced much resistance to this suggestion from the various health professionals she consulted, but she remains committed to this position.

### SCHOOL EXPERIENCES AND PEER RELATIONSHIPS

The overwhelming majority of the sample who were fat during their childhood and/or teenage years indicated that their weight negatively impacted their social skills in their interactions with peers. For instance, Trudy, describes her social awkwardness:

When I was in school, I was always introverted, always shy. I was never, never sure of myself, always, always second-guessing myself. I always felt uncomfortable around people.

Catherine was also introverted during her early school years and had difficulties integrating with other children:

I always felt like I was on the back foot. I know when I started school, Mum said they had problems with me not interacting with any of the other kids. I always felt like I never fitted in through primary school and my early school.

Many reported that they felt like outcasts or freaks because they never fit in. As Celeste describes herself:

I was the sort of the kid who didn't fit in very well. I had friends in school, but they were kind of fringey, like me. You know, a little on the outside. I put myself on the outside because I felt my weight was unacceptable.

With the exception of one person, all the sample members described constant teasing about their size by the other children and were always the last to be picked to play on sports teams. As a result of these humiliations, most tended to avoid other children and not be involved in extracurricular activities. They tended to have a few close friends, rather than cultivate an extensive friendship network. Joanne described her school years as particularly difficult, and she dropped out of high school as a result. As she elaborates:

It wasn't easy growing up. My parents moved a lot when we were young and so I was always the new girl, always trying to fit in. Because of my weight, I was also the fattest. This was just a deadly combination.

I noted that the heavier the participant was as a child, the more traumatic were her school years and the more fraught her peer relationships. The school experiences of Wanda, who is the heaviest person in the sample, illustrate this point particularly vividly:

School was nothing I would ever wish on anybody. I weighed 135 pounds by the time I was eight years old and I was the fattest person in school. I was also the tallest because I reached puberty very early and stood 5'9" by the time I hit third grade. I never could pass the Presidential Physical Fitness Test. I was always the last to be selected in games. I was always picked on. I was the butt of a very ugly practical joke. Somebody was paid in order to give me a kiss in junior high school, which was very traumatic. I was pushed down the stairs in high school because of my size—it was just misery.

Trudy and Doris also complain of mistreatment at the hands of schoolmates:

Trudy: School was terrible, terrible. I went to a Catholic school so we used to have boys segregated from girls in the playground. I remember in first grade—I was about six—and my older sister brought me to the tree that was in the middle of the schoolyard and then her friends who were guys, pushed this little boy under the tree and made us kiss. The principal, who was a nun, saw it and we got hauled into the school for it. That incident was so embarrassing and I got into trouble for it as well. I still can't believe that.

Doris: I was always the fat girl. There was a boy—of course we were in public school that at that time separated girls from boys—and there was one fat boy. And one fat girl. And so we got the things like, "fatty, fatty, two-by-four." And that I was in love with Joey—which was the boy's name—and that Joey was in love with me. We hated each other for the simple reason that we didn't know one another but we were put together by the skinny kids.

I noted some variation in the participants' demeanor when they described their experiences of weight-related name calling and teasing. The vocabulary drawn upon to tease fat children is extensive and cruel. The participants were subjected to taunts of "fatso," "lardy," "lardass," "tub of shit," "Crisco," and "fat-in-a-can" among various others. The French-Canadian women were called "*grosse toutoune*," which is the rough equivalent of "fat slob" in English. The term carries a further derogatory connotation in that it also suggests that the person is stupid. Two of the women actually laughed when they recounted the name-calling incidents to me. Ten of the sample members felt that children are cruel amongst themselves and will vilify those who they suspect are deviant, and thus, accepted name calling as a "natural" consequence of their unacceptable body. The remainder, on the other hand, was somewhat bitter about this deliberate cruelty inflicted on them by their peers.



It is important to emphasize, however, that the sample's school experiences were not entirely negative. Six women told me that their weight did not excessively interfere with their interactions with other children or their participation in school activities. For instance, even though Jeanne was obese throughout her childhood, other children did not tease her about her weight. She also participated in numerous school activities. Isabella recalls being very athletic and having many friends. Although she weighed 170 pounds in high school, she did not feel her weight was an impediment to her social activities or her ability to initiate and maintain romantic relationships. Cinzia also has fond memories of her early school years:

I was a fairly popular kid. I was overweight, but I was always an active overweight kid. I didn't suffer the "nobody-wants-to-play-with-Cinzia." I had those times when people would make fun of me, but overall, I would say I had a really good supportive network of friends when I was a kid. It was fun. For the most part, it wasn't a big deal until my teenage years.

Cynthia was subjected to constant teasing as a child, and chose to disguise her resulting lack of confidence and self-consciousness about her weight by projecting an image of a vivacious girl:

I was very outgoing, and I think the reason *partially* why I was outgoing was because I was insecure, but at times you get picked on and so, it was pretty hard, growing up (emphasis in original).

It was interesting to note that these participants felt their external self, the self they took great pains to portray (popular, outgoing, sociable) was not consistent with their internal, authentic self:

Julie: I was outgoing. I had a lot of friends. People saw me. The reality of how people saw me and the way I saw myself were different. I was constantly going out, I was doing things, I had a great group of friends. I was very active in school.... Yet, I perceived my life as I didn't fit in. I was an outsider. I thought people despised me because of my weight. People looked at my weight first. They just saw the person outside; they didn't see the real me on the inside.

Nadine describes a similar experience:

I had a pretty normal teenage life. I went out with the best of crowds. I went out to clubs. I was accepted by everybody, except for the bullies or people like that, but I always defended myself. It wasn't something that held me back from doing stuff. It's really strange: I didn't look like how I felt. By that, I mean I was popular on the outside, but felt like a freak and an outcast on the inside.

It would appear that for some of my participants, one effective means of dealing with fat stigma as a child and teenager was not to reveal to peers that their weight was a source of embarrassment to them.

This defence mechanism, I suggest, is similar to what Goffman (1963) calls “passing.” A stigmatized person who “passes” can disguise the stigmatized attribute or simply not make its existence widely known. For example, a homosexual can “pass” for a heterosexual and a former convict can, in some circumstances, not disclose his or her prison record. Obviously, it is impossible for obese people to disguise their weight, but some people choose the option to disguise their inner shame over their weight.

## **OBESE CHILDREN AND FAMILY DYNAMICS**

### **Parental Concern or Parental Damage?**

School may have been difficult for the majority of the participants, but unfortunately, home was not necessarily a haven for them either, a finding which is confirmed by the literature (Gimlin 2002; Millman 1980). The sample members reported their parents were concerned about their weight and that this concern manifested itself in various ways. For example, the participants who were overweight as young children were taken to doctors to see what was ‘wrong.’<sup>56</sup> Their caloric intake was often monitored and restrained by their parents and other relatives. They were also put on diets at young ages.<sup>57</sup> Three of the sample members, Marcia, Doris, and Yolande, described their parents as “concerned” about their high weight status but did not complain about verbal abuse from them. Marcia, who has been fat since babyhood, however, pinpoints her early childhood as the period in her life where she became acutely aware of her deviance. Her parents’ frequent consultations with doctors and other medical professionals about her weight also marked her entry into the experience of the extremely medicalized nature of obesity. The following is her recollection of her parents’ reaction to having a markedly obese daughter:

I’ve been overweight since birth, always a very heavy child. My parents weren’t happy with the fact that I was a fat kid. They always wanted me to try to lose weight. I was always on one diet or another. They took me to various doctors to see, initially, if there was something wrong with me because I was such a large child. And they had me to different specialists to find out if there was something wrong with me, physically. I remember going to doctors when I was a very small child and they couldn’t find anything wrong with me.

<sup>56</sup> Presumably, the parents were wondering if their daughter’s obesity could be attributed to an underactive thyroid gland. However, nobody in the sample suffered from a glandular condition that could trigger obesity. So, ultimately, nothing was ‘wrong’ in the medical sense of the word.

<sup>57</sup> Participants’ attempts to lose weight prior to their surgery will be discussed in a later section.

Ironically, Doris and Wanda were underweight in their first five years of life, and their parents initially consulted doctors out of concern that they were undernourished. They too wanted to know what was 'wrong' with their young daughters and how to address the problem. Doris, whose experience of reactive obesity was recounted earlier, described herself as a "scrawny" six-year-old who was prescribed tonics to gain weight. In Wanda's case, the underlying problem of her underweight condition was diagnosed and treated, but in the process, another problem—still involving weight—was inadvertently created. Wanda elaborates further:

I started gaining weight when I was five years old. Before that, I was suffering from malabsorption or what they called malnourishment at the time. Everything I ate, I threw up. I had severe allergies and when we found out what I could eat, I started eating those foods and I began to gain weight. It just kept going up and up.

For numerous participants, parental concern was also extended to include admonitions about their weight, warnings that no man would ever want to marry them because of their weight, and outright verbal abuse. Some participants describe their experiences of growing up obese in a hostile family environment and the impact it had on their identities and self-concepts:

Catherine: I think, when you look at photos, I don't think I was particularly heavy. I was rounded in the way that children are, normally. But I was never made to feel normal. I was always made to feel extremely large, and ironically, I felt extremely diminished as a result.

Wanda: I had been taught by my family that fat is ugly and that no one would ever care for me as a friend or as a girlfriend because nobody wanted anything to do with fat, it was disgusting. My family was constantly putting me down, telling me how horrible I was, that I wasn't going to accomplish anything in life as long as I was fat. When I was maybe 250, 300 pounds, my dad told me in so many words that I was an embarrassment to be seen with.

Jennifer: I think my dad was disappointed in me. He'd say things like "you'd be so pretty if you lost weight" type of thing. And my mom would make comments about "fat girls don't do this" and "don't do this, you don't want to stand out."

Rosemary's weight gain in her early thirties was a devastating experience and she feels this was exacerbated by the fact that fatness was continually disparaged in her family culture, particularly by her mother and female relatives:

I grew up very thin in a very thin family....As a child, I was taught very blatantly that overweight people were stupid and lazy. The words sloppy fat were used as though they were one word and people were described as, "Oh, she's sloppy fat." That means she's

more than 10 or 15 pounds overweight, she's enormous and she's sloppy fat. As I began to gain weight, it did an *enormous* number on my psyche (emphasis in original).

I noted that, of the participants who indicated their parents were abusive about their weight, their parents did not voice a concern for their daughter's health; rather, their comments focused on her non-conformity with cultural standards expected of women and the punishments that would likely be meted out to her. The constant warning that they were undesirable to men as a marital partner indicates a belief that attractiveness is a prerequisite for a woman's entry into the marital role. Previous research I have conducted on men's experiences of growing up obese found that they too were harassed by their parents to lose weight, but they were seldom warned that they would never marry because of their weight (Joannis and Synnott 1999). This discrepancy in behavior indicates that parents of overweight boys are less concerned about weight functioning as an impediment to entry into marriage. As Rodin et al. (1984) have observed, attractiveness is crucial for success in the female gender role. Success in the male gender role, on the other hand, is more likely to be influenced by educational, financial, and vocational accomplishments.

I was curious to determine whether fathers or mothers were more harsh with fat daughters, but discerning a gendered pattern was somewhat difficult. It appeared that, for the majority of the participants, both parents voiced concerns about their daughter's weight. There were some instances, however, where one parent was considerably crueler than the other.

Cynthia: My parents are divorced so when I was 13, I lived with my dad and he would make pasta seven nights a week. But then Dad would be, "Oh you need to lose weight, you're chunky." So I always got ridiculed by my dad. Meanwhile he was feeding me all this pasta. My mom [who is also obese] was always positive, but my dad would make those little comments.

Sherri: My father verbally abused me. He called me a fat slob. He told me that if I didn't watch out, I wouldn't fit through the door. And of course, no man would ever want me. My mother also harassed me about my weight. They both tortured me. My family was like, "Yeah, you're abnormal. I don't know what we're going to do with you."

Cinzia: My dad bullied me about it pretty much my whole life. I grew up in northern Italy, a very fashion-conscious area, so it was always a matter of, "You have such a cute face, if only you were thin." So, yeah, he had a major issue with it.

Celeste: Both my parents were concerned about my weight, but my father felt worse about it than my mother.

Casey: My parents—especially my father—are fatphobic. His mother had always been dieting so I guess it was ingrained in him to not want obese children.

Fiona: My father would always make nasty comments that he thought would entice me to lose weight. Of course, it never worked.

It is perhaps not surprising to hear that my participants singled out their fathers as the parent who was more clearly ashamed and disapproving of them. The literature indicates that men greatly value and desire good looks in women. In Western countries overweight women are widely perceived as being aesthetically unappealing. It may, therefore, be the case that the fathers were ashamed that their daughters would not be viewed as attractive to other men. If so, it would appear that they empathize with other men who despise female fatness, rather than with their daughters. Other research has found that male parents are opprobrious of fat children (Hesse-Biber 1996:101; Joannisse and Synnott 1999). For example, in Hesse-Biber's study of college women's body image, those participants who had been fat in childhood indicated their fathers were very critical of their weight.

It must be pointed out, however, that two sample members suffered considerable weight-related cruelty at the hands of their mothers. Jeanne and Marianne were eloquent in their bitterness over what they remember as lifelong verbal abuse from their mothers:

Jeanne: My father never commented on my weight. My mother was a whole other question. My mother was very controlling, very demanding—almost two people. In one respect, she was constantly on my back about losing weight, becoming thin. But then she would make all kinds of treats like butter tarts and date squares and then tell me I couldn't eat it. Then there were times when I was told I had to eat it. I was constantly told I was fat, I wouldn't ever be anything, nobody would ever want me, I would never find a husband. She nagged me all the time. In her eyes, I couldn't do anything right, ever.

Marianne: Every chance my mother had, she reminded me how grotesque and repulsive I was. She really made me feel abnormal. It was ingrained into me that I wouldn't get anything in life because of my weight.

Rosemary's mother also despised fatness and was very vocal in her contempt of overweight people. Although Rosemary was not victimized by her as a child because she was very thin for most of her life, she did have a painful encounter as an adult that continues to traumatize her. Since Rosemary has been estranged from her mother for many years, her mother was totally unaware that she had gained a

substantial amount of weight. Rosemary recounts her mother's reaction to her weight gain when she saw her after a long absence:

A few years ago the family was embroiled in a trial situation and my natural mother and I had not seen or spoken at that time in at least 12 years, something like that. At that time, I was between a size 12 and 14. [I had worn a size 6 for most of my life.] And when I was led into the room to give a deposition, I heard her make this very audible gasping sound. That's all, it was just a gasping sound. We never spoke and never met. But that sound, the sound of her gasp, has torn me apart for that many years [voice breaks]. And she's gone on for many years, on many occasions—our lives overlap here and there—with people that I knew that she also knew. For some reason she gets a great deal of pleasure telling people how heavy I am. She doesn't have a clue how heavy I really became! In her mind, I'm a size 14. Meanwhile, since the last time she saw me, I went up to a size 30 [laughs slightly]!

For seven participants, an obese parent—a morbidly obese mother in particular—was a source of support and unconditional love. The two sister dyads in the sample each had morbidly obese parents and they described their home environment as loving and nurturing. Joanne and Nadine grew up in a home where virtually every family member was obese and report no disparaging remarks from their parents about their weight. Their parents were also supportive of each other:

Nadine: I remember my parents never put pressure on us to lose the weight or never made comments on it. They never put salads in front of us. Both our parents are good eaters and they see eating as a pleasure of life.

Joanne: My mother is quite overweight, but my father doesn't love her any less for it. He never tells her to go on a diet. We are all very supportive of each other.

The other sister dyad, Gisèle and Suzanne, also grew up in a home where the majority of family members were obese and they too were sheltered from a fatphobic society by their parents' unconditional love:

Gisele: I had a very happy childhood, with good parents. From the age of 0 to 12, my childhood was fantastic. My parents never called any of us names. We never dieted. At home, in the house, we never spoke about obesity and dieting. It wasn't until we moved to the city, when I was 12 years old, that I was harassed about my weight. I was called names I wasn't used to hearing. It was only then that I began to notice that people thought weight and appearance were important. It wasn't like that at home. At home, we were accepted for what we were.

Three other participants also singled out their obese mothers as parents who loved them unconditionally. However, it strongly appeared that the overwhelming majority of participants whose

parents were obese themselves did not accept them.<sup>58</sup> The academic literature is replete with studies which indicate parental shame of fat children (Gimlin 2002; Millman 1980; Neumark-Sztainer et al. 1998; Rothblum et al. 1990; Stake and Lauer 1987; Wooley et al. 1980). Yet, these studies do not reveal the parents' own weight and the effect this may have on the treatment of their children. It would be somewhat easier to understand why non-obese parents would be so affronted by fat children, since in their view, they are anomalies in the family. However, it would be equally as reasonable to expect that parents who experienced fatness themselves might be more likely to be empathetic to their fat children and protect them from the virulence of fatphobia. The latter hypothesis is not confirmed by my sample's experiences. Virtually every sample member reported an extensive familial history of obesity, yet the overwhelming majority of them did not receive unconditional acceptance by their parents.

Why would my participants' parents subject them to weight-related cruelty, even when they were also obese? Several reasons may explain this finding. On the one hand, their parents may have wanted them to avoid the weight-related traumas they may have experienced and were willing to go to any lengths to protect against this from happening. They were perhaps well intentioned, by constantly admonishing their fat children about the horrors of obesity, thinking they were acting in the child's best interests. There is also the possibility the obese parents did not experience fat prejudice themselves, as fatphobia is a relatively new phenomenon, flourishing only after the Second World War (Seid 1989; Stearns 1997). However, even if these parents did not experience discrimination themselves in terms of finding employment, a life partner, etc., they have most certainly become aware that the sociocultural landscape has changed considerably with respect to what type of body is socially acceptable. Again, their ultimate intention may have been to protect their children from condemnation by the wider society.

On the other hand, the parents' own obesity may have also served as a possible reason *why* they victimized their fat children. Numerous studies show that fat people have internalized the cultural aversion to obesity. For example, researchers have found that feelings of self-loathing, shame, and

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<sup>58</sup> The protective effect, if any, of a fat father as the sole obese parent is impossible to determine in this research because no participant reported having a fat father and a normal-weight mother. I would guess, however, that the protective effect would be minimal, given that men tend to be so strongly prejudiced against fat women.

inferiority are common in fat people (Averett and Korenman 1999; Crandall and Biernat 1990; Crocker et al. 1993; Friedman and Brownell 1995; Millman 1980; Stunkard and Wadden 1992). Therefore, parents of fat children who are fat themselves and non-accepting of their bodies may view their children as the personification of their own failures and inadequacies. They punish their children for their transgression because they have come to believe that not only is fatness deviant, but that it is a poor reflection of themselves.

It must also be added that there is little evidence to suggest that fat people feel solidarity with other fat people. For example, research shows that normal-weight and overweight people dislike fatness to an equal extent (Crandall 1994; Crandall and Biernat 1990). Sadly, this lack of solidarity may extend to fat parents and their children.

A final point to consider is that while most sample members had obese parents, few sample members actually had a morbidly obese parent. The majority of the sample members were the first members of their families to become morbidly obese. So, while many family members were fat, the participants took obesity to a higher, unacceptable level and they were perhaps considered anomalous in that respect.

As mentioned previously, there is an abundance of studies in the academic literature which indicate that parents are embarrassed by obese children. However, the parents' own weight is never mentioned in any of these studies. This gives the impression that the parent himself or herself is of normal-weight, but since obesity has such a strong genetic component, this is probably not the case. Future studies of the dynamics between parents and fat children should specifically refer to the parents' weight in order to facilitate a more thorough understanding of how the impact of the parents' weight may mediate treatment of the fat child.

#### **What Does 'Supportive' Mean, In This Context?**

Many of the participants described their mothers—and in a few cases, their fathers—as “supportive.” To a large extent, my participants seemed to equate a supportive parent with a parent who was not abusive about their weight. Fathers who never remarked on their overweight condition were deemed supportive, even though none had ever defended their daughters from verbal abuse by their



mothers. Mothers who encouraged them to diet, without resorting to cruelty, were also labeled supportive. Obviously, all children need nurturing, accepting parents, but the concept of supportive parents in this context needs to be explored in greater depth. Is a supportive parent one who does not recommend weight loss to a daughter at all? Or is a parent being supportive by encouraging a fat daughter to diet in the interests of removing the stigma associated with obesity?

Both these tactics have distinct advantages and disadvantages. Many obesity researchers would argue that a parent who does not intervene in a child's obese condition is being negligent, if not contributing to, poor nutritional and exercise habits. Juvenile obesity is associated with serious medical conditions such as diabetes, hypertension, and sleep apnea (Andersen 2000; Davison and Birch 2001; Dietz 1998; Gortmaker et al. 1987). Eighty percent of obese children become fat adults who are also at risk of developing obesity-related health problems (Angel et al. 1989; Dietz 1998). Researchers who study obesity and weight concerns in children also note the derogation and torment to which they are constantly exposed from their peers and the negative impact it has on their self-esteem (Davison and Birch 2001; Dietz 1998). Since fatness is so stigmatizing, especially for girls, it may be argued that lack of parental intervention may be evidence of unrealistic expectations about the current and future problems faced by the fat child.

However, putting a child on a diet may not be in his or her best interests either. When a parent encourages a child to diet, he or she is also perpetuating the perception that the child is deviant, and this may erode the child's self-esteem. Since diets of all kinds have such high failure rates, repeated failure to maintain weight loss can further damage self-confidence and create feelings of inadequacy. Chronic dieting is associated with weight gain in the long term, thereby exacerbating the problem instead of resolving it (Brownell et al. 1986; Herman and Polivy 1983; Korkeila et al. 1999). Presumably, the younger a person is when he or she starts to diet, the fatter he or she is likelier to become later in life.

There is some doubt of the benefits that dieting can have on children's physical health. Physicians appear to promote putting children on diets, but dieting is contraindicated for children, whose skeletal systems are still growing and who need a high energy intake if they are to grow to normal size. Pugliese et al. (1983) report that children who are undernourished as a result of dieting suffer from stunted

growth and delayed puberty. In any case, parents' attempts to control their children's eating behavior is often futile, as studies have shown that the more parents restrict children's access to high-calorie foods, the more the children will be determined to eat these foods (Fisher and Birch 1999a, 1999b). Almost all of Millman's (1980) respondents reported that their parents' attempt to control their eating behavior created a hostile atmosphere in their homes, and they often rebelled against their parents by eating the prohibited foods in large quantities.

The growing prevalence rate of childhood obesity in industrialized countries is often referred to as an "epidemic" (e.g., Andersen 2000; Tremblay and Willms 2000). Yet there is another weight-related epidemic with deleterious consequences that is sweeping young children and that is the epidemic of weight obsession. Numerous studies have shown that significant numbers of pre-adolescent children living in Western, industrialized countries are worrying about their weight and engaging in dieting behavior even when they are not overweight (Braet and Wydhooge 2000; Brugman et al. 1997; Gustafson-Larson and Terry 1992; Hill et al. 1994; Schur et al. 2000). Girls are considerably more likely to worry about their weight, and this worry is starting to plague them at ever-younger ages. Feldman et al. (1988) have found that five-year-old Canadian girls are worrying they are too fat. A recent study has identified the same trend among five-year-old girls living in the United States (Davison and Birch 2001). Researchers studying these trends warn that weight concerns in children may be a harbinger of the onset of eating disorders in puberty (Braet and Wydhooge 2000; Davison and Birch 2001; Wardle et al. 1995).

Research indicates that children are introduced to dieting by their parents, usually their mothers (Hill and Pallin 1998; Schur et al. 2000). Parents may think they are acting in the child's best interests by eradicating a stigmatizing attribute, but inducting children to diet culture is not a solution. Diets, body image disturbances, low self-esteem and disordered eating do not enhance children's physical or mental health. To summarize, well-intentioned intervention may create a problem whose dimensions are also significant, perhaps surpassing the original problem.

Parents of fat children are thus faced with a dilemma as to how best to address the situation. There is a lack of consensus, even among experts, about the appropriate action a parent should take. However, it would appear that admonishing a child about weight is an action that will only prove to be

detrimental in the long term. Leann Lipps Birch (in Wallis 2001:A1), co-author of a study on the weight concerns of five-year-old girls (Davison and Birch 2001), cautions parents “never to tease girls about their weight, even in a gentle way,” as it can send the girl into a negative spiral that could last a lifetime. NAAFA (1995) recommends that the parents of fat children not put them on a weight loss diet but to encourage them in a non-judgmental way to eat healthy foods. While exercise should also be encouraged, it should not be forced or preached, lest the child view it as a punishment.

Based on the empirical findings in the literature and on the writings of fat activists, I would describe a truly supportive parent of a fat child as one who always assures him or her of unconditional love and acceptance, defends the child from a fatphobic society—including family members—and who does not try to militantly regulate the child’s caloric intake. Unfortunately, such a parent is too often viewed as irresponsible.

#### **Other Family Members**

The participants tended to describe the other adult members of their families such as grandparents, aunts, uncles and cousins as intolerant of them. These family members often made comments about their size to them and their parents and would also monitor the amount of food they ate. Contrary to the findings reported in the literature, however, sisters were generally described as supportive, even in the cases where they were underweight or of normal weight themselves. Their brothers, for the most part, did not remark on their weight. Sherri was the only sample member to report that a sibling was ashamed of her because of her weight.

#### **THE IMPACT OF OBESITY ON ROMANTIC AND MARITAL RELATIONSHIPS**

The academic literature consistently indicates that female obesity is a handicap in the formation and maintenance of romantic relationships, particularly because white, college-educated men are very prejudiced toward overweight women (Harris 1990; Harris et al. 1991; Regan 1996; Sobal et al. 1995). To a small extent, my findings corroborate this pattern.

Seven of the women reported that their weight was not an impediment to dating boys when they were in high school. However, the remaining 23 sample members indicated they did not date in their teen

years because of their insecurity about their weight and their perception that obesity was unattractive to boys. In some cases, the actions of the boys themselves certainly fostered that perception:

Julie: I avoided boys like the plague in high school.

Trudy: I was never comfortable talking to guys—ever.

Nadine: I never had any attention from the good-looking guys. When I passed the tenth-grade guys in the corridor, they would flatten themselves against the wall to make room for me so that I could pass.

Jennifer: I was teased a lot, especially by the boys.

Nicole: When I was dating boys in my youth, there were some that I thought were good looking and to my taste but they wanted nothing to do with me. They were nice to me but they weren't attracted to me. I know it was because I was overweight.

Yolande reported—with some bitterness—that she dated boys in high school but she knew they paid attention to her only because she was sexually permissive. As she explains, each party saw the arrangement as an exchange:

I had boyfriends, but they weren't always the ones I wanted. I went out with them so I wouldn't be alone. I think being overweight influences the way we behave. I was very liberal sexually; I let the boys do a lot so they would like me.

Male fatphobia has plagued some of the participants in adulthood as well. Seven of the women have never married, and this outcome is largely not of their choice. With the exception of one person, all attributed their single status to their obesity.<sup>59</sup> Trudy, who is in her late forties, indicated she has never been able to establish an ongoing relationship with a man. She ascribes her lack of male attention to her deep-rooted insecurities about her weight and the negative impact this has had on her self-esteem:

Trudy: [My weight] has been all my life a big factor because I never felt good about myself and if you can't feel good about yourself, how can you let somebody love you?....I've never really had dating years. I've never really dated. I've had blind dates, but I've never been asked out by a person just for me. I've had dates following blind dates with the same person. But that to me was not the same. Wouldn't it be nice if somebody asked me for me?

Sherri, Marcia and Juanita, who are also middle-aged, have had a few short-term relationships with men but have been unattached for long periods of time. Forays into romance have become increasingly rare and all say they have accepted the strong likelihood they probably will never marry or

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<sup>59</sup> The point must be made that these women were not necessarily unhappy with their singlehood.

co-habit with a man. All three women voice a belief that their weight is a strong factor in their lack of romantic relationships.

Men's general dislike of fat women was acknowledged by all members of the sample, both single and married. However, most of the women in the sample described male hostility to female fatness as being covert, more than overt, once they graduated from high school. They were not openly derogated by men, just overlooked by them. Men tended to view them as "good friends," rather than as prospective romantic partners. Marcia somewhat bitterly describes her constant experiences of men professing a desire for friendship with her, rather than romance:

I would meet men that I would be interested in and we would become friends but they would always be interested in thin women. They'd want to be friends with me. It would always be, "Oh I really like you, Marcia, but let's just be friends." I got to really *hate* that: "Let's just be friends." So I've had plenty of friends, but I didn't have any boyfriends (emphasis in original).

Celeste, who is now happily married, was the only sample member to encounter blatant male hostility during her early dating years. She describes a humiliating incident with a man who had an aversion to fat women and who was explicit about his feelings:

A girlfriend of mine set me up with a guy and we were supposed to go to his house and take off from there. I walked in the door, and he took one look at me and just looked so disgusted and he said, "Oh God, I told Beth I hate fat women."

Six of the participants have dated Fat Admirers. Fat Admirers, known as FAs, are men who fetishize extremely obese women (Gimlin 2002; Goode and Preissler 1983; Millman 1980).<sup>60</sup> The women who date FAs are gratified they can get male attention without being made to feel ashamed about their weight. Casey and Marianne are the only single members of the sample to take advantage of the FA subculture. While neither has met a potential life partner through this network, they are both enthusiastic about the existence of FAs:

Marianne: Fat women need to know there's a whole group of people out there to whom this [being obese] is perfectly acceptable, that there are men who *prefer* a woman who is fat but who aren't freakish themselves (emphasis in original).

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<sup>60</sup> Although the vast majority of FAs are heterosexual men, this population also includes homosexual men and heterosexual women (Sobal 1999).

Casey: I discovered a whole subculture of men that were interested in overweight women and began dating some of them and that really increased my self-esteem enormously.

Dating FAs was not an option for all the single women in the sample, however. Marcia explains why FAs are not interested in her:

It's really funny because once I joined the fat acceptance movement, I was about 300 pounds and I was too fat to appeal to the guys I liked outside the movement and too skinny to appeal to the men inside the movement! So I was still on the outside looking in! It was amazing, the guys inside the movement were looking for the ladies who were 5, 6, 700 pounds—the fatter the better.

Marcia's experience is supported by those of other women in NAAFA. Millman (1980), who conducted participant observation at NAAFA social events, observed a discussion during which a 220-pound woman noted that the women in NAAFA's lower weight categories had more difficulty attracting men than the women in the highest weight levels. Like Marcia, this woman "was too large for conventional men and too small for NAAFA men" (p. 23). Millman also noted that "few of the single women seem really satisfied with the relationships they have made with men through NAAFA" (p. 20).<sup>61</sup> Experiences with FAs demonstrate that whether they are fat or thin, women's desirability is almost entirely defined by their weight.

Ironically, while the majority of the participants professed discomfort in dating or even talking to boys as teenagers, they appear to have overcome this difficulty quickly. Fourteen of the sample members married for the first time at young ages, in late adolescence or in early adulthood. The participants described their husbands as either of normal weight or slightly overweight; only one woman's husband was morbidly obese himself. One woman's partner had previously been morbidly obese before he, too, underwent bariatric surgery. Nobody reported her husband was a Fat Admirer.

Given that white men are reluctant or overtly hostile to the possibility of partnering a fat woman, it would be logical to hypothesize that marital quality would be negatively affected by a wife's obesity. Some researchers have found higher rates of marital unhappiness among couples where the female partner is obese (Margolin and White 1987, cited in Sobal et al. 1995:748; Stuart and Jacobson 1987).<sup>62</sup> Yet, these

<sup>61</sup> See also Gimlin (2002).

<sup>62</sup> See also Sobal (1984b).

findings are inconsistent. For instance, survey research conducted by Sobal et al. (1995) found no relationship between spousal weight and marital quality.

Again, my findings are not entirely consistent with those reported in the literature. Twelve of the 18 married or co-habiting participants were satisfied with the quality of their relationships and were certain their partners had never been less committed to the ongoing viability of the marriage because of their wives' weight. The participants indicated varying degrees of support from their spouses. Again, support consisted of a spectrum where the spouses were silent about their wives' excess weight to reassuring them constantly that their weight was not an issue of concern for them, aesthetically. Some of the husbands indicated that they were concerned about their wives' health. The women whose husbands were vocal in their support of them concluded they were loved for themselves and this feeling gave them great security about the long-term viability of their marriages. This conviction gave me the impression they thought their husbands loved them in *spite* of their weight. The overwhelming majority of the women were at least somewhat obese when they met their husbands, so it might be reasonable to infer that their spouses did not disapprove of, or at least were not repulsed by, an overweight partner. Neill, Marshall, and Yale (1978) observe that obesity which has existed during the dating period and from the beginning of the marriage is associated with stability in a relationship.

Those participants recognized that, when their obesity was a source of stress in their marriages, it was more because of their *own* unhappiness about their weight, rather than their husbands'. For instance, most indicated their sex lives were not active prior to their surgery—not because of their husband's reluctance to have sex but rather their own shame about their bodies. As well, eight of the married women were clinically depressed; depression and its attendant burdens placed further strains on their marriages.<sup>63</sup> Nicole and Barbara's accounts of their decades-long torment over their weight illustrate how their chronic distress placed a strain on their marriages, although their husbands differed in their responses to their anguish:

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<sup>63</sup> Thirteen of the participants said they were depressed. Most attributed their depressed emotional state to their weight, but some indicated it was in response to traumatic events in their lives. See pages 134-135 for further details.

Nicole: I met my husband when I was 18. I was overweight. He obviously didn't have a problem with this because I got him right away. I was overweight, maybe even fat, but he never, ever told me I was too fat. He never told me that I should go on a diet. It was when he saw how unhappy I was about my weight, when I would have crying spells about it and say things like I'm fed up!, I don't want to live like this anymore!, he'd want to help me but there was nothing he could do. He'd advise me to go see a doctor, to try and get help. He thought it was unfortunate that I couldn't be happy living in my skin because he loved me the way I was....I got fatter and fatter and he loved me anyway. But because I didn't love myself, I couldn't believe that he could love me. My God, I really have put him through a lot. He's put up with a lot because of me. Today, I realize that for him to endure my crying fits, my depressed moments, to put up with all that, he must really love me.

Barbara: I started getting, really going up and up about 20 years ago. I gained weight after my pregnancies....I was having some really severe health problems and I was on quite a bit of medication....It took its toll on my marriage. My husband hated me overweight. He hated it because of what it had turned me into. I was crying all the time....I went into a major, major depression about ten years ago and that was hard on him and the other members of the family.

These women's experiences show how weight can dominate a woman's life and, in turn, her spouse's. However, Nicole's husband appears to have been more concerned and sympathetic to her plight, while Barbara's husband appears to have been exasperated.

While many of the married women in the sample believed their husbands loved them *in spite of* their weight, there were three women about whom it could fairly be said that their husbands loved them *because of* their weight. Renate's husband was morbidly obese himself, so he was in a position to truly empathize with his wife's agonies. Julie's fiancé had been previously morbidly obese; he and Julie met at a support group meeting for bariatric surgical patients before they each had their surgery. Julie feels the shared experience of morbid obesity and subsequent bariatric surgery gives them a unique bond:

I think it's a very special connection. Nobody else can understand what we've been through. We can empathize with each other. No one else may understand what we're talking about. When I say, I'm stuck, you don't know what that means; my mother doesn't know what it means. Barry will cry with me, knowing what it means. When I say I have to go to the bathroom, he understands I have to go *now*. When I was having problems and having to go to the doctor's, he understood what I was saying. It's wonderful. It's also because we did it together, from beginning to end. He remembers what I was like; he knew me at 380. He knew me at my heaviest. I don't have to pretend who this person was. If somebody came in my life now, how do I describe to that person what—here's a picture, that picture can't describe the person on the inside. I can't go back to explain the hurt that person had, the baggage that person had. Barry can at least help me understand it. So, because we've started from beginning to end, it's something that makes us even stronger (emphasis in original).



Finally, Jennifer's mother-in-law has undergone weight loss surgery twice, and she feels her husband is understanding and sympathetic to the problems faced by fat women, especially women who have undergone surgery. Her husband's unfailing support of his mother makes Jennifer feel secure in his unconditional love for her, no matter what the outcome of her surgery may be:

It [my husband's experience with his mother's surgery] makes me know that he loves me for me because he knows I might regain all the weight. He's been through this twice with his mom and he knows this might happen. He loves his mom anyway and he'll love me anyway.

Three participants, however, revealed that their husbands were eloquent in their displeasure when they gained weight. Of the three, Gisèle was particularly victimized by her husband, although she is no longer married to him. Gisèle met and married her ex-husband during one of the "thin periods" in her life. Although she had been a fat teenager, she had experimented with a lot of hard drugs in late adolescence which suppressed her appetite and resulted in substantial weight loss. She was "slightly overweight" when she married at the age of 20. Her ex-husband had never known her as very fat, although virtually every member of her family was extremely overweight. She and her ex-husband left her natal village soon after their marriage and moved to away to a large city. Gisèle compulsively overate as a means of dealing with her loneliness and subsequently gained a massive amount of weight. It was not until she became pregnant for the first time six years later, however, that she found out the extent to which her ex-husband found fat women aversive:

That's when it started in my life, really: during my first pregnancy. My husband thought that it was so fat and ugly, a pregnant woman. I was fat before my pregnancy, but he hated seeing me pregnant. I had my second son the following year. [My daughter was born four years later.] It was hell being pregnant with my ex-husband. He made comments about my size, all the time, a pregnant woman is so ugly, that sort of thing. After my sons, I lost a baby at six months and three weeks because he beat me: I was fat, I was ugly. That was the first time he beat me. He was so ashamed of me that he introduced me as his sister. Or he would say to his friends, "A fat woman knows how to make love very well. Do you want me to lend her to you?" Stuff like that.

Lara was also thin when she got married at the age of 17. She too had been overweight as a teenager but had managed to shed the weight for a period of time. Her husband had never known her as a heavy woman and was aghast when Lara's weight appeared to become uncontrollable after her

pregnancies. Lara recounts her husband's negative reaction toward her weight, the agony it has caused her and its impact on their marriage:

I weighed 117 pounds when I got married. I worked for a while and then I got pregnant. It was after my two pregnancies that I really put on weight. Then I got up to 180 pounds and that was hell. It was bad enough to gain weight but my husband made it worse. He didn't accept me, he didn't accept the fact that I'd gained weight. He told me so, bluntly. After that, I put on even more weight. I became depressed; not only about my weight but also about my husband who wouldn't accept me. My husband doesn't like fat women. Or to put it another way, he didn't like it that his wife was fat; other women that were fat didn't bother him as much. Relations with him were very difficult.... When I [reached 240 pounds] my husband told me I was too fat to make love to. That was a real slap to me. After that time I became very self-conscious around him. I couldn't take a bath in front of him or get undressed in front of him. Just before my operation, my husband and I were talking about separating. His excuse was my size. I was so amazed that my weight could determine the future of my marriage. That seems so trivial. When my husband married me, he married me for life and my weight didn't enter into it. But then I learned that my husband didn't think like that.

Suzanne, who is Gisèle's sister, also married at a young age and had maintained a slender figure until her second pregnancy. Gisèle described her sister as "a perfect 36-24-36. She had a body that looked like it had been sculpted with a knife." Suzanne did not describe her ex-husband as exceptionally abusive about her weight, but he would call her "Moonface," a term she found insulting. She experienced intense side effects from amphetamine use but her ex-husband appeared to be totally oblivious to her tribulations. She suspected he had been unfaithful to her throughout their marriage and found out that he had an extramarital affair with an exotic dancer while she was convalescing in the hospital after her surgery. Suzanne succinctly, but eloquently, describes her view of the extent of men's antipathy toward fat women: "A man will always prefer a low-class prostitute to a fat woman."

I suggest the two following points can explain why these three women experienced such exceptional hostility from their husbands. (1) They were the only members of the sample who were thin when they met and married their husbands, so their eventual morbid obesity came as a profound shock to them. (2) The social and environmental context in which people live is an important consideration. These women live in Quebec, an area of Canada that is especially image conscious and fashion oriented. Quebec also has the lowest obesity rate in Canada among adults (Reeder et al. 1997). Given these considerations, obese women living in Quebec are perhaps more negatively evaluated.

### Obesity as a Catalyst for Marriage

There is no indication that anybody in the sample married men of significantly lower socioeconomic status than themselves; again, this is inconsistent with the findings reported in the literature (Garn et al. 1989a, 1989b; Rimm and Rimm 1974). However, three of the women who had experienced marital rupture such as separation and divorce, indicated that their weight had motivated them to marry men they did not love and who did not love them in return. For instance, Jennifer and Joanne candidly describe why they married their ex-husbands:

Jennifer: He was an outcast in society as well. I think we were a match in that sense. I wanted somebody to take care of me. I needed to know that somebody wanted me.

Joanne: I wouldn't have married my first husband if I had not been overweight. I probably wouldn't have gone out with him, period. I went out with him and married him because he was one of the few men who showed interest in me, even though I was very overweight.

Jeanne, who is currently involved in a bitter legal battle with her estranged husband, reflects about her reasons for marrying him in the first place:

I know now I only married him because I wanted to show my mother that she was wrong when she told me that I would never be able to find somebody to marry me because I was too fat.

All three women seized the opportunity to marry when it presented itself, fearing it might never come again. The academic and mainstream media certainly give the impression that this is highly possible.

### PUBLIC HARASSMENT

Merely venturing into a public venue can be traumatic for the morbidly obese. The overwhelming majority of the sample reported being harassed in public by children, adolescents and adults. The harassment ranged from comments, stares, pointing, snickers, mooring sounds and laughter, at times, they were accosted by strangers. For example:

Isabella: I can remember down at Disney World, a guy came up to me with his friends. He asked me if I spoke Spanish and I said no. They just started rattling off all these things and laughing at me, obviously making fun of my size. That was so humiliating.

Elaine: People are not kind to the overweight. I had people come up to me in the grocery store and chastise me for what I was buying. Far be it for me to ever eat an ice cream cone in public... People didn't see it as discrimination; they saw it as being kind by telling me I was fat. I was also told, "Don't you think you ought to go on a diet? I'm just saying this because you know that people should lose weight."

Encounters with children were particularly embarrassing, but children were at least excused for their immaturity and their inclination to express the obvious without any malicious intent. However, teenagers and adults were not accorded that same understanding.

Barbara: Children are extremely innocent—but I remember one time when I was wrapping Christmas gifts for people in a mall, one little boy looked at his mom and asked, "Mommy why is that lady so fat? It's not the child's fault, but I was mortified."

Wanda: Sometimes kids come right up and say, "you're fat" or something... Teenagers, guys in particular, make offensive remarks. I'm usually more accepting of the children, because it's not their fault, they're just stating the obvious. They don't realize they're being hurtful. But I figure once they're about 12 years old, they should know better.

Jennifer: I've had a lot of name calling, especially by guys: "Hey fat chick, we don't want you"—that type of thing. That can come from teenage men to young adult men.

However, hurtful comments and verbal abuse of the obese is not limited to children and men.

Women are also overtly hostile to obese women, as Barbara relates:

In 1992 my husband and I traveled all over the Pacific Northwest and I was in the Bon Marché—that's a large, exclusive department store—I was dressed casually, he was dressed casually—we were travelling. Anyway, we were just standing on the sidelines just looking around the store. Well, three women in their thirties, maybe early forties, walked in. They came all three abreast. The one in the center started talking to the one on each side and she just *glared* at me, and she said to her friends, "You know what a BMW is, don't you?" They said, "Yeah, a car." Then they looked directly at me and she said, "No, Big Massive Woman." I could have slapped her. That was probably my most devastating experience. That experience has stayed with me all these years, nine years (emphasis in original).

These findings support other research which has found that fat people are frequently harassed by strangers (Rothblum et al. 1989). What is notable is the depth of feeling fatness inspires in others. Millman (1980:xii) observes that "obesity arouses emotions of surprising intensity, including horror, contempt, morbid fascination, shame, and moral outrage." Also noteworthy is the absence of the normative conventions of self-restraint usually governing interactions with others. The intense emotions elicited by the sight of a very fat person and the sense of freedom to convey these emotions are apparently related to the belief that obesity is self-induced (Millman 1980; Crandall and Biernat 1990; Wooley and

Wooley 1979). Fat people are not only considered to be responsible for their excess weight, but they have achieved this status through self-indulgence and laziness. These convictions, together with the widespread opinion that obesity is aesthetically unappealing, create an environment where there are few social sanctions against the expression of anti-fat attitudes (Crandall and Biernat 1990:229).

### EMPLOYMENT DISCRIMINATION

Since obese people are popularly stereotyped as being lazy and unintelligent, it was not surprising to discover that the sample members encountered both covert and overt discrimination in the employment process. This discrimination took place in various forms, from difficulty in finding employment to being explicitly told that they could not be hired on account of their weight. Various participants describe the discrimination they encountered from prospective employers:

Juanita: Yes, I think my weight has stopped me from getting better jobs in my life. I think employers don't want to hire someone who is fat. I think they hold that against a person. My sister had a job at \_\_\_\_\_ Company. I applied to \_\_\_\_\_ Company numerous times and went on a couple of interviews but never did get hired. And it was the type of place where if you had a relative working, that was a foot in the door. That was a good thing to have because that would help you get a job there too. And it just never happened to me. My sister was thin. I think it was because I was overweight that I didn't get the job at \_\_\_\_\_ Company. And not just there, but at other places I applied at. Yeah, I think there's a lot of prejudice in that area.

Marianne: I remember one particular job interview I went on. This woman confronted me directly about my weight, and asked me was I trying to lose weight, what was I doing to try to lose weight.

Marcia: It was hard to get a job, even though I was very skilled in my course of study in high school which was secretarial science, bookkeeping and so forth, employers were not hiring people who looked like me to work in the front office. When I interviewed for a legal secretary position, the interview was over two hours long with the partners of the firm. They were all very happy with my skills and so forth, but they told me they wouldn't hire me unless I agreed to lose 10 pounds a month and I would have monthly weigh-ins right there in their office. So I declined that position.

I noted that the participants who worked in the female-dominated service sector, where appearance often tends to be a prerequisite for employment (Wolf 1991), were told categorically told by prospective employers that their weight was an impediment to their being hired:

Gisèle: Appearance counts in the restaurant industry, where I had worked a long time before I was married and gained a substantial amount of weight]. I made a lot of applications, I had all the necessary qualifications, but I was never hired. I was told I

could get tired more easily than someone else. I was also told that "Appearance counts a lot for this job, that when you wait tables, the customers want a pleasing appearance and you don't have a pleasing appearance." I was told this a lot. It wasn't only from men, either. It was also from women. It's important that the wait staff have a pleasing appearance. Even if a fat person is always jolly and good humored, that's not enough. In any case, I had the proof when I had my surgery, I was slender and I could work anywhere.

Celeste: There was a trade show in town. I was 5'5½" and weighed 155 pounds. They liked my face very much but they felt they couldn't possibly use me at my weight. They told me this. The trade show was for automobiles, something like that.

It needs to be pointed out that the sample members did not experience differential treatment only from prospective employers. Some were told by their current employers that their weight was a source of dissatisfaction to them. For instance, two of the sample members who worked in the service sector were explicitly told by their current employers that their weight was repulsive to customers:

Wanda: When I was working at a nation-wide, world-wide really, chain store, I worked as what's called a floater: I went wherever I was needed. I had a good eye for fashion and I wanted to work in the clothing department. But I was told, in so many words by the manager, because of my size it was very unattractive to the customers. And things like that. I was often denied breaks at that same store because they assumed I would spend all my time eating.

Nicole: When I was a motel receptionist, the owner told me one time, "My God, Nicole, you've put on even more weight. You should be careful." She hurt me so much with that comment that I told her, "If you're no longer happy with my work, tell me so directly but leave my physical appearance alone. It doesn't stop me from doing my job. If you're not happy with my work, tell me so but don't talk to me about my size." She said, "Of course I'm happy with your work. You work well." I told her to be happy with that then. She said, "Well, you know, customers and the public, they get turned off by fat people."....Instead of appreciating my work skills, she was just looking at my appearance.

Wanda was approached by her female manager about the advisability of weight loss through a company-sponsored commercial diet program. Wanda expressed her doubts about the effectiveness of such a program, and her refusal to participate resulted in a transfer to another supervisor. This is how she describes this experience:

Probably the last 10 years of my work life I worked for the federal government and I had a manager ask me point blank if I was comfortable being large. She asked if she brought in Weight Watchers, would I please attend. I said that I had tried that before, that and everything else. It does not work. You only gain weight when you diet, so I'm not interested. Then it became a very chilly relationship. I was transferred to another supervisor. I have had a few incidents of that sort. I was always being told that I couldn't do certain jobs because of my size. I wouldn't fit in.

It is noteworthy that no participant who was told weight loss was necessary either for employment or for the retention of a current job accepted that condition. An obviously biased employer could create a difficult work environment and furthermore, an acceptance of these terms would require a compromise of integrity which they were not prepared to make. The women who were already employed were confident their skills were not undermined by their weight and expected their superiors to be aware of this.

It must be stressed that the participants who encountered overt discrimination are describing experiences that generally took place over 20 years ago before protective legislation came into effect. The younger women in the sample (under the age of 35) reported employer prejudice and discrimination, but they maintain that it is tacit rather than obvious. A few complained about the unspoken assumption that fat employees are not capable of carrying out similar functions as their thin counterparts:

Jennifer: Sometimes, in interviews, there's an assumption that you can't do certain things or wouldn't want to do certain things, even if you're already doing them. They never say anything, but you can feel it. They go through the interviews but you can basically tell it when it's just a half-hearted attempt.

Fiona: Employers have these pre-conceived notions about overweight people. They figure they can't do the same things as thin people.

While prospective employers may be legally restrained from displaying overt prejudice against fat workers, colleagues, however, can blatantly demonstrate their dislike of fat co-workers with impunity, as two of the women were painfully made aware. Their fatphobic co-workers created a climate of hostility toward them, and were not disciplined for their actions by management. Filomena and Wanda describe their experiences of co-worker harassment and management indifference to their mistreatment:

Filomena: I was harassed by someone at work years ago. She was leaving diets and leaving pictures of fat people on my desk—she didn't like me and that was her way of getting back at me. I went to the supervisor who didn't know what to do and it went on for a really long time. It was horrible. And then when finally we took it to another level, they asked me to go to another department. They asked *me* to leave and go to another department (emphasis in original)!

Wanda: I had a [female] co-worker tell me flat out that I was a fat pig. I went to the manager and said, "That is unacceptable. I will not tolerate this." They put it down just to a personality difference.

My findings of obese people's experiences of occupational discrimination are congruent with those reported in the literature (Rothblum et al. 1989, 1990). Fat people are considered undesirable as employees, and it is notable that this discrimination is often blatant. Employers appeared to endorse the belief that obesity prevents a person from carrying out job functions or detracts from a desirable public image. Co-workers also appeared to be influenced by the negative stereotypes of obese people as being less intelligent, hardworking, and successful than normal-weight people (Harris et al. 1982).

Despite the overt hostilities directed toward them, my participants refused to be intimidated by weight discrimination. They did not accept job offers conditional upon weight loss and they fought back spiritedly against employers and co-workers who suggested their weight undermined their work skills.

#### **WEIGHT-RELATED HEALTH PROBLEMS**

Since morbid obesity is commonly associated with copious medical complications, it was not surprising to discover that two-thirds of the sample was confronted by weight-related health problems and concerns. To ease the presentation of this data, the health problems are summarized in Table 5.1.

Type 2 diabetes, sleep apnea, musculoskeletal problems, mobility difficulties and stress incontinence are the most frequently cited comorbidities. Although almost every sample member revealed she feared developing heart disease or dying at a young age from a heart attack, no one in the sample actually had heart disease. Two of the women in the sample had Polycystic Ovary Syndrome (PCOS), a condition characterized by insulin resistance, which in turn causes weight gain (Pettigrew and Hamilton-Fairley 1997). Two women suffered strokes but were not certain if these were related to their weight.



Table 5.1—Co-Existing Conditions

Name of Participant	Weight-Related Health Problems (prior to surgery)
Barbara	Joint pain; difficulty breathing and sleeping; stress incontinence; high blood pressure; depression.
Casey	High blood pressure; arthritis in lower back; shortness of breath; easily fatigued; pain in knees and feet; depression.
Cinzia	Polycystic Ovarian Syndrome.
Cynthia	Hiatus hernia; reflux; gallstones; shortness of breath; history of diabetes on both sides of the family.
Doris	Severe sleep apnea.
Elaine	Polycystic Ovarian Syndrome; sore Achilles tendons; mobility difficulties; stress incontinence; borderline high blood pressure.
Filomena	Joint pain; stress incontinence; infertility; shortness of breath; depression; gestational diabetes; possible sleep apnea.
Isabella	Severe psoriatic arthritis; depression.
Jeanne	Arthritis in feet.
Jennifer	Diabetes; breathlessness upon slight exertion; mobility difficulties.
Joanne	Heart murmur; fatigue upon minimal exertion.
Lara	Depression; severe pain in knees.
Nicole	Pain in kidneys, legs, feet; easily fatigued.
Renate	Depression; infertility; arthritis.
Rosemary	Arthritic pain in knees, feet, hips; shortness of breath; mobility difficulties; lack of energy; plantar fasciitis; depression.
Sherri	Diabetes; sleep apnea; stress incontinence; arthritis; depression; mobility difficulties; shortness of breath; excessive tiredness.
Trudy	Mobility difficulties; shortness of breath; high blood pressure; sleep apnea; back pain.
Valerie	Diabetes.
Wanda	Asthma; osteoarthritis; severe sleep apnea; depression.
Yolande	Severe arthritis in spine. Note: May be occupationally related.

Morbid obesity does not only affect a person's physical health; it can negatively affect mental health as well (Adami et al. 1999; Myers and Rosen 1998; Rand and MacGregor 1990; Stunkard and Wadden 1992). Nine women in the sample had been diagnosed with clinical depression; eight of them attributed their depression to their obesity. Four other women, while they did not indicate they had been clinically diagnosed with depression, described symptoms consistent with depression such as low self-esteem, chronic despair, and prolonged bouts of crying. Two of these women felt depressed about their weight; the other two were depressed about traumatic events in their lives. Three sample members were

so distraught about their recalcitrant weight condition that they seriously contemplated suicide as a means of escaping what had become an intolerable situation. Barbara actually did make a serious suicide attempt.

However, it was interesting to observe that weight can reach very high levels before it becomes physically problematic. For instance, Jeanne was square dancing once a week when she weighed 387 pounds. Fiona was active in tae kwondo when she weighed 320 pounds. Jennifer only experienced mobility difficulties and shortness of breath when her weight went up to 521 pounds. Prior to that time, she had maintained a weight of 470 pounds for several years and never experienced constraints due to her weight.

#### **DISCRIMINATION BY MEDICAL PROFESSIONALS**

The majority of the sample complained about blatant fat bias from medical professionals, almost all of whom were male. For instance, Valerie describes the reaction of her doctor when she consulted him because her blood pressure was slightly elevated: "He looked at me and told me not to eat so much." Renate was told by her doctor that she was too fat to have a baby. Fiona had a similar experience, although the physician was perhaps not as insensitive:

About two years ago, my husband and I wanted to have another child. My doctor sent me to a gynecologist. When we met with him, he just looked at me and said, "You know, you need to lose weight." He said this very rudely. If my periods had stopped just because of my weight, I would have understood. But my periods had stopped when I was quite a lot less heavy. My family doctor didn't think it was because of my weight.

The fat bias of one company physician cost Marcia a job:

I interviewed for several jobs to work as a clerical type employee, but in one instance, when I went to the employee interview, I was hired, but it was subject to a physical. And when I went to the company doctor for the physical, it was a humiliating experience. He just refused to examine me. Even though I didn't have any physical problems at the time, he told the personnel director that I was too fat and that I probably wouldn't be able to find a chair to fit me, and that I shouldn't be hired. So I was rejected on the basis of not passing the physical—I actually didn't have anything wrong with me. I didn't fail the physical; the doctor had a fat bias.

Numerous participants complained that their family doctors attributed almost every presenting ailment to obesity and that they had to insist on getting proper medical treatment. For instance, Yolande

had an ear infection when she was morbidly obese and the doctor actually attributed that condition to her obesity. When Cinzia became immobilized because of a back injury, she encountered various doctors whose clinical judgement was obviously impaired by a tendency to assume fat patients' medical problems always have their genesis in their overweight condition. In the wake of an ice storm, Suzanne fell on a patch of ice and injured her knee. At the emergency room, she was lectured by the attending physician about her weight. Cinzia and Suzanne elaborate on their experiences with a fatphobic medical profession:

Cinzia: A couple of years ago, I suffered a back injury. But it wasn't an injury where I fell off a cliff or anything like that, it was a progressive thing that happened. It took probably about six months to diagnose because the doctors kept saying it was weight related: "No, you don't have a herniated disc, it's weight related. You just need to lose weight and exercise." I kept following instructions and doing it, but eventually I was bedridden. I begged for a referral to an orthopedic [sic] and was told that I was wasting taxpayers' healthcare money by going to an orthopedic. It turns out I did have a herniated disc. That's exactly what the problem was. The treatment for it, other than surgery, was complete bed rest—the opposite of everything I had been told. That wouldn't have happened if my doctor hadn't seen me as "She's overweight, naturally that's the problem. That's always the problem." So, I would say that medically I've been discriminated against. The thing with the PCOS, quite often what happens is doctors just say, "You never have a period, well it's because you're fat." Everything is because I'm fat.

Suzanne: I sprained my left knee during an ice storm a few years ago. Obviously, I went to the hospital in an ambulance. There was another woman who had been admitted to the hospital for the same reason, but she wasn't obese. The orthopedist treated her like a human being—because she wasn't obese. When he got to me, he started by saying, "If you weren't so fat, you wouldn't always be on the ground." He had absolutely no tact. I said, "I'm not always on the ground, it's the first time I've fallen. I fell because of the ice." He didn't pay any attention to this. "No, you're always on the ground. It's only the fat ones like you."....Given that I'm obese, I fell because I'm too fat to walk around. Never mind that there was a long line of patients who had fallen because of the ice storm. There were dozens of people who had injured their arms, their collarbones, their ankles, their knees.

Wanda's presenting condition, a sinus infection, was not even treated when she consulted her doctor; rather, he was more interested in giving her a prescription for weight loss drugs, despite her consistent refusals and her rationale behind her skepticism regarding the effectiveness of these drugs.

Wanda describes the encounter:

Recently I went to a doctor to see him about a sinus infection. And while I was there, he kept telling me that there are new diet drugs on the market, that I should let him give me a prescription for them, that they work. I informed him that I am not here for diet drugs; I don't believe in diet drugs, they kill people and they tend to be addictive. I'm not interested. I came here because of a sinus infection, nothing else. And he shook his

head at me and told me I could go. He didn't give me anything for the sinus infection but he did manage to charge my insurance company for the visit.

Two women complained of overt sexism in the medical profession. Rosemary, who became morbidly obese in her forties, went to various doctors, insisting that the upward weight spiral must be the result of a metabolic disorder. However, she found that doctors were not sympathetic to her or even willing to listen to her protestations that this was an aberrant situation for her. As a result of these encounters, Rosemary concludes that male doctors are disinclined to take their female patients seriously in general, and condescend to overweight women in particular. In her words:

I kept going to doctors, saying something is wrong. I am not normally a heavy person. I cannot keep the weight off. Now, of course, a lot of the doctors attributed my aging process as making it harder to lose weight and that sort of thing, but I kept saying—I continued to say to multiple doctors—*something is wrong*. My husband would even say to the doctors, “If I ate as little as she did, I would weigh 100 pounds.” Doctors, however, I find treat women sometimes dismissively. When you're overweight, if you go in and you say I have a sore throat, the doctor will say “Maybe you should lose a few pounds.” If you say I have an earache, “Maybe you should lose a few pounds.” You can imagine then, if you say I'm having a weight problem. You know, doctors mirror society's treatment of overweight people, and treat you like you're stupid or lazy or whatever. I would have them say to me, “It's simple mathematics: calories in and calories expended. You're taking in more calories than you're expending.” And then treat me as though, Oh sure, lady, like you're not going to stop by McDonald's on the way home. Treat me as though...actually in front of my husband behave as though he must not know what's going on, like I must be eating a pizza while he's asleep at night. I was a group leader for a period of time of a support group for one of the surgeons, and I have heard a *lot* of these stories (emphasis in original).

Suzanne also experienced sexism from medical professionals, but of a different nature than Rosemary. When she was in her mid-twenties, she underwent a gynecological procedure and the attending physician counseled her on the benefits of weight loss, not for her health, but for her appearance. As Suzanne recounts, “The gynecologist who did my curettage told me, ‘You look old because you're fat.’ He also said, ‘If you were thinner, you'd look much better and you'd be very pretty.’ This doctor clearly defines both fatness and aging in women as processes to be avoided because they detract from women's appearance. Besides upholding gender stereotypes which maintain women's oppression, the context of this doctor's remarks are objectionable. Expressing a personal opinion about a patient's appearance when it is unrelated to health is surely a breach of medical ethics.

The two participants who were treated by female doctors, however, indicated that they were non-judgemental, and even sympathetic, in their treatment of them. Despite the difference in class, education, and social status between them and their patients, women doctors are also affected by the current hegemonic ideals of beauty and can perhaps empathize with their patients' struggles to manage their weight.

### QUALITY OF LIFE ISSUES AND CONCERNS

In addition to worrying about the impact of their weight on their health, the participants also felt that their quality of life was greatly impaired by their presurgical weight. All complained that when they were at their highest weight, they could not sit in restaurant chairs or booths. Nor could they fit in chairs with arms. Theater and stadium seats were also problematic. They also had trouble fitting in cars, having to buy bigger, more expensive cars than they would have liked. Most had to use seatbelt extenders. Seatbelt extenders were also necessary in airplane travel.

Finding attractive, well-fitting clothing was also a source of frustration cited by virtually every sample member. Even the chain clothing stores that cater to large women do not carry exceptionally large sizes. The participants often criticized the cut and material used in clothing for heavy women and also pointed out that while the selection is limited, specialty stores sell their clothes at a premium. Catherine, who spent most of her life in New Zealand where there are few clothing stores for large women, had to spend thousands of dollars on dressmakers so she could clothe herself. To circumvent this problem, she learned how to sew but was resentful that she had to acquire this skill out of necessity.

The women also complained about having difficulty carrying out basic toileting, hygiene and grooming activities. The heaviest women in the sample indicated they were limited in all their daily functions. Some complained they could not bend over to put socks on their feet or to tie their shoes.

The immobility that can accompany morbid obesity is perhaps best illustrated by an experience Sherri had, at her presurgical weight of 456 pounds. She fell in a public venue and was unable to get up, despite the assistance of numerous people. Finally, the emergency squad was called and pulleys were used to get her back on her feet.

### WEIGHT LOSS ATTEMPTS PRIOR TO SURGERY

Weight loss, or rather, attempts at weight loss were the centerpiece of these women's lives before their surgery. Bariatric surgery is supposed to be a last-resort option; besides being morbidly obese, patients are to have exhausted all other weight loss options before they can be considered eligible for the surgery (NIH Consensus Development Conference 1992).

The overwhelming majority of the sample easily met these criteria. With the exception of two participants, all had strenuously engaged in weight loss pursuits for prolonged periods of their lives. The question, "Did you undertake other weight loss measures prior to your surgery?" was almost invariably greeted with snorts and guffaws of "You mean, what *didn't* I try?" The variety of their experiences, summarized in Table 5.2, indicates that they indeed run the gamut of the weight loss spectrum, with virtually every option represented.

Most reported first trying to control their weight at young ages, either at the behest of their parents or doctors. Four of the participants were as young as five years old when they first went on diets. Julie attended Weight Watchers meetings when she was seven years old. Casey's parents put her on a diet when she was nine. Doris and Marcia were prescribed amphetamines at the age of 12; Cinzia, Cynthia, Trudy and Marianne were 14 when they were prescribed amphetamines. Sherri and Julie attended children's summer diet camps when they were 10 years old. By the time they were 16 years of age, most of the sample members had dieted at least once.

Table 5.2—Weight Loss Measures Prior to Surgery

Weight Loss Measure	Number of Women
Standard low-calorie diets (LCDs)	28
Group dieting programs: e.g., Weight Watchers, Overeaters Anonymous, Take Off Pounds Soon (TOPS)	25
Fad diets and diets du jour: Atkins, Scarsdale, T-Factor, Rice, Grapefruit Diet, Cabbage Soup, etc.	21
Liquid protein diets and physician-sponsored VLCDs: e.g., Cambridge, Slim-Fast, Opti-Fast, Medi-Fast, Medi-Cal	21
Commercial diet centers: e.g., Jenny Craig, Nutri-System, Diet Center, Bernstein Health and Diet Clinic	8
Injections: e.g., Vitamin B <sup>12</sup> , HCG	6
Amphetamines	8
Contemporary diet drugs: e.g., Redux, Fen-Phen, Phentermine	5
Starvation and fasts (VLCDs)	6
Pritikin Longevity Center	1

The majority of the participants who had been overweight or obese since childhood reported that their parents were deeply committed to their quest of getting their daughters to lose weight. Some parents went beyond merely putting their children on diets. For instance, Sherri's parents paid her to lose weight and Julie's parents tried bribing her with a popular toy. Julie had been on every conceivable diet since early childhood and had never managed to lose a significant amount of weight. Her parents remained undeterred in their conviction that their daughter could lose weight once she found the "right" weight loss measure. When she was in her freshman year at college, her parents made a month-long enrolment at the Pritikin Longevity Center mandatory for continued funding of her college tuition. The Pritikin program is a highly structured, ascetic, expensive venture which preaches the health benefits of exercise and a very-low-fat diet. Clients are required to live at the Center for the length of their enrolment. The Pritikin program proved to be no more superior than less structured programs, and Julie estimates that her parents "pissed away \$30,000" (US) for her stay at the Pritikin Longevity Center.

When talking about their experiences with non-surgical weight control measures, the participants often used the metaphors of "merry-go-round" or "revolving door" to describe their entrapment in what

Fraser (1997:1) calls the “adventures of Dietland.” They expressed bitterness and frustration—often tempered with humor—about the lost energy, time, and money spent in the zealous, quixotic pursuit of weight loss. Only Wanda and Renate managed to lose a significant amount of weight (over 100 pounds); most reported only losing about 20 to 50 pounds using non-surgical weight loss methods. Not a single sample member ever maintained her weight loss; in fact, every person who dieted not only regained her previous weight but would add more weight after each diet cycle. Julie spoke for the sample when she explained, “I was real good at the first 30 pounds. That was easy. But that was as far as I got. I always lost 30 or 50 pounds and I always gained it back—plus more.” Some sample members, particularly those allied with NAAFA, speculated that if they had not so strenuously tried to lose weight, they might not have become morbidly obese. There is, of course, copious empirical proof which indicates the sample’s suspicions about the inefficacy of diets and their contribution to further weight gain are well founded (Cogan and Rothblum 1992; Douketis et al. 1999; Garner and Wooley 1991).

Nadine and Gisèle, the only two sample members who did not diet previous to their surgery, explained that although they wanted to lose weight, they thought that simple calorie control was an exercise in futility for the person who needed to lose at least 100 pounds.

### **THE MORBIDLY OBESE BODY AND THE SELF**

According to Millman (1980):

One of the most common adaptations to being fat is to disembodiment one’s self—to live only in one’s head. Fat people often think of themselves solely in terms of the “neck up.” Their bodies are disowned, alienated, foreign, perhaps stubbornly present but not truly a part of the real self. (P. 195)

My participants reported feeling a similarly profound sense of disembodiment and estrangement from the self prior to their surgery. When asked the question, “How did you feel toward your body before you had your surgery?” they almost uniformly answered they hated their pre-surgical body, describing it as ugly, gross, disgusting, repulsive. So great was their loathing of their bodies, they just refused to look at or even acknowledge them. They habitually avoided mirrors, especially when they were undressing. Valerie even kept her mirrors deliberately high up on her wall so that only her face could be reflected.



They also hated to be photographed and some refused outright to ever have their pictures taken. Casey was the sole participant to indicate a relatively high degree of acceptance of her presurgical body:

I have been overweight for so long that it's hard for me to think of myself in any other way. But I don't feel disassociated from my body. I've always felt this is me. I've never had any problems with looking in the mirror.

Virtually all sample members spoke about their body as having become an alien thing, that it had become unrecognizable to them. Many indicated that they thought their body had betrayed them when they gained massive amounts of weight and were unable to take it off. I noted that the body part which repelled them the most was the stomach. The presence of a bulging stomach appeared, more than any other fleshy part of the body, to make a woman look and feel fat. As Bordo (1993:202) notes, "[s]ignificantly, the part of the obese anatomy most often targeted for vicious attack, and most despised by the obese themselves, is the stomach, symbol of consumption (in the case of the obese, unrestrained consumption taking over the organism...)." Moreover, I believe that a factor contributing to the women's dissociation from their bodies stemmed from the fact that the size of their stomachs simply prevented them from even seeing areas below the waist, such as the pubic area or the feet.

While most women complained about how unattractive their bodies had become, most maintained they still had a "pretty face." Again, echoing the experiences of Millman's participants, they had apparently been told by numerous well-meaning people, "You have such a pretty face. If only you weren't so fat." As Millman observes, "[t]he implication of 'such a pretty face' is that the face is still unspoiled" (p. 198). Rosemary, who describes herself as having been "pretty horrified" with her body when she started gaining weight, made the irrevocable decision to undergo weight loss surgery when she saw that her morbid obesity had altered her face as well:

I was in a mirrored elevator one night. I was just looking at myself in the mirror. My face was unrecognizable to me at that point, it was so heavy. One of the things that people had always told me was, "You have such beautiful eyes." And my eyes had all but disappeared. It was at that point, at that moment in that elevator, I made the decision that I would re-address the surgery.

As long as Rosemary still had a pretty face, she may have felt she retained vestiges of her original identity; however, once she felt that her face was debased by her escalating weight, she could no longer tolerate the physical changes imposed by morbid obesity.

Fat women carry multiple burdens: They carry the literal burden of their physical weight; they carry the burden of society's disapproval and contempt as well as their own burden of shame and self-hatred. And as Millman (1980:220) points out, fat women are burdened with an additional self: "[I]ike Cinderella or the Frog Prince, the fat person lives with a double identity. Her present self-in-the-world may be fat, ugly, despised, or disregarded, but inside, carefully nourished, is a private future self that is beautiful, powerful, lovely." The belief in the presence of a fat person's secret self is vividly illustrated in the aphorism, "Trapped inside every fat person is a thin person trying to get out." All weight loss strategies hold the promise that a thin, *real* self resides within the fat person. The fat body, then, does not represent the real self.

While this theory gives hope to the fat person that the outer, fat self is temporary, a consequence of this conviction is a sense of incongruency between body and self. I questioned the women about the extent to which they felt they owned their bodies prior to their surgery; that is, to what extent did they feel their body was congruent with their self. Virtually all participants denied any sense of body ownership when they became morbidly obese, and as a result, they were profoundly alienated from their bodies. Related to their feelings of disembodiment was the sense of a lack of alignment between body and self. The morbidly obese body was not the true body and the self it represented was not the true self. The authentic self, the non-fat self, was buried or smothered beneath the layers of fat and could only be revealed through weight loss. Weight loss quests can be thought of as not only attempts to change the body aesthetically, but also as avenues which liberate the authentic self.

### SUMMARY OF FINDINGS

In this chapter, the sample members described their lives prior to their surgery. All but one participant had a longstanding history of obesity. Interestingly, a substantial proportion of the sample identified a reason other than overeating to explain their excess weight. These varied from medical intervention in their weight either as children or adults, weight cycling, personal trauma, the presence of an undiagnosed metabolic disorder, or simply having a genetic predisposition to gain weight. The

women's perceptions of how they came to be overweight contradict the popular, simplistic conception of obesity as purely the result of an imbalance between calories ingested and expended.

Almost the entire sample suffered derogation and rejection by their peers in their childhood years. They were called names and were subjected to various other forms of mistreatment. Numerous participants thought their weight set them apart from other children and they felt isolated and insecure. These feelings of isolation and insecurity, in turn, contributed to low self-esteem and inadequately developed social skills. The women who were well adjusted in their early school years felt a greater pressure to conform to traditional feminine weight norms once they reached adolescence and began competing for male attention. These findings demonstrate that emphasis on bodily appearance starts young: At a very early age children have incorporated some sense of what constitutes an appropriate body type and mete out punishments to those they feel do not conform to this type.

The participants also reported they were victimized by their parents as well. While the majority of the sample had at least one obese parent, they themselves had the distinction of being either the first or the only morbidly obese person in their families. In particular, the participants who were very overweight at young ages bore the brunt of their parents' shame and exasperation. Their parents sought medical advice in the conviction that obesity is a curable medical condition. These participants were inducted to diet culture by their parents and their family doctors. Some sample members reported that their parents also resorted to humiliation as a way of letting their children know about their deviance and how unacceptable it was to them. The participants who had at least one morbidly obese parent, however, indicated their parents were supportive and non-judgemental of them.

The majority of the sample was either married or involved in long-term romantic relationships. The women reported a wide variety in relationship experiences, from husbands who wanted to do everything they could to alleviate their wives' agony to husbands who blatantly expressed their distaste for their obese wives. Non-supportive spouses, however, represented a small minority. The majority of the women strongly believed that their weight was not a source of unhappiness to their husbands and felt their husbands accepted them and loved them in spite of their obesity. When their husbands expressed concern about their wives' weight, it tended to be in the context of worry about its impact on their physical and

mental health. These findings are contrary to those conclusions propounded in the popular media, and to some extent, in the academic media, which often portray fat women as freakish and unlovable.

The sample reported experiencing discrimination in a wide variety of contexts, the most consequential of these being occupational discrimination. The women in the sample who were 35 years and older tended to report more blatant employer-related experiences of discrimination. For instance, they were asked about their weight during job interviews; some were told they would be hired on the condition that they lose weight; some were explicitly told they were too fat to be hired for a job that involved interaction with the public. Even when the participants worked at a particular job and had never received a negative evaluation, employers admonished them about their weight. In most cases, employer discrimination was more subtle: The women simply were not hired even when they possessed the appropriate qualifications. Their experiences indicate that discrimination on the basis of fat is structural; that is, it is not based on individual preference but rather occurring at the institutional level.

The point must be made that the sample members who were discriminated against did not accept this treatment passively. In every instance, they resisted fatphobic employers or potential employers. No participant tolerated weight-related criticisms from current employers and no participant agreed to accept a job contingent on weight loss.

Although the women were capable of fighting back against fatphobic employers and resisting fatphobic partners, they internalized the widely held belief that their extremely obese bodies were repellant. All but two sample members reported feeling a profound sense of detachment from their bodies. The sample members voiced other concerns about their weight besides its lack of aesthetic appeal. They felt their massive weight created a low quality of life where their mobility was greatly reduced so they could not walk even short distances, play with their children, or dress attractively. Traveling in cars, buses, and airplanes was achieved only with difficulty.

Two-thirds of the sample reported obesity-related diseases such as musculoskeletal disorders, severe sleep apnea, Type 2 diabetes, stress incontinence, infertility and high blood pressure. The women's mental health was also adversely affected, with 13 women reporting they were depressed about their

weight. Two women contemplated suicide as an option of relieving them of their troubles and one woman did make a serious suicide attempt.

Not surprisingly, the participants felt enormous pressure to lose weight. Again, all but two sample members had tried to lose weight at some point in their lives. Those participants who were overweight as children were diet veterans—and much fatter. The women who had experienced the most parental and physician intervention were among the heaviest women in the sample. The weight loss attempts primarily consisted of standard low calorie dieting, but many had tried more extreme measures, including VLCDs and appetite suppressants. Every person in the sample who had dieted observed that this endeavor only resulted in further weight gain. The causal relationship between chronic dieting and long-term weight gain is only now attracting attention from obesity researchers. The sample also complained about being treated with disdain by the medical profession. They also indicated that their doctors viewed their weight as the genesis to virtually every ailment they ever experienced. Doctors appear to be shamefully ignorant about the complex, multifactorial nature of obesity and to treat it as a consequence of self-indulgence and laziness.

As a whole, the sample members' lives before their weight loss surgery was characterized by stigmatization and rejection from numerous sources, ill health, impaired quality of life, feelings of entrapment in the dieting merry-go-round and chronic unhappiness about a condition they could seemingly do nothing about. These findings illustrate how difficult it is to be so grossly fat in a society that so obviously despises it. This chapter has provided the context for understanding why women would undergo a surgical procedure as drastic as bariatric surgery. Ironically, it can be concluded they may have felt they had nothing to lose.

## CHAPTER SIX

### THE DECISION-MAKING PROCESS

This chapter describes the process involved in deciding about the surgery and the implementation of that decision. The participants recount how they first came to hear about bariatric surgery, why they chose to undergo it, and in some cases, why they chose a particular procedure. The reactions of spouses, family, friends, and family doctors to their decision will also be discussed. An interesting theme that arose concerning the decision-making process is whether or not these women are agents in this process. I argue that, in some circumstances, women who undergo bariatric surgery should be acknowledged as agents.

#### NEGOTIATING INFORMATION ABOUT BARIATRIC SURGERY

Deciding to undergo bariatric surgery involves a multi-phase process; awareness of the existence of the surgery serves as the initial phase. Information about other body-altering techniques such as various cosmetic surgeries is widely disseminated in the general population. But until 1999, when Carnie Wilson and Roseanne publicized their experiences with weight loss surgery, the public simply did not know about the availability of surgery for morbid obesity.<sup>64</sup> Even family physicians are not knowledgeable about the surgery; ultimately, the media and friends played a greater role in educating my sample participants than their doctors.<sup>65</sup>

Fifteen women became aware of the availability of bariatric surgery through various media outlets; nine of the women in this group were informed about the surgery by television shows or magazine articles. The extensive media coverage of Carnie Wilson's surgical odyssey also made them aware of the existence of the RNY and its high success rates, although no one cited Wilson as an inspiration or role

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<sup>64</sup> The participants aged 35 or older were aware of the JIBs that were widely performed in the 1970s. This surgery is no longer performed because of the high occurrence of intolerable side effects. See Appendix C.

<sup>65</sup> Similarly, Davis (1995) notes that women interested in cosmetic surgery obtain more information about the various procedures through other women and women-oriented media, such as "women's magazines."

model. The remaining six women in this cluster were aware of the surgery through other media sources such as medical journals, the Internet, and videotapes in the local library.

Nicole had perhaps the most profound reaction when she heard of the availability of the surgery after reading the story of a Quebec woman who had had the surgery at a near-by hospital. For Nicole, reading this article was a life-altering moment, as she relates:

I read a story in a magazine about a woman who been operated on at the \_\_\_\_\_ Hospital by Dr. \_\_\_\_\_. I had never heard of this surgery. I was spellbound by the story. When I finished reading it, I looked at the before and after pictures and figured it was impossible that this was the same woman. I started reading the story again to make sure I had understood it properly. When I closed the magazine, I started to cry. I started to cry because deep inside of me I knew that something was going to happen. I cried and cried—I don't know how long—until I had no more tears. When I stopped crying, I blew my nose, I sat down and phoned the \_\_\_\_\_ Hospital and asked for Dr. \_\_\_\_\_'s office. I asked his secretary for an appointment. When I hung up the phone, I began to cry again because this was the first step, I knew I had made the first step towards something wonderful.

While these women were inspired, or at least informed by strangers who related their stories via the mass media, nine women knew about the surgery as a result of the experiences of friends or acquaintances.

Six women reported they first heard of the surgery from a health care professional; most often this was a specialist they had consulted in relation to treatment of comorbidities.

The point should be made that the original source of information did not always serve as a catalyst for the decision to have the surgery. For example, Filomena's psychologist was the first person to mention the surgery to her, yet Filomena was not convinced this was a viable option for her until she heard former patients recount their surgical stories on television a few months later. Trudy, on the other hand, first heard about the surgery from the media but only gave the surgery serious consideration when her family doctor suggested it to her. Isabella knew about the surgery when her friend had a primitive VBG. However, the friend regained her pre-surgical weight and Isabella did not want to repeat her friend's experience. She was unaware that more successful surgeries had been developed until her family doctor informed her about the development of the RNY.

A related point is that as anxious as all the women in this sample were to lose weight, not all were immediately receptive to the possibility of surgery as the solution to their weight problem. Eight women

reported initial resistance or indifference to the surgery for varying reasons. All indicated that the surgery initially sounded too drastic for them, and that they preferred either to do nothing about their weight or to lose weight using other methods. Jeanne and Rosemary also cited the possibility of accruing surgically-induced health problems as a deterrent to having the surgery. Six of the women in this cluster reported pondering the possibility of surgery for several years. A change of heart was typically motivated by factors such as further weight gain, the constraints of immobility, and traumatic events in their lives related to their morbid obesity. According to Rand, Robbins, and Kuldau (1983), stressful life events often act as a catalyst to undergoing bariatric surgery.<sup>66</sup>

#### **WHY WOMEN UNDERGO BARIATRIC SURGERY**

Querying bariatric patients why they underwent the surgery may seem like a trifling detail. Obviously, a person who has this procedure wants to lose weight, but I was trying to determine whether women undergo this surgery for cosmetic reasons, health reasons, to save a marriage, etc. According to some sample members, insurance companies in the United States are increasingly refusing to cover bariatric surgery on the ground that it is cosmetic surgery. Critics of bariatric surgery also disdain the procedure as cosmetic, rather than health promoting (MacInnis 1993; Wolfe 1983).

Fifteen women in the sample indicated they were primarily motivated by health concerns in their decision to undergo weight loss surgery. Many feared possible further weight gain, with resulting immobility and early death. These fears were apparently justified: As was discussed in Chapter 5, two-thirds of the sample suffered from co-existing medical conditions that a substantial weight loss could alleviate. For example, Isabella was wheelchair bound from psoriatic arthritis and badly needed knee replacement surgery, but no orthopedic surgeon would operate on her because she was considered too high a surgical risk. Elaine, Renate and Cinzia were all infertile as a result of their obesity and they wanted to have a child. Almost all of the women in the sample complained their mobility and subsequent quality of life were greatly reduced. While Rosemary was horrified by the changes in her body as she became

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<sup>66</sup> See also Castelnovo-Tedesco (1987).



morbidly obese, she maintained that it was her worry about her mobility which was the primary motivator for undergoing the surgery. The women who were not currently experiencing circumscribed health feared developing heart disease or dying prematurely. The mothers of young children expressed fears about possibly not being able to watch them grow up. The women who cited health concerns—both current and imminent—as a primary motivator for the surgery were more likely than the others to stress that their weight goals were realistic and that cosmetic change was not a major factor in their decision. They also expressed impatience with people who were expecting them to become slender:

Jennifer: Personally, my goal was never to get to thin. My goal was to get healthier than I was.

Elaine: Everybody was asking me so what size do you want to be after the surgery? I kept telling people, you don't understand, I'm not doing this to get to a size 6 or anything. The only reason why I did the surgery was because I was getting to a point where I was looking at life in a wheelchair because I couldn't walk. I couldn't stand. I was gaining more weight and I probably would have kept on gaining weight, and my body just couldn't handle it. It wasn't that I was uncomfortable with my weight *per se*; I was uncomfortable with my *life*. I was uncomfortable with my *health*. The weight just happened to be a factor in my health (emphasis in original).

Trudy: The reason why I did the surgery was not to wear a thong. The reason was to get back to work, to be able to do the little things that I couldn't do. I couldn't do the seatbelt up in my car. I couldn't bend over to pick things up. I couldn't walk anywhere without getting breathless.

Casey: I would say that my health was at risk. I needed to do this for me not because I was against being overweight, but because I was going to die earlier and I was not healthy...I really didn't feel healthy and that's why I did it. That's the biggest reason I did it. Yeah, there's some vanity there, but...I don't want to get down to be a skinny little person either.

Fiona: I reached the point where I thought I could be dead of a heart attack five or 10 years from now and not watch [five-year-old child] grow up. And that was my main reason for getting it done.

Five women cited dissatisfaction with their appearance as the primary motivator behind the decision to undergo surgery. Concern with appearance, in this context, does not refer to adherence to normative attractiveness standards. None of these women expected to become beautiful; they just wanted to be "normal."<sup>67</sup> They saw surgery as an opportunity for them to "correct" what they considered to be

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<sup>67</sup> Researchers who study women's decision to undergo cosmetic surgery (Davis 1995; Gimlin 2002) also note that these women have the surgery to be ordinary, rather than beautiful.

very deviant bodies. The women in this sub-group were more likely to describe themselves as “freakish,” “gross,” and “disgusting,” among other pejorative adjectives. In contrast to the women who had the surgery for health reasons, they were more likely to believe weight loss surgery was the gateway to greater personal happiness. In their words:

Nadine: I had the operation because I felt like I was a freak, an outcast. If I was 250 at 21 years old, can you imagine how big I would be at 31? I just couldn't take it.

Yolande: I got this done for the physical aspect, not for my health. I didn't like how I looked, physically. I hated seeing myself so big.

Lara: I had this operation for cosmetic reasons. I really hated the way I looked.

Marcia: ...the reason that I basically had the surgery was so I could get married. I really wanted to get married and have children and I wanted my life to go in that direction. But I wasn't attracting the men I wanted because of my weight.

Three women whose marriages had ended or were faltering indicated they thought weight loss surgery was the vehicle to greater autonomy. Gisèle's husband had become increasingly physically and verbally abusive toward her and their children. She wanted to leave him, but she was financially dependent on him. She had difficulty finding employment because of her weight, and realized that this barrier would exist as long as she was morbidly obese. Gisèle was determined to break free of her husband's violence but was convinced she had to lose a significant amount of weight to be employable. As she recounts, she had the surgery because she viewed weight loss as her only route to freedom from a dysfunctional marriage:

That's when I made the decision to have the operation. I figured that if I wanted to have independence and autonomy, I'd have to start all over again. But if I wanted to start all over again and go out and work, I'd have to lose weight fast. I got this operation not so that I could become pretty and make my ex-husband happy. I did it so I could get some autonomy. My plan was to lose weight, get a job, get a divorce and start a new life.

Doris and Joanne also wanted to start new lives after separating from their husbands, and weight loss surgery represented the gateway to this new life. Doris, like Gisèle, felt she was unemployable and wanted to upgrade her education. But she felt she could not properly pursue her educational goals as a morbidly obese woman because of her chronically low level of energy and stamina. Joanne, who was just 24 when she had the surgery, was determined to no longer compromise her standards in men, having

previously felt that she settled for inferior men because of her weight. Quotes from them illustrate the point vividly:

Doris: I left my husband in 1981....I lived on mother's allowance basically for the first few years of the 1980s....I *wanted* to be able to go to work but I hadn't worked for 20 years and I couldn't find any employment, no matter what I did. I thought, I've *got* to go back to school, but I weighed 330 pounds and I was tired. I didn't see how I could change my life if I was 330 pounds and tired....So I got [surgery] done in 1984....In 1985....I went to \_\_\_\_\_ College and took an executive secretarial course...I always say that if I hadn't lost 100 pounds with the surgery, I wouldn't have got that education. My life was much better afterwards--until I had my stroke (emphasis in original).

Joanne: [Having the surgery] was always in the back of my head but I never really thought about it until after my separation. I was in bad relationships and I thought maybe it was because of my weight. I didn't want to be caught in that kind of relationship again....I didn't want to be in that kind of relationship again, thinking that's all I can get because of my weight, that kind of man.

Three women underwent the surgery to gain acceptance from their parents or spouses. Jeanne and Wanda had grown up being harangued by one or both parents and they felt that weight loss surgery provided them with a means to at last be accepted by them:

Jeanne: Everybody was now going to be off my back and I was going to be me. I was going to be a human....My mother didn't make me feel like a human. She had made it so rough for me. She criticized my weight all the time to me and to the aunts and uncles. I was tired of my mum being on my back about being heavy. This was going to be the answer to my prayers.

Wanda: I had the surgery because I was sick and tired of my family putting me down, telling me how horrible I was, that I wasn't going to accomplish anything in life as long as I was fat. I had heard this all my life. I was 25 years old, and it was time to make a change.

Suzanne had been very thin at the time of her marriage, and her vast weight gain was a frequent source of conflict between her and her husband. Suzanne thought having the surgery would make her more attractive to her husband and that an improved appearance could save a shaky marriage:

I did it for him. It was for him that I was doing this. It was for him....I wanted to be slender to please him, not to please myself.

Possibly more than anything else, the motivation to have the surgery was driven by the conviction that the sample members had reached a point of no return in relation to their weight. Their bodies and their lives had become wildly out of control. They had exhausted all conventional weight loss options, and the

surgery represented their only chance to lose a significant amount of weight. Hopelessness and despair permeated every account of the reason why the participant had surgery, as the following quotes illustrate:

Filomena: I felt that there was nowhere else to turn. I was at a point in my life where I had gone about two years without going on a diet because I was so frightened about losing weight and gaining it back again. I thought, Where do I go from here? I'll be over 300 pounds if I do that....I realized that I had to come up with something because the next thing that was going to happen was that I was going to die from [being morbidly obese].

Trudy: It was a last-ditch effort. It was like, if this doesn't work, why go on?

Celeste: I felt that absolutely everything else was absolutely hopeless. I had tried dieting, Weight Watchers, everything else. I wanted a permanent solution. I wanted a situation in which I could just eat a meal and not worry about anything. I wanted food to be in its right place in my mind.

Women, then, have weight loss surgery for a variety of reasons. Only one woman maintained she had the surgery to save her marriage. Every woman in the sample felt that her weight was an impediment to her physical or psychological health or constituted an obstacle to personal happiness. Some women may have had it for cosmetic reasons, but nobody considered this procedure to be purely cosmetic surgery. Surgery was an appealing option to my participants because it represented their only chance to lose a substantial amount of weight on a permanent basis.

### **CHOOSING A SURGEON AND A PROCEDURE**

Bariatric surgery is available in only four provinces in Canada and few surgeons perform it. The operation, which costs between \$20,000 to \$40,000, is a drain on the country's beleaguered health care resources. The surgical technique is also very specialized and this is perhaps another reason why the surgery is not widely available in Canada. Consequently, Canadians who want experienced surgeons can face waiting lists of one year or longer.

American patients, on the other hand, may have an abundance of choice, depending on where they live. Bariatric surgery is a profitable enterprise in a country where the market model of medicine prevails, and the surgery is performed in almost every state in the United States.<sup>68</sup> As a result, the American

<sup>68</sup> According to the American Society for Bariatric Surgery ([www.asbs.org/](http://www.asbs.org/)), the only states where bariatric surgery is not available are New Mexico and Wyoming.

participants who had the operation more recently had an impressive choice of surgeons and were more likely to have their preferred choice of operation. Every American participant indicated she received approval from her insurance company promptly, usually within a two-week period.

The sample members found their surgeons, all of whom were male, through various channels. These included family doctors, former patients, surgical support groups, the Internet, and seminars held by the surgeons. Two Canadian women told me the sole reason why they chose their particular surgeons was because they had short waiting lists. Two Americans indicated that one factor in their decision to choose their surgeons was the fact that they were on the list of their insurance company's health care providers.

There are numerous variants of bariatric surgery, but bariatric surgeons appear to specialize in one procedure over another. As a result, the surgeon's specialization can determine what procedure the patient will ultimately have. Fifteen women underwent a particular surgical procedure simply because that was the only procedure the surgeon performed and there was no other surgeon practicing in their region. In three cases, it was the surgeon who decided what the surgical procedure should be, based on reasons such as his own preference and the existence of medical conditions which favored one technique over another.

Not all surgeons were immediately forthcoming about their firstline procedure, however. Elaine, who had assumed she was going to have a proximal gastric bypass, only found out a year after her surgery that she had a medial gastric bypass. The medial gastric bypass is a more complex operative procedure and is associated with more complications than the proximal gastric bypass (Baltasar et al. 1998). While Elaine is satisfied with the outcome of the surgery, the point remains she was not fully informed about the procedure she underwent.

For 13 of the sample members choosing a surgical procedure was a careful, well thought-out decision. These women had the advantage of being able to research the surgery on the Internet and were aware of the advantages and disadvantages of various surgeries, particularly the RNY versus other procedures. They also took advantage of the information provided by on-line patient support groups, and

when they could, attended support group meetings in person.<sup>69</sup> They were also in the enviable position of having access to more than one surgeon in their area.

The women who methodically chose one procedure over another explain the rationale behind their decisions:

Barbara: I found out the different types through the Internet and why people chose the various types that were available. I knew in my heart of hearts that I wanted not necessarily the easiest surgery but I wanted one that was time proven and I wanted one that wouldn't interfere with my health and life too much. I chose the proximal RNY, open RNY, because I found that with distals and with some of the others, there were things like excess gas to contend with, malabsorption of your intake of food—and I just didn't want to deal with anything like that. They say the gold standard of weight loss surgery is the proximal, open RNY.

Trudy: First of all, I felt the RNY was very invasive. The VBG is less invasive. I also didn't like the idea of the malabsorption of the RNY. Being that I'm 48 years old, I'm not a milk drinker—calcium absorption. I see what osteoporosis does to people as they get older and I didn't like that. My thought was, If I can't do it with the VBG, I can't do it with the RNY, both being a tool, both having to do with my input as well....I didn't like the idea of them bypassing 100 centimeters of bowel. I didn't like the idea of you can get strictures where they anastomose that piece of bowel to the stomach. If I were to have problems with the VBG, I could always go to the RNY. The other way around, you can't change that.

Rosemary: The DS offered me some things that the RNY did not. The RNY, for one thing, with all of the side effects that it creates, like the dumping syndrome and that sort of thing and having to take vitamins and supplements for the rest of my life because I wasn't going to be getting it through nutrition. That was too much for me.

Cinzia: I had a Silastic Ring Vertical Gastroplasty. Specifically, it's a solely restrictive surgery as the VBG is, but from the research that I'd done, the use of the band where the stoma outlet is seems to cause more problems than the ring does....The other thing I was specific about was that I wanted a pouch that was under two ounces and I wanted a ring that was not too wide. 'Cause some of the restrictive surgeries are sort of built like a cylinder. Some are more like a funnel. And from what I'd come to notice, those people who tend to have a pouch that's built more like a cylinder seem to get full quickly but they lose that full feeling very quickly.... At the same time, I knew that too large of a ring would cause you not to feel full for very long. So I was pretty specific about the dimensions. Dr. \_\_\_\_\_ was doing what I was looking for: a one-ounce pouch and a ring with an internal diameter of just over one centimeter.

Casey, Catherine, Sherri and Julie had been influenced by the fat acceptance movement prior to their surgery. I asked these women how they reconciled having the surgery when the fat acceptance

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<sup>69</sup> The role of support groups will be discussed at greater length in Chapter 7. Support groups serve many useful purposes, but their primary mission is to offer pre- and postoperative patients information and encouragement.

movement is vehemently opposed to this weight loss technique. They all explained that they underwent the operation to improve their health and their quality of life, rather than to make their bodies conform to hegemonic cultural ideals. All chose to have gastric restriction surgeries as a compromise, feeling that these procedures are less invasive and therefore the integrity of the physiological digestive process would be maintained. Hence, gastric restriction did not “mutilate” the fat body to the same extent as the more invasive procedures and was ideologically acceptable to them:<sup>70</sup>

Catherine: I had the surgery because it was a way of solving the practical issues that I faced...I had a lot of conflict, obviously, with the fat acceptance. I had been reading so much stuff and that had given me so much strength and the ability to go forward and go on with my life. I felt like there was a bit of tension between the feeling like I was letting the side down by undergoing weight loss surgery. I had a really horrible couple of days... And then a few days later, I found out about the lapband...It wasn't as invasive; it wasn't irreversible; it didn't interfere with any of the natural processes—so it seemed to me that if I was going to consider weight loss surgery as a way out, that this was the best one I had heard of.

Julie: ...I liked the fact that I could take it [AGB] out....It's minimally invasive; it can be removed; it does not touch your body parts; you're not re-organizing your intestines. I figured, I'm not changing my body...

Sherri: I didn't like the invasiveness of the RNY. That's why I chose to have the [VBG].

Laparoscopic bariatric surgery is quickly gaining favor among surgeons and patients (Deitel 1998; Lonroth and Dalenback 1998; Schirmer 2000). Its benefits are many: There is no scarring and the hospital stay and recovery period are much shorter. Despite these advantages, however, most of the women in this sample were not attracted to the possibility of having laparoscopic bariatric surgery. Only three women in the sample had their surgery done laparoscopically; of these, Julie was the only one who specifically chose a laparoscopic procedure on the basis of its benefits. While a small number of the other women in the sample had the opportunity to have their surgery done laparoscopically, they said it was not an option for them because they wanted the surgeon to be able to see what he was doing.

### Surgical Consultation

The consultations with the surgeons averaged between 15 to 20 minutes. The surgeons generally

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<sup>70</sup> Julie chose to have an AGB because she was originally determined not to have her digestive system significantly altered. However, the AGB caused intolerable side effects and Julie later had a DS, a relatively complex bariatric procedure.

drew a diagram for them and explained that the surgery was only to be regarded as a tool that they had to use themselves in order to lose weight; the surgery alone was not going to do it for them. They were also advised they would have to regulate their food intake for the rest of their lives. Most provided their patients with reading material on bariatric surgery. This literature ranged from low-quality photocopied articles stapled together to thick packets containing articles, booklets, and videos. The literature provided by the American surgeons appeared to be more copious and more professionally presented. As well, the American surgeons tended to give their patients reading material before the consultation with them or their Patient Advocates, whereas the Canadian surgeons gave them information after the consultation. In Yolande's case, she only received reading material after her operation.

Five of the Quebec participants did not speak English; their surgeon and his dietician spoke very little French. Only the Quebec women who were operated on after 1990 received any literature about the procedure, and that just consisted of a very thin booklet. Despite the fact that the hospital is located in a predominantly French-speaking city, they had difficulty obtaining a copy of this booklet. As a result, they did not know the risks involved with this operation or what postoperative course to expect. They obviously were not in a position to ask questions of the surgeon. However, when I asked if they thought they had made an informed choice, they all brushed aside this concern, saying that their inability to understand the surgeon was a matter of little consequence to them. This surgeon was the only one available in their region and they therefore had no choice but to go to him if they were to have the operation. Lara typified the response of this group of women when she said, "The only thing I cared about was if he was going to do it."

Numerous surgeons recommended that prospective patients speak with others that had already had the surgery to find out about their experiences from their perspective. For example, when Jennifer first contacted her surgeon's office, she was provided with a short list of names of patients who had had bariatric surgery performed by him. This list included some people who were not satisfied with the results. Jennifer was urged to contact all these former patients before making an appointment with the surgeon. Barbara's and Rosemary's surgeons require attendance at a minimum of two surgical support group



meetings before they perform the surgery. While most surgeons did not make attendance at support group meetings a pre-condition for the operation, they did stress the benefits of attending these groups.

Two surgeons made extravagant predictions about the probable outcome of the surgery. For instance, Marcia, who had a JIB in 1982, was told by her surgeon that she would soon be wearing a size 9. While bariatric surgery can enable patients to lose up to 60 percent of their excess weight, patients rarely achieve a normative weight (Halverson and Koehler 1981). Therefore, Marcia who weighed 376 pounds before her surgery could not reasonably expect to wear a size 9, and her surgeon was surely aware that this outcome was highly improbable. Twenty years later, however, some surgeons still inculcate unrealistic expectations in their patients. Sherri, who had her second surgery in 1999, weighed 456 pounds and was assured by her surgeon that she would soon be wearing short shorts. Sherri stressed she was more interested in regaining mobility than in wearing short shorts. But the surgeon, who obviously assumed she wanted the surgery because she was unhappy about her appearance, repeatedly emphasized how “great” she was going to look and how “wonderful” her life would be after the operation. Numerous other women indicated that their surgeons would calculate their desired post-surgical weight according to the 1983 Metropolitan Life Insurance Height and Weight Tables. Again, according to the medical literature, patients should not expect to reach “ideal” weight after weight reduction surgery (Balsiger et al. 2000a; Brodin 2002; NIH Consensus Development Conference 1992). Balsiger et al. (2000a.:480) caution that “[r]ealistic expectations are that patients weighing 300 pounds achieve a weight of about 200 to 220 pounds (not 120 to 150 pounds)” (emphasis in original).

Preoperative protocol for bariatric surgery requires the screening out of patients who harbor unrealistic goals about weight loss and who believe weight loss is the panacea to all of their problems (Balsiger et al. 2000a). Yet, my participants’ experiences with their surgeons indicate that surgeons themselves are capable of having unrealistic weight loss expectations or regarding weight loss as the ultimate solution to fat women’s problems. This is particularly problematic because surgeons are in a position to influence their patients’ expectations. However, if the patient does not lose the amount of weight originally anticipated, or if her life does not become “wonderful” after her surgery, it is she who must deal with the ramifications of these perceived failures.

Although the surgeons were obviously convinced bariatric surgery is an effective solution for morbid obesity, none of the women reported that she felt her surgeon was pressuring her to have the surgery. There was a general refrain of “he just told me about it and left it up to me to make that decision.” Four of the participants indicated their surgeons gave them a month’s “cooling off” period before scheduling the surgery, to make sure this was actually the route that she wanted to pursue. While no one felt the surgeon was insistent that she have the surgery, three women complained they were not given a chance to weigh the benefits of the surgery against its risks. Marcia estimates that the time between her surgical consultation and her operation was only two weeks. She suspects that her surgeon saw her as a “cash cow” and his swiftness was designed to prevent her from changing her mind. Marianne’s and Wanda’s surgeons resorted to scare tactics about the health implications of obesity in order to justify the surgery, without counseling them to also consider its implications and the impact it could have on their lives:

Marianne: The doctor...explained it to me very thoroughly and matter-of-factly because he’s totally convinced this is his gift from God, to save people from the horrors of being fat. He was very convinced that it was a good procedure. As far as the risks of the surgery, his position was that you have to weigh these against the risks of obesity.

Wanda: I went to his office, sat through the seminar. He has a three to four hour seminar for his prospective patients, checking out your insurance, telling you what to expect, showing you a few slides, telling you how you’re going to die if you don’t have the surgery, etc. It’s really kind of ironic because he’s a short, fat man himself, but he let you know he’s 80 pounds less than the minimum for the surgery.

Most surgeons, particularly the Canadian surgeons, stressed that bariatric patients could die during the surgery. After making that point, they would indicate the mortality risk was actually very low. According to the literature, the mortality risk associated with bariatric surgery varies from 0.1 to 1 percent, depending on the procedure (Kral 1992b; Mason, Renquist, and Jiang 1992; Schirmer 2000). Contrary to the guidelines established by the Task Force of the American Society for Clinical Nutrition (1985), however, the morbidity risks associated with bariatric surgery do not appear to have been discussed at length during most of the surgical consultations. The women who were very well informed about the surgery prior to the consultation speculate their surgeon was aware of their knowledge and simply wanted to avoid repetition. Sixteen women feel their surgeons did not adequately inform them about possible

morbidity risks; few of them complained about this omission, however. Virtually all women in the sample felt the most important information the surgeon could provide was the announcement that they were suitable candidates for surgery. This level of willingness to proceed with the surgery on the basis of very little information is a testament to these women's desperation. The desire to have a "normal" body overrode all other concerns, rendering them null. Not one person in the sample appeared to consider the possibility that the surgery could leave her worse off than before. This is perhaps because these women felt that morbid obesity represented the nadir of their lives and that their situation could not possibly get worse.

When I asked my sample members about their fears of possibly dying during the operation, very few women indicated this was a substantial concern to them, largely because of the low mortality risk. Some women said that they simply refused to think about the attendant risks, instead preferring to concentrate on the outcome of the surgery. The overwhelming majority indicated that while they were somewhat apprehensive about the surgery, the mortality risks were not sufficient to dissuade them from undergoing it. Virtually all said they would rather die during surgery, rather than to continue to be morbidly obese. The following quotes underscore the state of hopelessness which imbued them before their surgery:

Nicole: It could have been 99 percent [mortality risk] and I would have gone. Anything would have been better than continuing to live that way. I didn't want to live that way anymore. I could even tell you that I would rather have died than to live like that.

Sherri [about her first surgery]: It was okay with me if I died. It was better than being fat.

Yolande: The surgeon didn't tell me the mortality risk. I didn't ask, either. Even if I had known, I would have had the operation anyway.

Trudy: I knew the consequences but I thought I had nothing to lose. I was ready to die on my own. I had gotten to the point where I no longer wanted to live like this. I had actually thought of killing myself. So if I died on the table, did it really matter?

Julie: I looked at it as I'm a good operative candidate, and I was willing to die than to remain where I was because I was feeling dead in my skin.

Celeste: It was better to be dead than it was to be overweight.

Interestingly, when I asked the participants how high a mortality risk they would accept, most indicated they would not accept a mortality risk higher than 20 percent. The women with children did not

want them to be without a mother, but the women without children were also reluctant to take an exceptionally high surgical risk. Even those who appeared to be the most determined and the most desperate were not willing to take a higher surgical risk. Barbara had been so depressed about her inability to control her weight that she made a serious suicide attempt two years prior to her surgery. Trudy and Wanda also indicated they were so despondent about their weight they had seriously contemplated committing suicide. Although these women were eloquent in articulating their desperation and many said they would rather be dead than fat, it would appear that if they had to seriously choose between death and morbid obesity, they probably would choose to live with their morbid obesity. It is noteworthy, that despite the consistent findings in the literature about the negative effects of obesity on mental health, the suicide rate among fat people is lower than that of the general population (Ciliska 1993; Fraser 1997; Seid 1989).

Two participants reported that their surgeons warned them the surgery could have a dramatic, negative consequence on their marriages. As Fiona's surgeon advised her and her husband during her consultation:

When I first saw him, he basically tells you—he tries to make sure you're very serious about this and that you understand the whole concept of it. One of the things he asks you is, "Are you sure? Are you sure you want this because it will change your life dramatically? It will change your husband's life dramatically." He said, "I've had patients whose marriages have broken up because of this surgery because the women have changed. They've lost weight and they feel such a sense of freedom." So he gives you all that right up front.

Cynthia's surgeon insisted on meeting with her husband as well, so that he could ascertain that her husband was adequately informed of how the dynamics of the marriage could change after a wife's substantial weight loss:

One thing that Dr. \_\_\_\_\_ did, the thing that he did that I liked was he turned and he looked to my husband and asked him, "How are *you* going to deal with it?" And my husband was taken back and said, "What do you mean? She's my wife and I'm excited I can spend a couple more extra years with her in life. Our life could improve. Why are you asking me this question?" Dr. \_\_\_\_\_ said, "A lot of husbands are not supportive." My husband said, "Well that's why I'm here." But Dr. \_\_\_\_\_ said some husbands are not supportive at all. My husband still doesn't understand it. I understand it and I've tried to explain it to him that the reason why is because the weight issue is more of a control thing.... You've got that control as long as she's at that weight. If she has the surgery she might have a better self-esteem and think [she] can do better and she drops him. My

husband had a hard time understanding that, but I understand it. I say, "Well you know, sweetie, sometimes men use the weight as a kind of control" (emphasis in original).

The empirical literature indicates that surgeons' concerns about the negative impact of weight reduction surgery on marital quality are justified, but only to a limited extent. Early studies on the impact of bariatric surgery on marital quality found that the procedure was associated with marital disruption, particularly if it was the wife who underwent the surgery (Marshall and Neill 1977; Neill, Marshall, and Yale 1978). The couples in these studies who experienced marital deterioration reported increased conflicts surrounding the surgical recipient's desires for increased autonomy and independence. Hafner (1991) also found that the husbands of women who have undergone bariatric surgery expressed dissatisfaction with what they considered their wives' "excessive" sociability since their weight loss. However, most researchers studying this topic report that bariatric surgery enhances a marriage (Castelnuovo-Tedesco 1987; Goble, Rand, and Kuldau 1986; Rand, Kowalske, and Kuldau 1986; Rand, Kuldau, and Robbins 1982; Stunkard, Stinnett, and Smoller 1986).

More than half of the sample members described their surgeons in complimentary terms; for example, numerous participants reported their surgeons were friendly, cordial men who laughed easily and often. Some women tended to refer to the surgeon in reverential tones, referring to him only as "he," rather than "Dr. \_\_\_\_." Indeed, Nicole compares her surgeon to God because, as she says, "He made me. I am what I am today because of him." The descriptions of the remainder reinforced the negative stereotypes of the surgeon as the austere, remote practitioner. However, the women who described their surgeons as distant or surly tended to excuse them, explaining they were more concerned about the surgeon's skills than his personality. Not surprisingly, the women who were dissatisfied with the results of their surgery tended to speak more caustically of their surgeons.

The sample members who hold their surgeons in high esteem may do so because they view them as their saviors from the prison their bodies had become. Sherri, who is a size acceptance activist, however, does not have such a benign view of bariatric surgeons:

You know how I compare these surgeons: The surgeon looks at me and he sees a 450-pound woman and he says, "Look what I can create." It's like re-decorating a room. The room is a mess and then you re-decorate it. Except this time you're re-decorating a person. The surgeon looked at me and he said, "We'll move this here and we'll move

that there. And then it'll be perfect." They look at you the same way everyone looks at you.

Sherri's metaphor of the bariatric surgeon as decorator is insightful because it underscores the fact that bariatric surgery is performed with the intention of not only restoring health and mobility but with the added feature of making the morbidly obese body at least somewhat less deviant. While most surgeons are concerned solely with their patients' inner machinations, the work of bariatric surgeons also has an impact on their patients' outward appearance. Their patients' preoperative bodies are not bodies inasmuch as they are spaces badly in need of rearranging.<sup>71</sup>

Some participants complained their surgeons behaved in an unprofessional manner. Marcia, in particular, had a disturbing encounter with her surgeon a few days before undergoing her surgery. Up until that time, her relationship with him had been cordial, but when she indicated she might not have the surgery if it could interfere with a possible pregnancy, her surgeon not only did nothing to allay her concerns, he also responded very crudely:

I had wanted to ask him—I had read some bit of information about the surgery that sometimes when you have this malnutrition, when you become pregnant, I was concerned that it might hurt the fetus. And so I asked him that question, that if I had this surgery, is it going to interfere with the pregnancy I might have because of the nutritional needs of the fetus. And he said, "What do you mean *if* you have the surgery?" I said, "Well, I'm not going to have the surgery until Thursday so there's still time for me to change my mind." And he said, "Well, we're not operating on your diddler." That was his professional response to me. I was appalled (emphasis in original).

The surgeon Catherine originally chose to do her AGB was not amenable when she conveyed information concerning a recent development in AGB surgery and indicated she wanted to take advantage of this development:

The first surgeon was obnoxious and a little patronizing....About six weeks before my surgery I said to him that I had heard of a new band that had come out that had a reinforced port which was stopping a lot of port replacement surgery which had happened with some of the earlier patients. I said to him that I wanted him to look into it and find out whether he could get the band over here, the revised one, before my surgery. The reaction that I got was, first of all, he didn't believe me. I couldn't possibly know

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<sup>71</sup> The literature overwhelmingly demonstrates that medical professionals share the widespread cultural aversion to obesity; however, there appears to be no empirical work on bariatric surgeons' views of their patients. It would be interesting, in a future analysis, to compare the attitude of bariatric surgeons about fatness to the rest of the medical community.

something that he didn't know. Then he basically tried to talk me down from it. When I finally convinced him that a new band did exist, I gave him a week to look into it and let me know. I went back in a week and he hadn't done a thing about it. It just struck me that that wasn't very professional. I mentioned that if I was a professional surgeon, that I would really want to know exactly what was going on, to keep on top of what I was doing.

Catherine was so annoyed about the surgeon's unconcern to her request that she switched to another surgeon, even though he was located in another city. Her first surgeon may have been indifferent to the development of a new technique, but it is also possible that he was concerned about losing his position of authority if he were seen as following the instructions of a patient. Maintaining power and dominance over their patients may be a factor in how these doctors interact with them.

Finally, three Canadian participants mentioned that their surgeons complained that they were getting too little compensation from the government in relation to the complexity of bariatric surgery. However, it should be emphasized that the women who heard these complaints were sympathetic to the surgeons and did not feel these confidences were inappropriate.

Overall, the majority of the participants indicated they were satisfied with their surgeons or at least with their surgical skills, but it must be emphasized that the surgeons spent only a cursory amount of time discussing the surgical process with them. They tended to treat their patients on a need-to-know basis, providing them only with minimal information. Some surgeons were overtly defensive or hostile to questions or suggestions from their patients. As a result of surgeon apathy and paternalism, the women were largely left to their own devices to find out more information about the surgical procedures. Yet, with the exception of one person, the women in this sample were prepared to tolerate these surgeons as long as they could get access to the surgery.

My participants' interactions with their surgeons illustrate the enormous power bariatric surgeons wield over their patients; in fact, I suggest that bariatric surgeons are in a position to dominate their patients more than any other medical specialty. Patients are often desperate to have the procedure so they are likely less inclined to challenge the surgeon's authority.<sup>72</sup> Their eagerness to have the operation at almost

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<sup>72</sup> I am not only extrapolating from my own findings; this seems to be a valid conclusion considering the stigma of extreme fatness and that patients are eligible for the surgery only if they have exhausted all other weight loss options.

any cost also precludes them from asking numerous questions about surgical risks. If the surgery fails to work, it is the patient's behavior that often comes under scrutiny, not the surgeon's competence or the efficacy of the procedure. Thus, bariatric patients are extremely vulnerable and it appears that their surgeons exploit that vulnerability to their own advantage.

### DECISION TO DISCLOSE

The participants reported that, on the whole, they received a very high degree of support for their decision to undergo weight loss surgery from spouses, family members, and friends. The majority of the women who were married at the time of their surgery tended to describe their husbands' involvement in the process as their being with them "every step of the way."

Some reports appear to challenge this perspective, however. For example, only Cinzia indicated she solicited her partner's opinion about whether or not she should actually have the surgery. The other married participants all emphasized this was a decision they made themselves, and then announced it to their husbands:

Catherine: It was a big decision and I had to talk to my husband about it. But by the time I spoke to him, it was like this is something I think I really want to do. So it was more of, How are we going to make this happen, rather than will you give me permission?

Elaine: When I first broached the subject of the surgery, his big thing was, I don't want you doing this for me. It's like, "Guess what? You're not even entering into this decision. I'm doing this for me and I'm doing this for my health."

Valerie: I had already decided, once I found out that I could have it, that I would get it, no matter what my husband said, or anybody else, that I was gonna have it done....My husband didn't like that idea [possibility of surgical fatality] too much but he knew I wasn't going to change my mind.

Cynthia: I had this surgery for myself, no one else. I did this for me.

All but four of the women who were married at the time of their surgery described their husband's initial reaction to their decision as one of fear and anxiety. Their spouses were apparently nervous that they might die during the surgery.<sup>73</sup> The women, however, were resolute in their determination to take these

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<sup>73</sup> There is a lot of mythology surrounding the probability of fatality during weight loss surgery—probably more so than other major abdominal surgeries. It would seem that everybody knows of someone who "died on the table" during a JIB procedure, a surgery that dominated the bariatric surgery field in the 1970s.



risks and undergo the surgery anyway. Besides assuring their partners of their determination, most participants alleviated their spouses' fears by providing them with literature on the low fatality rates of bariatric surgery. All the women who had access to surgical support groups brought their husbands to meetings. Most husbands also accompanied them to their consultations with the surgeons. After meeting with former patients and the surgeons, husbands' fears were apparently allayed, as they did not raise the topic of risk again and fully engaged in the preoperative process. The women who did not have access to information resources or were uninterested in them simply maintained their determination to undergo the surgery. So, support from spouses appeared to be composed of a combination of resignation and confident expectation of a safe, effective surgery. Numerous women observed that while their husbands were anxious about the risk posed by the surgery, they had witnessed their wives' agony and recognized that bariatric surgery represented their last hope of substantial, permanent weight loss.

At the time of their surgery, Renate, Jennifer, Wanda and Sherri were dating men who preferred fat women but these men also respected their decision to have the procedure. Their relationships foundered afterwards, but for reasons they feel were unrelated to the weight reduction surgery.

Five of the sample members described their spouses as estranged from the process, either because they themselves did not involve them or because the husbands did not want to engage. Jeanne's husband had always been emotionally distant and did not become animated because his wife was going to have weight loss surgery. Gisèle's and Suzanne's husbands expressed no interest in the surgery at all and did not even visit them while they were in the hospital. Lara and Celeste suspect their husbands were unenthusiastic because they were frightened about the possibility of their wives becoming attractive to other men.

Parents, mothers in particular, were also fearful that their daughters might die during the surgery. Even the participants whose parents had been abusive to them about their weight expressed fear about the radical nature of the surgery and its attendant mortality risks. Parental concern, like spousal concern, did not act as a deterrent. The participants communicated the resoluteness of their decision to their parents in much the same way as they did their spouses. They explained to them that they had exhausted all conventional weight loss options. The women who were very well informed about the surgery sought to

alleviate their parents' fears by providing them with literature and answering their questions about the surgery. Not all parents were convinced the procedure was entirely safe, but they too resigned themselves to the inevitability of their daughters' decision, as their daughters made their determination very clear to them:

Yolande: My mother was happy for me, but she was very, very worried....[But] she saw that I was suffering and if that was the solution, then she was all for it. She didn't push me to do it nor did she try to stop me. In any case, nothing would have stopped me.

Joanne: They were worried and excited at the same time. My parents are the kind of people that know when we have something in our minds, nothing will take it out, so they encouraged us. They didn't have a choice.

Valerie: My mother thought I was nuts. Most of my family thinks I was pretty crazy because I have a [child] and they said, "You're risking your life for vanity," and stuff like that. But I didn't let that stop me.

Julie: I did a tremendous amount of research: I must have had a 3-inch binder full. Once I completed my information and actually already had a pre-op, already had a consultation, I came back to my mother and presented everything to her. I would have done it without *anyone's* support. She turned out to be my biggest supporter and remains so until today (emphasis in original).

Two sample members whose parents had always been extremely critical of them applauded their decision to have the surgery, but not in an empowering manner:

Catherine: I think that my mother and father had been distraught about my weight for years and they were so relieved that I was finally going to do something about it and that I wasn't going to die an early death. They didn't have any patience for this nonsense about fat acceptance.

Marianne: My father was scared because it was surgery. My mother, on the other hand, thought this was wonderful: I was *finally* going to do something about my weight. This was a big issue for her; the fact that I might have died was secondary (emphasis in original).

Jeanne: My father didn't like the idea. My mother could only see one thing; she had tunnel vision: This was the only thing that could get my weight off. Nothing else mattered, go for it.

The participants who had children reported that they were also extremely anxious about the possibility that their mother might die. Like other family members, however, they too could not dissuade them from undergoing the operation:

Jeanne: My daughter was a little concerned [about the mortality risk]. [She] said, "No, Mom, I don't want you to go." Well, my mind was already made up: I was going, no matter what. And if I didn't make it, fine; and if I made it, okay.

Siblings were also often characterized as encouraging and supportive. I did note, however, that the siblings who found the surgery objectionable were more vociferous in expressing their concerns about the surgery than parents were. They were also more likely to express skepticism about the surgery's probable success. Sisters, much more than brothers, expressed strong opinions about the surgery, either positive or negative. I also noted that two participants who had sisters who were also morbidly obese, tended to describe them as having oppositional attitudes to their decision to have the surgery. For instance:

Lara: My sister was even bigger than I was. She's probably going to be in a wheelchair soon because she can't walk. She has high blood pressure, diabetes, and a lot of other things. But she was very much against the operation. She kept on saying that I shouldn't get this done, that I should just accept myself the way I am. She also kept saying that she knew some women who'd had the operation and it didn't work for them. She would say that I'm taking a terrible chance. She is incapable of being neutral or understanding my motivations.

Trudy: There is one sister who is as obese as I was before the surgery that hasn't been interested in my surgery or the surgical process.

The point must be made that not all participants revealed their decision about the surgery to parents, siblings, children and friends—or even life partners. The tremendous lengths to which the women were willing to go in order to hide the fact that they were undergoing bariatric surgery are remarkable. Isabella told her family—including her adult son—and most of her friends that she was going to have benign tumors removed from her stomach. To this day, her son and other members of her family are unaware she had bariatric surgery. Yolande told her partner of 12 years that her third bariatric procedure was a herniotomy. He was partnered to her at the time of that surgery. Marcia told her family she was going to have gallbladder surgery. Suzanne never informed her family about the surgery until she was in the hospital. Rosemary has never told any of her family members that she has had weight reduction surgery.

I asked those participants who were exceptionally discreet—to the point of resorting to subterfuge—why they were so determined about shrouding the procedure with secrecy. All revealed, unhesitatingly, that they were driven by a fear of humiliation in case the surgery proved to be unsuccessful. All but two sample members had an extensive history of failed weight loss attempts, and they were

mortified about the possibility of yet another failure. The drastic nature of bariatric surgery intensified this fear of humiliation as the following accounts illustrate:

Isabella: Because every time I did something, I failed. I was bound and determined not to tell anybody what the surgery was for, so I lied. I said that I had a tumor. My thinking was that I had failed at every single thing that I had done. I had always told everybody: I'm going to Weight Watchers; I'm going to Jenny Craig; everybody knew I was on the fast. So I said, I'm going to keep this to myself.... Maybe I'm afraid that I'll fail again, I don't know. But I'm not gonna tell them. Maybe I have a feeling deep down inside that if I tell people, I'm gonna fail at this.

Julie: I had a history of failing. I always lost 30 or 50 pounds and I always gained it back. Why would I put myself out there to fail and people would know I spent \$20,000, got cut open and still failed? I wasn't willing to put that risk out there. It's bad enough to fail at Jenny Craig, when you've pissed away a couple of thousand dollars. It's a whole different level with the surgery. The stakes have moved up to a much higher level.

Yolande: I didn't tell my boyfriend that I had the bypass [third operation] for the same reason I didn't tell anybody else: I was too embarrassed to tell anybody that I had to have three operations to lose weight. People understand when the first operation doesn't work, but when the second operation doesn't work, you look bad. People think you must be a real pig to eat so much that two operations aren't enough, you have to have a third.

Another reason for discretion that was commonly cited was a desire to avoid negative, discouraging counsel from well-meaning people. Many sample members were warned by at least one person, "Don't you know you could die from this?" Nicole was so determined not to hear disparaging remarks about the surgery that during her 18-month wait to get her surgery, she never told her any of her family members, including her husband, about her decision until the week before the surgery was scheduled:

I figured I wouldn't talk to my husband about it because I knew he would be scared. I was feeling so positive about this and I didn't want to hear any negativity from *anybody*. So I resolved not to tell anybody. I didn't tell anybody because I didn't want to hear any negative comments about the operation. That, I didn't need. I already had an extremely positive attitude and I needed to keep this. My husband will be scared, he'll be worried. He'll tell me, "What if anything goes wrong?" I didn't want anything to do with negativity (emphasis in original).

Once Nicole told her husband about her upcoming surgery, she instructed him not to tell anybody in the family. Their sons were only told of the operation when she was admitted to the hospital.

Trudy, one of six children, indicated she told only two of her sisters about her upcoming operation. Both sisters were supportive, but she chose not to tell other family members because she too wanted to avoid hearing critical remarks and having her judgement questioned:

They're a judgmental kind of family. And I didn't want them to influence my decision because I thought they would be negative: Why would you be doing something so drastic, that sort of thing. I wanted this to be *my* decision (emphasis in original).

Close friends were more likely to be brought into a participant's confidence than family members. Even women who did not disclose their surgery to their families confided in at least one close friend. Their friends appeared to be more encouraging of this decision than their family members in that they voiced less concern about surgical risk or failure. A substantial number of the sample members' confidantes were morbidly obese themselves, so perhaps they were expected to be more empathetic than others who did not personally experience morbid obesity. However, some participants also described their morbidly obese friends' reactions as extremely negative:

Cynthia: Actually, it's kind of hindered my relationship with one friend. She's a heavyset woman as well. I told her that I'm having an RNY done. And she just flipped. She said, "Oh my goodness, don't do it. I'm so scared. I've heard of people dying." She was totally negative about it.

Julie: One of my closest friends is well over 400 right now. When she walks, she wheezes. She can't bend....The answer's out there....[But] I can't even bring up the topic with her. She won't even discuss it.

Cynthia speculates her friend feared she would lose weight while the friend herself remained morbidly obese.<sup>74</sup> Julie believes her friend, who was actively involved in NAAFA, was opposed to the surgery on ideological grounds. Julie's friend also knew of someone who had died after the surgery, although she conceded that this person was non-compliant to her physician's instructions.

Family doctors were also implicated in the decision-making process, since most surgeons now require a referral from them. Seven participants reported that their family physicians were either staunchly opposed to the surgery or at least urged them to take the risks into consideration. Two family doctors refused to give the participants a referral to a weight loss surgeon on the grounds that the surgery was too dangerous. One of these participants found another family doctor who gave her a referral and the other obtained a referral from a doctor at a walk-in clinic. Four family doctors revealed that they were not knowledgeable about the surgery themselves but gave referrals to weight loss surgeons anyway.

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<sup>74</sup> The impact of surgery on friendship will be discussed in detail in Chapter 7.

I noticed a gendered dichotomy in the reactions of the medical professionals. Every doctor who voiced concern or opposition about the surgery was male. These doctors were also described as “older” and maintaining more “old-fashioned attitudes.” Every woman who was treated by a female practitioner, whether it was a physician, psychotherapist or Patient Advocate, reported that they received unqualified support for their decision to have the surgery. Moreover, it was often these health care workers who suggested the surgery to them. For example, Barbara, who had been dissuaded from the surgery by her male family doctor, went to consult another doctor a year later. This doctor’s female Patient Advocate suggested to her, without any prompting on Barbara’s part, that she have the surgery. She added that she was having it done herself, as was the office nurse.

Several reasons may explain why female practitioners appear to advocate the surgery more so than male practitioners. The female doctors seemed to be considerably younger and therefore they may have been better acquainted with the refinement of bariatric surgical techniques. It is also likely that female doctors, though differentiated from their patients by their higher social status, are also deeply affected by the sociocultural pressure for women to maintain an acceptable body weight and shape. Therefore, they can perhaps empathize with very fat women more than their male counterparts.

### **THE PREOPERATIVE PROCESS**

The required preoperative procedures varied somewhat, with the minimum being blood work. Some sample members had to have gastrointestinal examinations and ultrasounds. I noted that the more experienced the surgeon, the more rigorous was the preoperative process. The preoperative protocol also included consultation with a nutritionist or dietician about the dietary regimen following bariatric surgery. However, not all surgeons employed their own dieticians and their patients had to consult hospital dieticians instead. These dieticians were not well versed on the needs of bariatric patients, and this later proved to be problematic for two sample members, as will be illustrated in the next chapter.

The bariatric surgery literature strongly recommends a psychological evaluation prior to weight loss surgery (Kincey et al. 1996; Randolph 1986; Schirmer 2000; Valley 1984; Valley and Grace 1987; Waters et al. 1991). Assessment by a mental health professional is useful in screening patients for

psychiatric disorders, substance abuse, and unrealistic expectations about the surgery. However, only 13 of the 30 sample members underwent evaluation by a mental health professional as part of their preoperative work-up.<sup>75</sup> Marcia's and Yolande's surgeons spoke of sending them for a psychological evaluation but never arranged the consultations. Even though the literature recommends that a psychologist or psychiatrist carry out the evaluation, most of the women were evaluated by social workers. These consultations varied from a brief meeting with the therapist to talking to him or her on the telephone. Joanne and Nadine's psychological evaluation consisted of a questionnaire, which took approximately 10 minutes to complete. A psychologist administered the questionnaire, but he did not contact Joanne and Nadine afterwards. Despite its purported value, almost all the women who met with a mental health professional were derisive of the experience:

Julie: The psyche consultation, I did over the phone. It was the biggest crock of shit. It was just a waste of time and money. The woman who did it, she'd never met me.....I fed her the questions and the answers.

Catherine: I had to consult with a psychologist....And it was *very* lax. I wouldn't consider it to have been a stringent screening process at *all*. We had an hour and a half consultation and just chatted, basically (emphasis in original).

Giséle: When I was in his [psychiatrist's] office, he asked me if there were any obese people in my family—yes. Do you want to have the operation?—yes. Do you know that there are risks?—yes. He asked if I had met the surgeon—yes. You tell yourself that if you say no to any of the questions, you run the risk of getting refused for the operation. Then he said, "Okay, sign here." It took all of 10 minutes.

The women who did not express derision did indicate that their psychological consultation tended to be brief, and that the "right" answers to the questions were obvious. Jeanne was the sole participant who felt that her evaluation by a mental health professional was thorough and that it made an impact on the surgeon's decision to operate on her or not.

Few of the participants appeared to be aware of the importance of a psychological evaluation before weight loss surgery. They had a tendency to describe the encounter as "she only wanted to see if I was sane." Four sample members, however, recognized that the transformative nature of the surgery could either initiate or exacerbate mental health issues; two of these women took pre-emptive action by

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<sup>75</sup> Filomena is not included in this number. Her surgeon stipulated that she undergo psychological evaluation, but a letter of support from her own psychotherapist sufficed.

consulting a psychotherapist independently of the surgeon. Fiona sought counsel for her tendency to eat in response to stressful situations, fearing she could possibly sabotage the results of her operation if she did not learn to recognize emotional triggers that could induce her to overeat. Filomena feared the possibility of the loss of her old, fat self and sought reassurance that her new, surgically-induced self would be acceptable to her:

Actually, what happened prior to my surgery was that I became a little depressed, or even mourning the fact that *I* was going to die, that the Fil that I knew, currently, before the surgery was going to die and a new Fil was going to emerge. I didn't know that person and it was scary. It really bothered me that I had this very sad feeling inside of me because there were parts of me that I really liked; I really did like *me* but I didn't like the *fat*....It was really kind of frightening for me and I did discuss that with my psychologist...I was able to realize that they were going to do surgery on my body and not my mind. The Fil that I knew would still be around (emphasis in original).

Filomena's fear of losing her old self, which she liked, and her eagerness to lose her fat body, which she hated, underscores the earlier finding of my sample's lack of alignment between their selves and their bodies. The body is widely viewed as the physical manifestation of the self; the fat body, believed to have its genesis in character defects, is therefore emblematic of a deeply flawed self. Yet these women and their loved ones knew that their selves were not inferior or aberrant. Their exterior self did not represent their authentic self. However, as long as they remained morbidly obese, they had no way of revealing their authentic self to others. Millman (1980) and Gimlin (2002), who have conducted in-depth interviews with fat women, also note the lack of congruence between the fat woman's body and her sense of self. I return to this theme in the next chapter.

### SUMMARY OF FINDINGS

Bariatric surgery was a last-resort option for all 30 women in this sample. They were desperate to lose weight to the point where some were suicidal. They first heard of the surgery through diverse sources, but the media played a dominant role in providing these women with information about the procedure. Once they became aware of the availability of the surgery, however, most did not immediately leap at the opportunity to have it. Six women actually took several years to decide if this was a viable avenue. Factors such as the radical nature of the surgery, possible complications, and the possibility of weight



regain impacted on the decision-making process. The 13 women who had access to the Internet at the time of their surgery were able to weigh their surgical options and to assess the reputation of various surgeons in their area. They also attended surgical support groups so they could hear first-hand accounts of the experiences of individuals who had already undergone the surgery.

Various reasons were cited for undergoing bariatric surgery. Concerns about health and quality of life appeared to predominate, but aesthetic reasons were cited as well. The women who cited dissatisfaction with their appearance did not indicate a desire to be beautiful, but they did want their bodies to be more "normal." Only three women had the operation specifically to make themselves acceptable to family members. The other participants maintained this was something they wanted for themselves, that it represented a gateway to a better life.

Desperation about a hopeless situation pervaded the participants' accounts of their decision-making process. They had tried other weight loss options to no avail. The majority insisted that death was preferable to continuing to live as a morbidly obese woman; however, few indicated they would have had the surgery had it involved a greater than 20 percent mortality risk.

Significant others objected to the surgery on various grounds. In particular, they expressed the worry that the participant might die during the surgery. But my participants remained steadfast in the face of this opposition. Those that had access to the Internet and support groups used the information provided by these sources to assuage the fears of spouses and family members. Some sample members dealt with opposition by maintaining a position of resolute determination or simply by not disclosing their decision to those individuals who they thought would be obstructionist. In some cases, lack of disclosure extended to prevaricating about the actual surgery they underwent. The participants also indicated that they feared public humiliation if the surgery failed and that this was a primary reason for not discussing the decision.

Initial consultation with the surgeon tended to be brief, but few participants objected to this. Most of the participants were provided with reading material on the surgery, but slightly over half the sample appeared to not be fully informed by their surgeons about the morbidity risks associated with the surgery. Women who had surgery prior to the age of the Internet tended to dominate this group. Four women in the sample were unilingual francophones whose surgeon did not speak French. Only two of these women

were even provided with literature written in French. Bariatric patients appear to receive more information from the Internet and from surgical support groups than they do from the operating surgeon.

Surgeons were lax in other ways. Although the bariatric surgery literature has long emphasized the importance of a psychological evaluation prior to the surgery, fewer than half the sample were referred to a mental health professional. Those who were evaluated by a mental health worker, who was typically a social worker, indicated that the appropriate responses to the questions were obvious. Few felt the evaluation would be treated seriously as a screening procedure for the surgery. Two women complained their surgeons behaved unprofessionally toward them by belittling their concerns. Overall, however, the women pronounced themselves satisfied with their surgeons and their preoperative care. It would appear that the benefits the surgeons had to offer superceded any other concerns.

#### **ACTIVE AGENTS OR OPPRESSED VICTIMS?**

These women's decision to undergo weight loss surgery, as I have indicated throughout this chapter, was largely driven by desperation. Can women whose lives are so dominated by despair be possibly cast as agentic individuals? On the one hand, there is considerable reason to believe these women have been oppressed by societal norms regarding body and beauty. For instance, several women were concerned they were sexually unattractive to their husbands and virtually all described their bodies as "ugly," "gross," or "disgusting."

On the other hand, there is an argument to be made that these women—to a great extent—are acting agentially. There is, moreover, support for this position in related areas of research. For example, recent researchers who study women's conformity with appearance standards and involvement with body improvement practices increasingly make the argument that women who engage in these practices, e.g., wear make-up, do aerobics, diet, have cosmetic surgery, are agents rather than the cultural dopes portrayed by earlier feminists (Beausoleil 1994; Davis 1995; Frost 1999; Gimlin 2002). In her study of Dutch women and their decisions to have cosmetic surgery, Davis suggests how feminists can overcome the problem of the unflattering depiction of women as cultural dopes: [we] must "be able to explore [women's] lived experiences to their bodies, to recast them as agents, and to analyze the contradictions in

how they justify their decision to have cosmetic surgery” (p. 58). She argues cosmetic surgery is the rational choice of an active, thinking adult. She bases this conclusion on the grounds that her participants did not embark casually in the decision to have the surgery, they were fully informed about its inherent risks, and that they had it for themselves, rather than with the intention of attracting men or saving flagging marriages.

However, in Davis’s elaboration of her reaction to a television program about women who underwent multiple weight loss surgeries, she clearly indicates she does not extend the same sense of agency to weight loss surgery patients:

Their desire for surgery seems almost pathological. In spite of the side effects and less-than-satisfactory outcomes, they are unstoppable, prepared to go to any length for the sake of beauty. As a feminist viewer, such programs invariably leave me with several contradictory responses. The first response is anger at the misrepresentation and downplaying of the hazards of the surgery. I cannot help but suspect that, had these women [bariatric surgery patients] known in advance what they were getting into—that is, been properly informed about the risks of the surgery, they never would have gone through with it. The second response is mystification at the apparent irrationality of their insistence on having such dangerous surgery and at their willingness to not only put themselves through repeated operations, but to take the—often major—side effects in stride. I find myself wondering how they can engage in behavior which seems so manifestly against their own welfare. (Pp. 116-117)

Davis argues that her subjects who chose to have breast implants established a context of suffering and are therefore agents because they resolved a legitimate problem. However, unlike her preparedness to understand why women enlarge their breasts, she does not show evidence that she understands the reasons why fat women might be desperate to undergo serious medical procedures. I find it interesting that while Davis was so easily able to acknowledge that women choosing to have breast implants did so because they suffered not because they wanted to become beautiful, there did not seem to be a similar ability to recognize the suffering that fat women experience. Rather, she appears to believe fat women want the surgery as part of a quest for beauty. It may be that Davis is simply unaware of the suffering that accompanies morbid obesity. Or it may be that she assesses the risks associated with bariatric surgery as much greater than the risks associated with breast implants and may feel that the risks override the benefits of the surgery. Still, it is ironic that Davis can make the argument that cosmetic surgery patients desire normality while bariatric patients desire beauty.

I would argue that my participants—in some instances—conform to Davis's criteria of agentic behavior. They should be considered agentic because instead of passively accepting the status quo and continuing to suffer, they actively engaged in a problem-solving quest. It is obvious that a substantial number of the women in the sample did not enter into the decision to have major abdominal surgery lightly. Few sample members indicated they would accept exceptionally high mortality risks. They wanted to lose a substantial amount of weight, but none expected to become slender. Moreover, the decision to undergo the surgery was a decision they largely made themselves. Surgeons who do not fully inform their patients about the risks associated with the surgery or who encourage them to harbor unrealistic expectations about the amount of weight that they could lose deprive them of their agency. This is a problem which must be addressed if patients are to truly be able to give informed consent, but undergoing the surgery itself should not necessarily be considered as an act of submission to a fatphobic society. The patient is the only person who can gauge how unbearable her suffering is or how beneficial surgery can be, and she is the only one who can make this decision. I suggest that Davis should apply her own reasoning to the context of weight loss surgery:

As the person who has to live "within" her body, she, rather than the medical expert or anyone else for that matter, is the one who should be the final judge whether a particular procedure is in her best interests or not. She is the only one, ultimately, who can determine whether the level of pain is acceptable, the risks worth taking, or the procedure excessively invasive. The refusal to respect this right is a violation of her personhood. (Pp. 118-119)

I propose that a patient who is fully informed about a bariatric surgical procedure's associated risks and typical outcome and who chooses to have the surgery independent of coercion should not be viewed as any less of a competent decision maker than anyone else in a similar position.

I return to the theme of agency and bariatric surgery in the next chapter.

## CHAPTER SEVEN

### LIFE AFTER BARIATRIC SURGERY

This final data findings chapter chronicles the experience of the surgery and how my participants made the transition from morbidly obese person to bariatric surgery patient and beyond. Not all participants had successful surgeries, and the factors which mediate surgical success and failure are analyzed. Both success and failure had a profound impact not only on the participants' weight and sense of identity and self but on their health, marital and friendship dynamics. The role of two weight-based support groups, surgical support groups and the fat acceptance movement, are evaluated and critiqued. Lastly, the theme of agency, which is interwoven throughout the findings chapters, is re-examined. In Chapter 6, I argued that women who undergo bariatric surgery should be viewed as agentic individuals on the grounds that they took action to alleviate suffering beyond endurance. In this chapter, I propose that the women whose surgeries were deemed failures but who renegotiate their identities as fat women, are equally agentic. Agency, for fat women, ultimately involves the right to change their bodies or challenge a culture that hates fatness. The overwhelming majority of my sample support fat women's right to choose the best course of action for them.

#### UNDERGOING BARIATRIC SURGERY

Over three-quarters of the participants reported that their surgeries and perioperative course were uneventful. The majority of the women estimated their surgeries took approximately two hours, although some surgeries took as long as seven hours to perform. The length of the surgery depended on the complexity of the procedure and the presence of complications. The hospital stay for the women who experienced no complications averaged three to four days. Abdominal pain tended to be severe for the first few days, but this was relieved by analgesics. Within a few hours, most could get up and walk to the bathroom with the aid of a nurse. As expected, the women whose surgeries were performed laparoscopically had a shorter hospital stay and a shorter recovery time.

Seven women suffered severe perioperative complications such as pulmonary embolism, wound infections, pneumonia, etc., during their hospital stay (see Table 7.1). With the exception of Sherri, the women who experienced perioperative complications were required to stay in the hospital up to seven weeks.

Table 7.1—Perioperative Complications

Complication	Name of Participant
Pulmonary embolism	Gisèle, Renate
Wound infection	Suzanne, Yolande, Nadine
Pneumonia	Yolande
Staple line disruption	Sherri
Liver infection	Yolande
Malabsorption	Suzanne, Julie

Most of the women expressed satisfaction with the quality of the hospital care they received, but it is apparent some hospitals who perform bariatric surgery are either unaware or uncaring of the special needs of bariatric patients. During their hospital stay, such patients are first to be fed intravenously and then given clear liquids (juice, broth). However, Valerie and Trudy were given the same food as the other hospital patients.<sup>76</sup> Renate and Sherri complained that the hospitals where they stayed did not have equipment adapted to the needs of morbidly obese patients. For instance, these hospitals did not have beds capable of supporting their weight. The gowns did not fit, thereby exposing them to cold and ignominy. Blood pressure cuffs also did not fit. Scales that could adequately weigh morbidly obese people were also not available; instead, Renate and Sherri were subjected to the humiliation of being weighed on a grain scale.

The surgeons who operated out of these hospitals also did not have adequate medical equipment in their private offices. This lack of adequate facilities extended to not having chairs without arms in their waiting rooms.<sup>77</sup> Bariatric surgeons' patient population consists entirely of morbidly obese people; they,

<sup>76</sup> In fairness, it must be pointed out that Trudy was in a convalescent home, not the hospital where she was operated, when she was given solid food. But her surgeon required his patients who did not live in the area to stay there for two weeks after the surgery. He had been associated with them for many years and thus, this treatment center was aware of the postoperative regimen needed by bariatric patients.

<sup>77</sup> See also Kaminsky and Gadaleta (2002).

more than any other medical professional, should be aware of their needs and provide facilities to accommodate them. Renate and Sherri articulated their displeasure very clearly to their surgeons, who it appeared, were taken aback by their vehemence. It is notable that these points should have had to be made in the first place and that the surgeons were nonplussed. Even though bariatric surgery patients obviously have special needs, surgeons and hospital administrators seem to be reluctant to invest in the equipment, furnishings and gowns to make the surgery a more positive experience for their patients. It is unclear as to whether or not the unavailability of appropriate beds, furnishings, and gowns is related to indifference or lack of access to these resources. There may be other factors as well, but at the very least it indicates gross insensitivity to the needs of their patients. Such inattention undermines the quality of medical treatment morbidly obese patients receive and further reinforces their deviance.

Four women complained the nursing care was inattentive and that their convalescence was impeded as a result. In Gisèle's case, she had been recovering uneventfully until the actions of an extremely irresponsible nurse caused her incision to open, the consequences of which she had to endure for three months:

Gisèle: I buzzed for some Kleenex. The nurse came to the door and asked what I wanted. I said, "I need some Kleenex." She returned to her station to get one of those small packages of Kleenex. When she came back, she didn't come up to my bed; she threw the package of Kleenex at me. She apparently thought that I wasn't yet operated on. So the box of Kleenex landed on my wound. And then it opened....It started to bleed heavily. There was blood everywhere. My temperature was rising and rising. Around 11 p.m. or midnight, I had a pulmonary embolus. I fell into a coma....It took about three months for that wound to close. I can't help but wonder if all this would have happened had that nurse not thrown the box of Kleenex at me, instead of bringing it to me, the way a polite person should have.

Renate: I have a history of pulmonary embolism, and I told the nurse that I was concerned that I should go home with a blood thinner, given my history. She told me, "Don't worry about it." That night—I was due to go home the next day—I was getting horrible chest pains. I called the nurses to tell them that my chest hurt and they walked out of the room without checking....So I ended up going home and a couple of weeks later, I was having problems breathing and I was having problems digesting....Sure enough, it was a pulmonary embolism.

Suzanne: It was written on my chart "nothing by mouth." There was this nurse there that insisted on giving me pills by mouth. That would hurt so much. It stayed, it couldn't get past the tube in my stomach. She did this three times. Finally, I told her I'm not taking anything else orally.

Filomena: I thought the hospital care was pretty poor and the nursing staff at the hospital, they were less than adequate. They were non-attentive. I think they jeopardized my health by not coming in and getting me up to walk and helping me....Here I was, laying in bed, and they should have been coming in and getting me up—and they weren't. And so my catheter ended up having to stay in longer....I just felt that the nursing care was bad in that hospital.

Valerie suspected one of her nurses was prejudiced against fat patients, while Renate and Isabella were overtly victimized by fatphobic nurses:

Valerie: I had a couple of nice nurses, but I had one who thought it was completely ridiculous. She wouldn't even help me out of bed or anything. I don't know if it was because I was overweight and she was against it. But she had a real chip on her shoulder.

Renate: The nurse told me [when I complained of severe abdominal pain] that if I was prepared to eat so much as to make myself morbidly obese, then I had to suffer the consequences.

Isabella: Everybody was very nice, except one aide that gave me showers. I didn't like her because she was always saying, "How could you get so fat?"

It was also evident that both the surgeon and the nursing staff casually dismissed the women's concerns. Every single participant who expressed an opinion, request, or concern found herself being brushed off by health care professionals.

Renate: The one thing I had told the surgeon prior to the surgery, when I first saw him, was that I had wanted the filter put in. I had done my research on that....so if there was a blood clot, it wouldn't go to my lungs. He said he would look into it. Right before the surgery, I asked again and he said it wasn't necessary. But he was wrong. After all was said and done and I went back to him a month later, he said to me, "I made a mistake: I should have put in the filter, like you said. I will make sure, that for the next person, I will not make that mistake."

Casey, who had a VBG, developed an incisional hernia soon afterwards. Hernias are a relatively common side effect of bariatric surgery (Brolin 2002; Schirmer 2000). When she first told her surgeon she had a bulge in her abdomen, he replied, "Oh, it'll eventually go away." The bulge did not go away and it was five months later before she was diagnosed with an incisional hernia. By that point Casey was in much pain and it was greatly affecting her quality of life. She eventually underwent a herniotomy, but she points out that if the surgeon had warned her that she could develop a hernia after the operation, she would have worn a binder as a preventive measure.

Nursing staff also did not attend to patient worries or concerns. Sherri, whose first bariatric surgery was a VBG performed in 1979, burst her staples in the hospital after eating Jell-O. She told a nurse



that she could feel something tearing inside of her and insisted, "Something's going on, something's going on." The nurse, however, told her, "No, no, no. You're postop. This is the way it's supposed to be." Since Sherri was only the first female patient in her county to undergo this procedure, it is difficult to discern how the nurse figured "this is the way it's supposed to be."

Other research has shown that the concerns of bariatric patients are overlooked. Castelnovo-Tedesco (1987) describes incidents whereby the postoperative complaints of intestinal bypass surgery patients were dismissed by their surgeon, and these proved to be serious complications. Medical sociologists and feminist health writers have long noted the existence of patriarchy and sexism in the medical profession and complain that physicians, particularly male physicians, trivialize the concerns of female patients (Laurence and Weinhouse 1994; Trypuc 1994). Nurses also dismissed patients' concerns. The literature has shown that nurses dislike fat patients and do not want to take care of them (Bagley et al. 1989; Maroney and Golub 1992). Therefore, I speculate that the nurses' failure to take my participants' complaints seriously may have its genesis in fat hostility. They also may have had inadequate training in the care of bariatric patients. It must also be pointed out that while there is an imbalance of power in the doctor-patient relationship, the same dynamic is noted in the nurse-patient relationship. Nurses, like doctors, are in a position to ignore or dismiss their patients' complaints or concerns.

The overwhelming majority of the sample reported an uneventful convalescence once they were discharged from the hospital. Their nutritional regimen typically consisted of clear fluids for the first and second week postoperative. Full fluids (i.e., purées, Jell-O, pudding) were introduced during the third and fourth week. Solid foods were resumed about four weeks after the surgery, although some surgeons insisted they only return to solid food eight weeks after the surgery.

The women who were in the paid labor force at the time of their operation reported they had generous sick leaves from their employers. Most of them indicated that they did not tell their employers or co-workers about their surgery, citing a desire for privacy. They merely informed employers and colleagues that they would be taking time off for surgery and did not divulge further information.

The sample members had been told they could resume normal activities one month to six weeks postoperative. Some had taken an eight-week sick leave from work in order to assure a full recovery.

However, the sample members who did not experience complications claimed they felt well enough to resume normal activities two weeks postoperative, although none returned to work before their anticipated date.

Three sample members experienced a tumultuous postoperative course after they were discharged from the hospital. Isabella was afflicted by various staphylococcus infections, one of which required further surgery and her surgical wound took eight months to close. During this time she was chronically nauseous and unable to tolerate solid food. She was admitted to the hospital intermittently during the first two months after her surgery and then spent six weeks in a nursing home. Once her incision healed, she was no longer nauseous and the rest of her postoperative course proceeded normally. Isabella's preoperative weight was 460 pounds, and her surgeon felt that her massive pre-surgical weight, together with her psoriatic arthritis, impeded her convalescence.

After Gisèle was discharged from the hospital, her incision opened constantly, and one month later, she hemorrhaged. She was diagnosed with an umbilical infection, and the umbilicus was removed without anesthesia. Gisèle suffered enormous pain during the procedure. She did not experience further problems once her wound healed but remains convinced her postoperative course would have been markedly different had the nurse not thrown the box of tissues at her.

Valerie's postoperative course could not be described as eventful but like Sherri, the ineffectiveness of the procedure she underwent was quickly apparent. Two months after her laparoscopic VBG, she actually started gaining weight instead of losing it.

Numerous participants experienced surgically-induced morbidities later in their postoperative course. These will be discussed in detail in a subsequent section.

### **SURGICAL SUCCESSES AND FAILURES**

There are currently no universally accepted criteria for assessment of results of bariatric operations, but Brolin (1992:577S) notes that the majority of clinical reports have expressed weight loss outcome in terms of mean percent excess weight lost. The excess weight is the difference between the preoperative weight and ideal body weight. According to Balsiger et al. (2000:480): "With current state-

of-the-art bariatric surgical procedures..., patients lose an average of 50% to 60% of excess body weight (weight above ideal body weight) and a decrease in BMI of about 10 kg/m<sup>2</sup> during the first 12 to 24 postoperative months.” The standard of success for bariatric surgery is that at least 70 percent of patients attain a loss of at least 50 percent of excess weight and maintain it five years after the surgery (Balsiger et al. 2000a; Baltasar et al. 1998; Halverson and Koehler 1981; Kral 1992a).

Twenty women in this sample felt, at the time of the interview, that their surgery was a success because it had yielded the desired results without causing intolerable side effects. Four of these women had to undergo multiple surgeries before they could maintain a significant weight loss (they are popularly known as “re-ops”). I refer to these 20 women as “surgical successes” (see Table 7.2). The remaining ten women considered the surgery a failure, either because the procedure did not result in permanent weight loss or because it had to be reversed due to unmanageable complications (see Table 7.3). Accordingly, I refer to these women as “surgical failures.”

It should be noted that the boundaries between these groups of participants are not discrete. The women who have undergone multiple procedures have experienced both failure and success, and most of the surgical failures were successful at least for a period of time. Given this overlap, I do not treat the experience of the women in the surgical failure group as separate and mutually exclusive from the experiences of the women in the surgical success group. For example, the stories of the women whose surgery was eventually unsuccessful are included in the discussion of the transformative effect of weight loss. The experiences of the women who underwent more than one procedure before they could achieve surgical success are also included in the discussion of surgical failure.

Table 7.2—Surgical Successes

Surgical Procedure	How Many Successful (n=30)
RNY	8
VBG	4
DS	2
AGB	1
SRVG	1
Multiple Procedures	4

Table 7.3—Surgical Failures

Surgical Procedure	How Many Failed (n=30)
JIB	2
HBG	1
VBG	7

### THE TRANSFORMATIVE EFFECT OF BARIATRIC SURGERY

Consistent with the literature on bariatric surgery, the participants who were longer than two years postoperative reported the maximal amount of weight was lost in the first postoperative year. The majority of the women who were less than one year postoperative at the time of the interview reported steady weight loss.

As Millman (1980:211) notes, “those who lose a great deal of weight do have an experience of being transformed.” For most of the women in the sample, the initial postoperative period was a chrysalis period in their lives. Their bodies, which had been so long hated and rejected, now became objects of wonder and delight. They kept careful track of weight loss. Shopping for clothes, once an onerous project, now became a pleasure, not only because they could wear smaller sizes but they also had access to wider choice of attractive clothing.

Numerous women thought their bodies had become unrecognizable to themselves, and they were literally unrecognizable to others. Many women described the enormous pleasure they felt when family members, friends, and acquaintances did not recognize them:

Nicole: I had been looking forward to people's amazed reactions to the "new" me, how surprised they'd be. And that's how it was. There was one time when I went to the supermarket—I used to do hairdressing in my home and I had a customer who came to see me for two or three years. I saw her at the supermarket and it had been at least five years since I had last seen her. So I went to speak to her. But before I could, a cashier asked me about my trip to Mexico. So I was telling her about it. At one point, my former customer approached us and said, "This is a voice that I know, but I can't place you." I said, "Yes, Annette, I styled your hair long enough." She answered me, "Oh Nicole, goddamnit! I never would have recognized you if you hadn't spoken." Somebody recognized my voice, but they didn't recognize me. It was great!

Celeste: I had this startling, startling experience. We were being seen at \_\_\_\_\_ Hospital in \_\_\_\_\_ for my daughter's illness. Part of the treatment modality was the head of the department had hired a social worker to lead a group for parents. She was wonderful, she worked for about six months and then had terrible back pain and had to quit or take a leave of absence. One year later, which corresponded to the time I had had the surgery and lost 100 pounds, I was getting into the elevator at \_\_\_\_\_ Hospital and I saw a familiar-looking lady. I said, "Monica, how are you? It's great to see you! How's your back feeling?" And this woman stared at me blankly and finally said, "I'm so sorry. I recognize your voice, but I don't have a clue as to who you are." I said, "Monica, it's Celeste," and her jaw dropped. It was so much fun. It felt a little like I was walking around in disguise.

Elaine: So many people didn't recognize me. I went down to see my best friend—I was going to be the maid of honor at her wedding. I lived with her in college, she has known me for over 10 years now—she walked past me three times at the airport and did not recognize me.

Barbara: I didn't come home right away to my husband. I spent six weeks in [city where I was operated] and I went to [another city]....and spent two weeks with my sons. At that point, I had lost 42 pounds when I first came back after six weeks. My son Robert was going to pick me up at the airport. I got there and he wasn't there...So I waited.... Finally, just when I decided that I was going to make a phone call, someone came up behind me and just put his arms around me and said, "Mom, I can't believe you! I didn't recognize you!" [breaks down in tears]. He gave me a big hug. That was a special moment.

Julie, however, is overwhelmed by the frequent exclamations over the change in her appearance.

She attributes her discomfiture to the fact that she had been virtually invisible while she was morbidly obese and now, ironically, has become more noticeable since she lost 200 pounds:

People's reactions to me, now, when they start going "Oh my God, you're so beautiful! Oh my God, I can't believe it! Oh my God, what did you do?"--I don't tell anyone. First of all, I'm mortified. As a fat woman, no one recognizes you in your body, they don't acknowledge you. Now I have people over-acknowledging me and going crazy and it's making me very uncomfortable. I've gotten to the point, okay, I'm not cringing anymore, but it's a little...it's very nerve-wracking for me. I just say thank you and try to change the topic very quickly.

Several women acknowledged the problematic nature of being complimented for a more pleasing appearance since their surgery. Comments such as “Gee, do you ever look good now!” obviously imply that the person’s earlier appearance was deficient. When friends told Gisèle and Suzanne how “terrific” they looked after their surgery, both said they no longer regarded these people as friends because true friends would think they look terrific at any weight. Fiona also expressed resentment about her parents’ lavish praise for her post-surgical body:

My mum and dad were just like, “Oh my God! Just look at you! You’re so beautiful!” It’s like Catch-22 with that. You look at them and you think, So I wasn’t beautiful before because I was fat? And now I am?

Consistent with the findings reported in the medical literature, the substantial weight loss had a positive impact on the women’s health (Balsiger et al. 2000a; Bufalino et al. 1989; Eckhout and Willbanks 1989; Miller and Goodman 1989; Mun et al. 2001; Pories et al. 1995; Sugerman 2000). The seven women who had diabetes or pre-diabetes prior to their surgery now have normal blood sugar levels. Isabella no longer has psoriasis or arthritis. Once she lost a significant amount of weight, she became an acceptable candidate for knee replacement surgery and has since had both her knees replaced. The young women who once feared a premature death are no longer consumed with their mortality and are confident they will live long enough to see their children grow up.

Elaine, perhaps more than other sample participant, experienced the most profound change in her body after her operation. She lost 186 pounds the first year after her medial RNY bypass, or 90 percent of her excess body weight. Elaine and her husband had long wanted to have a child, but they had been informed that Elaine was infertile as a consequence of her morbid obesity.<sup>78</sup> Elaine had been advised to wait a year after her surgery before getting pregnant; once this time was up, she conceived and had an unremarkable pregnancy. At the time of the interview her daughter was eight months old and a source of great joy:

The best part of the surgery has probably nothing to do with the surgery directly, but it’s my daughter. It’s the fact that I have my daughter. That isn’t *directly* because of the surgery, but without the surgery I wouldn’t have been able to conceive her. I would never have been able to have her. My body wasn’t ovulating....We tried fertility treatments....The first time after surgery that we tried to get pregnant, it happened

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<sup>78</sup> This participant also had Polycystic Ovary Syndrome, a condition implicated in both morbid obesity and infertility.

[laughs joyously]. So without the surgery, there would be no [daughter] (emphasis in original).

For the first time in many years, many of the women experienced the freedom of unrestricted mobility and increased access to public spaces. Fitting in the seats in stadiums, theaters and amusement park rides and public bathroom stalls, as well as maneuvering in crowded restaurants is no longer problematic. Various participants describe the joy of greater freedom of movement and the difference it has made in their lives:

Jennifer: I loved it when I started losing the weight...I found I was able to do more. My husband and I can go out now on our bikes. It's just a night and day difference. What I can do at 325 is so different than what I can do at 520—that's 200 pounds. What I can do at 325 is also different than what I can do at 470. I could never go out and ride a bike before; I had never ridden a bike in my adult life. I can go out on a bike and see things I hadn't seen before.

Isabella: I can walk. I can go anywhere. I can do anything. I can swim in public. I snorkeled last fall and swam with dolphins. Last year, we went on a cruise to Alaska. I flew in a helicopter, which I could never have done before. I can get on an airplane and fit into any seat. I can get in and out of any car. I mean, it's a whole new world. Yesterday...we went grocery shopping. I didn't have to get one of those carts they have. I just walked through the store and it was like nothing. I mean, I'm like a normal person. I feel *normal* (emphasis in original).

Cinzia: I like the fact that I can run. I like the fact that I can sit in small places. I like the fact that I can be inconspicuous. When you're large, it's hard to go anywhere without...you take up space, you're usually in the way....I always remember walking somewhere and knocking something over. If I want, I can run [incredulous tone].

Another positive aspect afforded by the weight loss surgery was the reduction in conspicuousness. Most of the surgical success participants do not appear to experience as much public harassment as they did before the operation and attribute this outcome to the fact that they now "look normal" and are accepted as such by other "normals" (Goffman 1963):

Isabella: No one stares at me. No one makes remarks. I can go anywhere and there's no kids pointing at me. There's no people staring at me—nothing like that anymore. I look normal; I feel normal.

Casey: When I walk around in public, I don't know if people are looking at me, but I feel okay about them looking at me—men, in particular. I hold my head up more and I look people in the eye instead of not really meeting people's gaze because of what I might see in their faces.... I feel more accepted I guess because I am more of a normal size than I used to be.

These women's accounts illustrate that successful bariatric surgery can be a truly liberating experience for those who felt entrapped in their morbidly obese bodies. A massive weight loss freed them from the prison of immobility, public opprobrium, and in Elaine's case, infertility. Their bodies, which had so long served as an impediment to normal functioning had now been converted to a vehicle which enabled them to realize a normal lifestyle.

Transformation in the body was usually accompanied by extensive psychosocial benefits, a common finding in the literature (Chandarana et al. 1990; Kincey et al. 1996; Solow, Silberfarb, and Swift 1974; Wampler et al. 1980). The women reported that positive changes in mood and attitude accompanied the weight loss. They experienced a remarkable surge of self-confidence and a corresponding increase in self-esteem after they lost weight. Numerous women reported having become more assertive. This, in turn, prompted them to become more outgoing and adopt a more positive attitude toward life. The women who were once incapacitated by depression before their surgery reported that they are now more optimistic and less reclusive:

Casey: My life has changed so much since my operation...I feel a lot better about myself. I feel more attractive. I'm just a lot more happy with my body. I'm just so much happier in general. My depression—even though I was medicated—was still a big factor in my life. I would come home from work and just plop in front of the TV and eat. Where I was living before, I *never* decorated, I never cooked. I've totally done so much more with myself. I'm busier with friends. Most of my friends, my circle, is the weight loss surgery group. But I'm just a lot busier in my own private life. I'm dating...I don't have a serious boyfriend but I am seeing people now and then and I'm a lot more confident about that (emphasis in original).

Jennifer: My outlook has also changed: I'm more optimistic now. I can see more things. I can accomplish more things. It hasn't made me more assertive, because I've always been assertive, but at least now I don't stand out as much in a crowd....It's not the surgery that changed my outlook; it's the result of being able to move my body in a certain way that I couldn't before.

Trudy: I feel wonderful, both physically and mentally. There have been, in the time that I was off the year and a half from work [before the surgery], during that time I isolated myself. I wouldn't even talk to people on the phone. I had just...I didn't do anything. Now I want to do everything. I want to garden because I can. I want to walk to the mall because I can. Things I couldn't do before, I can now.

Barbara: All I can describe is...I have my life back. I have my personality back....I was lacking in self-esteem and since my surgery, I know it's only three months but I've lost more than most people in three months, I've seen such drastic changes with my appearance. It's affected my whole outlook on life and it's affected my self-esteem, how I feel about myself. And I've noticed I'm coming out of the shell that I've built around



myself...I want to get up in the morning now. Before my surgery, I spent days and days in bed in darkness, with my blinds drawn and wondering when I got up in the morning—if I got up in the morning, it could be the afternoon, I woke up tired no matter how many hours I slept and I couldn't wait to go back to bed for a nap. Now I look forward to getting up.

These dramatic changes in body and attitude had a profound, positive impact on the women's professional lives. Numerous participants felt their weight loss enhanced their employability, not purely as a cosmetic function but acting in complementarity with their newfound self-confidence:

Nadine: I'm sure that if I didn't have this operation, I wouldn't have this job. Before the operation, I finished high school—that's as far as I went. I was a receptionist and a secretary, stuff like that. After the operation, I did odd jobs, again, being a secretary. And then I [was hired by] \_\_\_\_\_, which is a building corporation, and I had my big break and I loved the field. The fact that I looked good and [clients] responded to me and...I'm sure that if I was 250 pounds, I wouldn't have this job. I'm just being realistic.

Filomena: I'm much happier, I have more confidence. I feel that more opportunities have opened up for me at work because of my weight loss. It's changed my life in every way.

Cynthia: After I lost weight, I got the confidence and I said, I want a better job. I went to \_\_\_\_\_ and I found a kick-ass job, working with [high-profile employer]. It's just a big boost.

Similarly, Doris and Nicole felt sufficiently confident to return to school for secretarial diplomas, an achievement they feel they never would have accomplished without first losing weight. Successful bariatric surgery is correlated with increased vocational and educational opportunities (Brolin 1987; Bufalino et al. 1989; Näslund 1999; Powers and Rosemurgy 1989).

#### **From Disembodiment to Re-embodiment: The Case of the Surgical Successes**

The women in the surgical success category noted that the surgery induced positive changes in their construction of self by establishing a reconnection to a formerly alien body. In Chapter 5, I explored the extent to which my sample participants felt disembodied prior to their surgery. They felt no connection to the pre-surgical body and regarded it only as a source of anguish. Their bodies not only betrayed them by resisting their best efforts to bring them under control, but they also caused a fracture in these women's sense of identity, as they felt the pre-surgical body was not congruent with their sense of self. This incongruity was articulated in the frequently expressed conviction the body misrepresented the authentic self ("this isn't who I really am"). As Millman (1980:220) observes, "[l]ike Cinderella or the Frog Prince,

the fat person lives with a double identity. Her present self-in-the-world may be fat, ugly, despised, or disregarded, but inside, carefully nourished, is a private future self that is beautiful, powerful, lovely.”

Virtually all surgical successes described their post-surgery body as representing the “real” them, or the authentic self. Consistent with Millman’s suggestion, they maintained this self was not a surgically-constructed self but a self that had always existed; it was the self they had long nurtured but was buried under the layers of fat. The following quotes indicate my participants were burdened with a double identity prior to their surgery and that the successful outcome of the surgery resulted in an alignment between the body and the self:

Julie: I feel I’m closer now to how I really am. I’m still a fat chick—I’d be a fat chick in a thin body. The person I really am is coming through. I like myself. I like how I feel and how I fit in the world. It’s kind of bizarre, because I identify with the fat side of me; that was my frame of reference for so many years. I’ll still be fat framed. I’m still the same person I was though, before my surgery. I haven’t changed in that way. I’m still the same person in how I treat people, in how I view people. How I view myself is what changed.

Cynthia: I’m still the same person on the inside but I feel a lot better about myself. This is me, someone who is vibrant, who has a lot of energy, who loves herself, and who loves her family and friends. I think that was the real me before the surgery, but it was hindered by my lack of self-esteem. It was hidden because I wasn’t as outgoing, as outspoken before my surgery.

Fiona: Yes, I’m a lot more sure of myself. I guess I got myself back. This is the way I used to always be. But when my weight hit the 270 mark to the 280 mark to the 320 mark, I got more reserved, moody and tired—and hiding. And since I’ve had the surgery I’ve come back to the personality I used to have. And I feel better about myself, a lot better about myself. No, I don’t think I’m a different person. I’m the same person that was gone for awhile. With this surgery, it’s given me the self-confidence to come back and be me again.

As the physical body changed and acquired more normative proportions, the sample participants felt they had the freedom to reveal—or in some cases, reclaim—their authentic self and shed the burden of the double identity. These women’s accounts reveal the surgery resulted in a congruency of the body with the self: The more normative body reflected a normative self, the authentic self. Thus, they position the post-surgical, more normative body as the true indicator of selfhood. In Western culture the body is seen as a physical manifestation of the self (Fallon 1990), and the women whose surgeries were successful appear to endorse this belief. A consequence of the realignment between the body and the self, I argue, is that these women became re-connected to their bodies, and thus, re-embodied.

It is also important to emphasize that re-embodiment does not depend on the achievement of “ideal” weight as calculated by the BMI. As previously mentioned, only three sample participants had reached a normative weight at the time of the interview. The other women in the surgical success group are fat by clinical and cultural standards, while two are still morbidly obese. The women who were less than one year postoperative at the time of the interview expected to lose more weight but pronounced themselves satisfied with their current weight. That is, if they were to remain at that weight, they would still consider the surgery to be a success:

Filomena: I have never really figured out what I should be at for my height or anything. I’m so happy where I am that I feel like anything over and above this is just icing on the cake. I’m so comfortable just with what I’ve lost. I feel normal. I know I’m not thin, but I feel within normal limits, I guess it is.

Fiona: At 220, yes, I’m happy with my life. It’s not my goal weight, but if I stay at this weight for the rest of my life, I’m very happy with it.

In our weight-obsessed culture, it may be peculiar to hear women who weigh over 200 pounds express happiness about that weight. These women’s contentment refutes the conviction of feminists who claim that women are only satisfied with their body image if they closely approximate the slender ideal (Orbach 1986). While emaciated models and actresses may serve as referents for normal-weight or moderately obese women, they are an irrelevance for women who were once morbidly obese. *Their* referent is their former body and they do not want to emulate a cultural icon as much as they want to acquire a more normative body shape and size that will enable them to engage in routine activities. While other women may compare themselves to extremely thin women and find themselves lacking, formerly morbidly obese women compare themselves to their previous weight and conclude that at least they are no longer as deviant as they felt they once were. Their lives have improved in almost every respect, and that is sufficient reason to be happy with the results of the surgery.

Re-embodiment, then, can take various forms. This process involves a convergence between body and self, but it does not necessitate the attainment of the ideal body as represented by the media standard or even the realization of ideal weight by clinical standards. While re-embodiment for the surgical successes was premised on a substantial weight loss, it involved other factors such as the achievement of an internal standard that does not only govern physical appearance but also what a person can do with her body. These

women's aspirations about their bodies are quite modest; they do not want to be beauty queens or perform great athletic feats. They merely want to be able to engage in routine activities and enjoy a greater security about their health. The exuviation of their weight enabled them to shed both the physical burden of the restrictions it imposed and the psychological burden of a false self.

### REACTIONS FROM OTHERS

The sample members reported the reactions from their spouses and other significant individuals were, on the whole, very positive. Husbands who had been loving and accepting of their wives at their highest weight were supportive and proud of them as they lost weight. The women whose partnerships were strong before they had surgery felt the quality of their relationships increased because of the improvement in their mood and because they were now physically capable of participating in social activities with their families. Their sex lives also improved significantly because of their greater ability to move their bodies and their lack of self-consciousness about being naked. These findings are consistent with those reported by other researchers (Castelnuovo-Tedesco 1987; Goble et al. 1986; Rand et al. 1982; Rand et al. 1984). The subjects in Rand et al.'s studies reported an increase in marital quality and significant improvement in their sex lives. This improvement was attributed to more positive attitudes, greater self-confidence, increased assertiveness, less defensiveness, and improved appearance on the part of the surgical recipient.

While the great majority of the sample members joyfully recounted how their post-surgical weight loss improved the quality of their relationships with their partners, the converse was true for the women whose relationships were troubled prior to their surgery. Jeanne and Suzanne believed their weight loss was instrumental in the breakdown of their already troubled marriages. Both their husbands were apparently indifferent to their weight loss; that is, they never complimented them or remarked on the changes in their bodies. However, they felt threatened by their wives' weight loss and this insecurity manifested itself in various ways. Jeanne noted that her husband would make excuses about why they could no longer participate in the couple's busy social life and suspects he was feeling insecure about her 120-pound weight loss which she had achieved eight months postoperative:

My husband...never told me he was happy I was losing the weight. But once I got down to losing 120 pounds, friends that we went dancing with together--we had made an enormous amount of friends—and the whole group of us all went out together dancing—and they would phone and say, “What if we went to so-and-so Saturday night and go out dancing?” And I noticed, suddenly, that we weren’t going anywhere. One night I heard him on the phone saying, “Oh we can’t go because Jeanne is having trouble with her feet or Jeanne’s having trouble with this or Jeanne is having trouble with that.” When I confronted him, it was I didn’t think you wanted to go. When I look back on it later, the first few times when people started to notice the weight—and they didn’t notice until I had lost about 70 pounds, and then suddenly people were mentioning it—and they would say to me, what are you doing, you look so great! The weight’s coming off! This is great! It was at that point that I noticed we weren’t going anywhere...I don’t want to say he was jealous...but sometimes I think back later and I think what was he afraid of? Was he afraid that I was going to look at somebody else or somebody else was going to look at me and I was going to be interested and as long as I was heavy, he didn’t have that worry? I don’t know...

Jeanne also expressed a desire to “do different things, go to different places, and he didn’t like that because I’d go on my own....even if it was up to the plaza, I would go by myself. That caused a problem. Before that, we never went anywhere unless we were together.” Her husband, whom Jeanne describes as a very controlling man, apparently could not accept her newfound independence and eventually left her for another woman.

Although Suzanne’s husband had been critical of her obese condition, he was not complimentary when she lost 100 pounds. Suzanne believes her weight loss bothered him because he was already worried about his aging process after having entered his thirties. Her husband apparently felt further pressure to prove his virility once she lost weight and wanted to go to strip clubs on a regular basis. Suzanne did not share his interest in these activities and the couple had frequent arguments. Her husband left her for another woman eight years after her surgery. Looking back at her marriage and how it was impacted by her weight loss, Suzanne concludes:

I think it bothered him more than it made him proud. He was afraid that I’d leave him. It’s reassuring to have a fat wife because you can be certain she’ll never cheat on you and that other men won’t be attracted to her.

Gisèle, whose husband had been so eloquent in his displeasure about her weight, found that he was still not satisfied, even after her surgery:

My husband would make very sarcastic remarks. He thought I would weigh 100 pounds when I left the hospital....Then, when I lost 150 pounds, he got mad. At first, he was mad because I was fat. Then he got mad when I got thin. He became very jealous because I was pretty; I was pretty because I was thin, according to his logic. But he

noticed that even more people were looking at me. So, ultimately, people were looking at me all the time.

Gisèle left her husband two years after her surgery because he had, by that point, started beating their children as well. After she recovered from the rigors of her surgery, she started working as a cook in a restaurant. Having a full-time job gave her the financial security she so desperately needed, and she remains convinced she never would have been hired had she presented at her pre-surgical weight.

Celeste describes her husband's attitude as "suspicious and fearful" when she lost 100 pounds. He too left her for another woman five years after her surgery. Celeste is not certain whether her marriage foundered because of her husband's insecurities about her improved appearance or because of her extreme distress over the progression of their daughter's terminal illness, which she says made her into "a crazy person." But she does feel her substantial weight loss played a relevant role in the breakdown of the marriage.

Lara, at 136 pounds, is one of the few sample participants who has reached a normative weight. Despite this outcome, her husband still finds reason to be critical about her body. Although Lara's marriage has remained intact since her surgery, she is aware that the relationship is not solid. However, the successful results of the surgery have given her the confidence to assert herself with her husband and to contemplate a life without him:

He never speaks to me about it [weight loss of 100 pounds]....Shortly after my operation, one of his friends told him kiddingly to be careful for his wife now that she had lost weight. He didn't react...but I think he's become insecure since I've lost weight. He can't criticize me about my weight anymore so now he tries other things. He tries to manipulate me in other ways. He tells me the skin on my thighs is sagging. He tells me what a good figure our neighbor has, how pretty she is. He likes to think I'm jealous and possessive when I tell him his remarks are in poor taste. If it's not one thing, it's another. I'm so fed up with this. We have our reasons for staying together now, but I know we'll separate at some point in the future. Losing weight has made me independent. I'm aware that there are other men out there and they'll have sex with me if my husband won't. I tell him, if he doesn't want me anymore, he can always leave. He doesn't say much to that.

These women are aware that their husbands are very insecure men who sought to dominate them by exploiting their anxieties about their weight. In other words, these men gained security through their wives' insecurities. A fat wife's presumed gratitude for attention and guaranteed sexual fidelity were essential props for these men's weak egos. Weight loss was associated with diminishment in their power

over their wives and they were obviously reluctant to relinquish that power. Numerous researchers have noted that while marriages which are strong prior to bariatric surgery are enhanced by positive results, weak marriages are destabilized and often end in divorce (Goble et al. 1986; Rand et al. 1982; Rand et al. 1984; Stunkard et al. 1986). Rand and her colleagues conclude that couples whose marriages were solid before surgery were better able to deal with the changes that occurred after surgery. Stunkard et al. (1986) suggest that dysfunctional marriages have greater difficulty adapting to patients' positive changes after surgery.

Similarly, parents who were supportive of their daughters when they were morbidly obese expressed happiness that their daughters were enjoying a greater quality of life. However, some of the participants who had described their parents as critical of them prior to their surgery, indicated they expressed their pleasure over their weight loss in a snide manner:

Jeanne: All I got from my mother was, "Why didn't you do this years ago?"

Catherine: Mum and Dad just like telling me that I look amazing and all that kind of stuff. I look closer to where they think I should have been all those years. It's not supportive in a good, warm way; it's supportive in a you-finally-look-how-our-daughter-should-look way.

It would appear, then, that weight loss following bariatric surgery does not improve a dysfunctional relationship—even when the purported cause of the dysfunction is obesity; rather, weight loss seems to either maintain the relationship or precipitate a rupture.

Disruption in other relationships was also noted. It was particularly evident that for many of the participants, their weight loss negatively impacted their relationships with other people who were morbidly obese. Lara's sister, who never supported her decision to undergo the surgery, attributes Lara's "every little ache or pain" to the operation and remains skeptical about the long-term benefits of weight loss surgery. While the literature notes weight loss is associated with an increase in social activities and a corresponding increase in the friendship network, an ironic note is that the surgery can result in the rupture of longstanding friendships as well. For instance, Cynthia attributes the waning of a friendship with a morbidly obese woman to her successful surgical results. The friend is hostile to weight loss surgery and refuses to consider it as an option for herself. Fiona confided in a work associate who she also considered a

friend that she was going to have the surgery and asked her not to share this information with other colleagues. However, the friend broke her confidence and started “quite the rumor mill” while Fiona was away on sick leave. Fiona notes this woman is also quite overweight herself and ascribes her behavior to jealousy over Fiona’s weight loss.

Isabella, to her dismay, feels the tremendous success of her operation has cost her the friendship of a woman she had known for many years. Her best friend has had two weight loss surgeries and both ended in failure. The second surgery was with the same surgeon as Isabella’s. Isabella achieved spectacular results, while her friend lost 100 pounds only to quickly regain them. Isabella’s success and her friend’s failure apparently motivated the friend to decide to end the relationship. Isabella recounts the story and the pain this has caused her:

My friend Marlene, she went to Dr. \_\_\_\_; she didn’t tell me until just before she went into surgery. She had the same surgery done that I had. And she lost a quick 100 pounds. She also gained it right back. Now, we were the best of friends. She used to go down to Florida with us....she was there holding my hand when I came out of the first surgery [weight reduction surgery]. She was there for me for the second surgery [knee replacement]. She took time off work when [husband] couldn’t be there. But last November [2000], I talked to her—we hadn’t been talking as much, she was busy, stuff like that. She finally told me, “I can’t deal with you anymore. Don’t call me, I’ll call you.” I haven’t heard from her since. It’s the strangest thing, I lost my best friend. It was like a death in the family....She also doesn’t stay in contact with another friend who’s lost weight because of the surgery.

These experiences with friendships that fracture over weight loss demonstrate the extent to which weight and body size can affect interaction with significant others. Apparently, obesity may serve as a basis of friendship for some women; they seek refuge with other fat people, more than likely feeling a sense of kinship with them. However, the equilibrium is upset when one of the individuals loses weight, and the friendship disintegrates.

### **THE PREOPERATIVE AND POSTOPERATIVE ROLE OF SUPPORT GROUPS**

The literature shows that attendance at a support group meeting both prior to and following bariatric surgery is of enormous value to patients (Algazi 2000; French, Galbraith, and Deitel 1989). Surgical support groups provide a forum for patients to share their experiences with each other and to individuals who are contemplating having the surgery. Spouses are also encouraged to attend. Group



members praise each other's success and provide education about life after surgery. Some senior group members, known as Angels, accompany new patients to the hospital when they have their surgery.

Surgical support groups are sometimes facilitated by a mental health professional or a nutritionist affiliated with the hospital where the surgery is taking place. Outside the hospital setting, groups are self-led by patients (French et al. 1989; Hildebrandt 1998). There are also numerous on-line surgical support groups, with the Online Surgical Support Group (OSSG) being the largest of these.

Sixteen of the 30 sample members are either currently or formerly active in surgical support groups, both live and on-line. Those participants who are currently involved in a group showed an extraordinary commitment to the group, sometimes driving long distances in order to be able to attend the meetings. Casey, Rosemary, and Cinzia are currently or formerly group leaders. Cinzia and Catherine have initiated their own on-line support groups, and Catherine has also created a Web site for AGB patients.

According to the information provided by my sample members, meetings are held on a weekly or monthly basis and vary in structure. The loosely structured meetings are shorter in length and generally consist of informal sharing of experiences and concerns. The more tightly structured meetings typically feature a guest speaker who will focus on a relevant theme such as body image, nutrition, or exercise. Occasionally bariatric surgeons are featured as guest speakers.

Consistent with the findings reported by Algazi (2000) and Hildebrandt (1998), the sample members describe the live and on-line groups as a valuable information resource. They receive advice about proper nutrition and educate each other about how to deal with unpleasant side effects such as dumping, diarrhea, or intestinal gas. They disseminate information about products that can alleviate their symptoms, such as bismuth powder or whey-free protein bars.

Another benefit a support group can offer to its members is the assurance of an in-depth understanding of the condition of morbid obesity and a non-judgemental atmosphere--what Algazi (2000:186) calls a "safe harbor." As Valerie observes, "I feel more comfortable with them. There's none of that judging stuff. They completely get it, where you're coming from." Julie adds, "Having the support group is important because *nobody* understands" (emphasis in original). Group members also support each

other by praising weight loss and by providing encouragement when members hit the dreaded plateau (temporary cessation of weight loss). If a member feels she is not losing a sufficient amount of weight or is experiencing difficulties related to her surgery, her fellow members often try to help her identify the problem. Group members also share information about surgeons in the area; e.g., high success or failure rates, attitudes toward patients, length of waiting list, etc.

Hildebrandt (1998) has found that group meeting attenders report more weight loss than nonattenders do. The more often patients attended group meetings, the more weight they lost. My sample members who were involved in a support group identify regular attendance as an essential element in the successful bariatric surgery process:

Casey: I think it is key to being successful. You need the support of people who are going through what you're going through. I can't tell you how great it is to have people understand how I feel, *really* understand because they're there too. I feel closer to these people than even to some of the people I was close to in the church. It's amazing. It's because we have this common bond. I'm having a lot of fun with it. I really like to help people with it, with their experiences. Help in any way I can, like go to the hospital with them or give them advice. It's been very positive for me. And I'm very involved. I plan to stay involved. I know it's going to help me be successful. If I shut them out of my life, then I can go back to my old way of sabotaging myself (emphasis in original).

Cinzia: It's played an enormous role.... Before the surgery I wanted to hear it all. I was really hungry for the information. Even after the surgery, I find it helpful to be—even as postop as I am now, I still find it really helpful because it reminds me of where I was. You identify with so many other people in little ways. So it reminds me of how far I've come. It reminds me of where I was and where I don't want to go back. It also helps because I'm motivated to help others in whichever way I can....At the same time, it's a great support network for me.

Rosemary: When people come to support groups and if they find them enjoyable—and they generally do—they are anxious to come back after the surgery to report, "Hi, I'm three weeks postop and I'm doing great, I've lost 40 pounds."...Everybody cheers you on...We also have an extensive phone list of people that can mentor them sort of, that they can call and ask questions....[After the surgery] there may be things happening that you're a little nervous about or you're not sure if this should be happening—is it okay if I have diarrhea, that sort of thing. You can call people. You can voice all these concerns at the support group.

Support groups not only function as an information resource but also serve as a social network.

Some groups meet weekly outside the meeting context in informal areas such as bars or restaurants.

However, two participants were ambivalent about the group's foray into social events. They complained it

had become too focused on social activities and strayed too far away from its original mission of disseminating information and providing support to members:

Fiona: I used to go to group meetings, but I don't anymore. It's too much a cliquy kind of group. It's not something I was really looking for. I found that in this particular area ...there's a certain group that really sticks together and it's kind of hard to break into that little group. Different groups have started out of that because of that. What I was looking for was people to pass information, to exchange information, ideas, problems, how they dealt with it, that kind of group was what I was looking for. I wasn't looking for much of a social group—I don't mind social but I don't like gossipy kinds of groups. That's not what I was looking for, so I don't go anymore....In some ways, it was a useful source of information. In a lot of ways they give you a lot of good ideas.

Cynthia: I've had tons of questions and they're always there to help.... They're always there if you have any questions. We have gettogethers, information sessions. It's been a positive experience, but I don't use the support group very often anymore. I find I used it more prior to my surgery. Now I have my husband for support. If I'm feeling down, I talk to my husband....My husband is my support group now. I took it as more of an information resource. I've known of a lot of people out there who've made a lot of good friends, a lot of good support networks through these support groups....I think one of my problems is...I think they take it too far as a social thing. Everybody gets together every Friday for a drink and stuff. Those are a lot of people that are single. So they're using it more as a gettogether. I'm married, and I have a child and I can't get together every Friday. So I go in for information and that's about it.

Algazi (2000), in her case study of a surgical support group setting, describes a context in which members offer each other unadulterated support and encouragement. This may be indeed the case when the support group is confined to members who have all had the same type of surgery. However, when the support group is composed of members who have had different bariatric surgical procedures, the dynamics of the group may be affected, as Trudy's experience suggests:

I'm the only one at the support group that has a VBG and people with the RNY tend to look down on the VBG; they think of it as a lesser surgery. Even though theirs is more drastic, I can get the same results in a longer time.

I noted that numerous participants demonstrated a strong tendency to derogate other surgeries than the ones they had. This was particularly notable in the interviews conducted with the women who had researched the surgery extensively on the Internet and who were knowledgeable about the advantages and disadvantages of each surgery. For example, the RNYs are often disdainful of the VBG, claiming it is not as effective as the RNY in terms of rapidity and extent of weight loss. The VBGs defend themselves by pointing out their surgery is not as invasive as the operations that involve intestinal malabsorption and that they are likely to suffer fewer side effects. They also note that if their surgery is not effective, they have

the option of converting to an RNY or other procedure involving intestinal malabsorption. The VBGs also critique the AGB, saying it is not as effective as the VBG. The AGB patients deny this claim and point out the band is non-invasive and has the advantage of being inserted laparoscopically. The DS patients maintain they lose more weight than the RNYs and that there are fewer side effects associated with the DS. The RNYs also criticize other RNYs according to whether they have had proximal, medial or distal bypasses—and so on.

It is also interesting to note that in the interviews the women tended to say “I *am* a VBG (or whatever surgical procedure),” rather than I *had* a VBG.” This suggests that the women identified the surgery as a part of themselves, as opposed to a procedure that was performed on them. This interpretation is supported by the fact that it was only the women who experienced surgical success who talked in this way. This strong identification with the surgery might be related to the participants’ tendency to criticize all surgeries other than the one they had themselves.

Listening to these debates is similar to reading articles by surgeons in medical journals; surgeons have a first-line procedure which they defend strenuously and want to disseminate the value of their preferred procedure as widely as possible. Presumably, their preference is also conveyed to their patients who then take on the debate as theirs.

Overt derogation of members’ surgeries can only have a negative impact on the dynamics of a support group context; members want succor from each other and this assistance is obviously undermined if some group members feel they must constantly defend their decision to other group members. Rivalry based on surgical technique may be best managed by organizing groups on the basis of a specific surgery, but this may be difficult to achieve for patients living in remote areas or who have had surgeries that are not widely performed. In any context, group leaders must be sensitive to competitive overtones and ensure that each member’s integrity is respected.

The sample members who were deeply entrenched in support group culture were adamant this involvement would last “a lifetime.” However, it would appear that membership in a live surgical support group may not be an ongoing commitment, even for those who are initially very involved. For example, Rosemary who was once a group leader is no longer able to attend meetings because these have been

rescheduled to a time which is not convenient for her. Barbara expressed frustration with the group she was involved in at the time of the interview, citing its lack of direction. She indicated she would possibly leave the group if she did not see an improvement in the near future. Fiona and Cynthia are disenchanted with the group's emphasis on social events and no longer attend meetings. Over time, the disengagement with the support group may intensify, as the surgery no longer features as a salient part of the patient's identity. As senior members drop out, new members may not have the opportunity to discover the long-term effects of the surgery. Moreover, it is logical to speculate that patients who have experienced postoperative difficulties would be less inclined to participate in support groups and are therefore underrepresented. The 'support' in the surgical support group phenomenon may well refer to the support successful patients receive from other successful group members.

To summarize, support groups provide an invaluable service for their members. Since bariatric surgeons often do not provide a sufficient amount of information regarding the postoperative course, prospective patients can freely ask questions in an atmosphere of warmth and encouragement. Patients advise each other about what they can expect during the peri- and postoperative course. Support groups, particularly when they are patient-led, reinforce my argument that patients themselves are the experts on bariatric surgery. But, over time, the significance of the group may be less important.

#### **SHARING KNOWLEDGE ABOUT THE SURGICAL EXPERIENCE**

While almost all of the surgical successes are eager to share their surgical stories in a support group context, they were considerably more reluctant to divulge these stories to people who are merely curious about how they lost weight. In the previous chapter it was noted that most of the sample members went to great measures—including deception—to hide the fact they were having the surgery. Most defended this decision by explaining they feared humiliation if it were widely known they had to resort to a drastic measure to lose weight. The fear of humiliation was compounded by the fear of derision should the surgery be unsuccessful. Even in the cases where the surgery was successful, some women prefer not to reveal the fact they have undergone bariatric surgery. Rosemary's and Isabella's family members still do not know about their surgery, and these women remain resolute in their determination never to tell them.

Likewise, Yolande has no intention of ever revealing to her partner that the operation she referred to as a herniotomy was actually an RNY. Julie and Barbara also prefer not to tell people outside their family and close friendship circles that they had the surgery. Other women indicated they were leery about confiding in their colleagues that they had bariatric surgery because they did not want to become subjects of gossip and because they did not want aspersions cast on their decisions:

Trudy: It's still not general knowledge. The environment where I work is a very gossipy environment. There have been, in the past, people...that have had the old stomach stapling and have gained the weight back. I didn't want anybody to know because I didn't want their judgement because it's such a drastic thing.

Filomena: I didn't tell them at work. Everybody else knows—I've been open with everyone else—but not at work. I don't trust some people I work with. I really wanted it to be private. I just didn't want to tell them. I guess I didn't want someone thinking that I took an easy way out and had surgery, rather than losing it on my own through dieting or whatever.

The women who refuse to disclose their surgery on a widespread basis respond to questions about their weight loss by explaining they “watch what they eat” and have regular workouts. All the women who use this strategy point out they are telling the truth about their regime; they are merely omitting the mention of the surgery. Others say they have had a herniotomy or other abdominal surgery. The fear of public disclosure dogs these women. As Goffman (1963) observes, stigmatized individuals who are able to remove or disguise the stigmatizing attribute are vigilant about information control. They are aware that their reconstructed status as a person who formerly had a stigma may be a stigma in itself. While these women understand their morbidly obese condition was widespread knowledge, they are self-conscious about potentially being acknowledged as morbidly obese persons who lost weight through surgery rather than dieting. Weight loss achieved through dieting is believed to involve self-control, a widely admired trait in our society (see Chapter 3). Those who have so little self-discipline they cannot lose weight “by themselves,” are forced to have their bodies brought under control by an external source. While diet-driven weight loss is evidence of the individual's competence, determination and will power, weight loss induced by surgery portrays a person who is incompetent, desperate, and incorrigible. It is understandable why bariatric surgery patients would want to avoid such negative labels.

All the women who had successful surgeries expressed a profound empathy for the morbidly obese and expressed a desire to inform them they had the surgery and what it did for them. However, they recognize that such an action would infringe on the fat person's privacy. Those who have access to the Internet circumvent this dilemma by posting their stories on-line and offering to answer any questions others may have. The Internet performs a valuable function in that it serves as a vehicle of information to prospective patients and maintains anonymity.

One sample participant in particular has been particularly vocal about her successful experience of bariatric surgery. Elaine has appeared on various media outlets to describe the success of her surgery and how it has changed her life. Her intention, however, is not solely to propound the effectiveness of the surgery but to make the point that morbid obesity is a disease. Elaine maintains that her state's insurance companies frequently turn down requests for coverage of weight loss surgery, citing it is a cosmetic procedure. Elaine is actively campaigning to have her state enact legislation making it mandatory for insurance companies to approve weight loss surgery on the grounds that it is a health measure which addresses a health condition.

### **EXPLORING SURGICAL FAILURE AND OTHER NEGATIVE ASPECTS OF BARIATRIC SURGERY**

Both the surgical successes and the surgical failures note that one unpleasant feature of the substantial, rapid weight loss is sagging skin on fleshy areas of the body such as the arms, breasts, thighs, and particularly, the stomach. Deitel (1998) and Freiberg (1989) note that plastic surgery to remove sagging skin after weight loss from bariatric surgery is common. Virtually all the women in the sample had already had, were planning to have, or wanted to have cosmetic surgeries designed to remove flabby skin such as a panniculectomy (the removal of the pannus, or the apron of hanging skin) or abdominoplasty (popularly known as a "tummy tuck"), breast lift, or arm reduction. Some women expressed a desire for all these procedures.

The Canadian women face a bigger challenge in having excess skin removed, as cosmetic procedures are not covered by the provincial health insurance plans. Thus, any Canadian patient who

wants to have sagging skin removed has to pay out of pocket for the surgery.<sup>79</sup> Since the procedures tend to be expensive, this may not be an option for the Canadian women in my sample. Gisèle and Jeanne express anger and bitterness about not having been informed at the time they had bariatric surgery that subsequent operations for the removal of sagging skin would not be covered by health insurance:

Gisèle: Since the surgery was considered experimental when I had it [1987], you were considered as having given your body to science, so you were allowed to have plastic surgery. ... When they called me back for the plastic surgery, they told me they would do my breasts and my stomach. When I heard I could get plastic surgery, I was happy. I hadn't been told this before the operation....I thought I'd get everything done. But then they didn't want to do the arms and the thighs because of budgetary limits—they had already surpassed the budget. They had a budget for each patient. Since my budget was already surpassed, I'd have to pay for any more plastic surgery that I wanted. If I had known in advance, I would have had my arms done, instead of my breasts. Instead of having my stomach done, I would have had my thighs done....I cried a lot when I heard they wouldn't do any more plastic surgery. I found that with the large amount of weight loss, there's lots of hanging, flabby skin and it's uglier than fat. I told them, that if they had told me, I would have preferred getting my thighs done. They said all women prefer getting their breasts done. I told them that it would have been better if they had asked me first, because for me that wasn't important. At least the breasts are covered, but the arms and thighs are not. They really should have asked me. They should have told me they had a budget limit for every patient. I really thought I was going to get it all done.

Jeanne: I also don't enjoy, with having lost the weight, that I have all this extra flesh. When you're going through with these doctors, they're telling you that once you have the staple, you lose the weight and you can have all the extra flesh cut off and you're really going to look like something. But they don't tell you that OHIP [Ontario Health Insurance Plan] won't okay it. If you don't have the money, it just doesn't get done. So here you are, you've lost the weight. And for me, I've put 76 pounds back on, which I don't like, but I've got all this extra flesh that I want removed. On one arm, I've got two arms, basically: the extra flesh plus my own arm. And nobody will do anything about it. OHIP won't okay it and say it'll help you. You go to a plastic surgeon, they send in pictures and say this has to be done and they come back and say, it doesn't look like a necessity. Right now, it's not causing you any health problems. But it's like dragging another person around.

Other problems were described as well, and these were considerably more problematic than sagging skin. Twenty-three participants experienced surgical side effects (see Table 7.4). These ranged from manageable and treatable (e.g., hernias, flatulence, anemia) to intolerable (e.g., frequent vomiting, autoimmune disorders).

<sup>79</sup> According to Lara, up until 1992, the Quebec health care plan did cover at least one plastic surgery procedure related to prior weight loss surgery. Thus, Joanne's, Gisèle's, and Suzanne's procedures were covered. Cynthia is under the impression that bariatric patients are "entitled" to an abdominoplasty under the terms of the Ontario health care plan, but I have not been able to confirm this.



Table 7.4 – Complications of Bariatric Surgery

Name of Participant	Side Effects	Surgical Procedure
Casey	Occasional vomiting	VBG
Catherine	Occasional vomiting	AGB
Celeste	Autoimmune problems	JIB
Cinzia	Occasional vomiting	SRVG
Cynthia	Intolerant of high-carbohydrate and high-fat foods	RNY
Doris	Frequent vomiting	VBG
Elaine	Occasional dumping	RNY
Fiona	Intolerant of high-fat foods	RNY
Isabella	Malabsorption of calcium and iron	RNY
Jeanne	Frequent vomiting	HBG
Jennifer	Anemia	RNY
Joanne	Vomiting for 3 years; anemia	VBG
Julie	Flatulence; watery stools	DS
Lara	Hernia	RNY
Marcia	Foul flatulence; frequent diarrhea; autoimmune disorders	JIB
Nadine	Vomiting for 3 years	VBG
Renate	Chronic vomiting; anemia	VBG
Rosemary	Flatulence; hernia	DS
Sherri	Occasional vomiting; hernia	VBG
Trudy	Occasional vomiting; intolerant of fibrous meat	VBG
Valerie	Intolerant of high-carbohydrate foods	VBG
Wanda	Chronic vomiting	VBG
Yolande	Frequent vomiting; hernia; dumping	VBG x 2; RNY

Vomiting is a frequent side effect of gastric restriction surgeries, particularly when food is improperly chewed or eaten too fast (Deitel 1998; Kral 1992b). Almost all the participants who had restrictive surgeries experienced vomiting episodes in varying degrees, and most of these women cannot tolerate certain foods such as fibrous meat or foods with a high-carbohydrate or a high-protein content. Five women who had gastric restrictive surgeries experienced frequent, debilitating vomiting episodes which greatly impaired their quality of life. For example, Wanda lost 150 pounds in 10 months, but she estimates she threw up between 10 to 15 times a day. “It got to the point that if I went to a bathroom and literally just *saw* a toilet, I vomited” (emphasis in original). She eventually had her procedure reversed.

Renate, who also threw up at least 10 times a day, became anemic as a result of the frequent vomiting and also experienced the indignity of weight regain despite her suffering:

I lost 100 pounds in the first seven or eight months. Then I slowly gained....I was only able to eat junk food. Meat wouldn't stay down, pasta wouldn't stay down. Things just wouldn't stay down. I was vomiting all the time. I lived on cheese crackers for the first year. For some reason, crunchy food went down and stayed down. As I could eat more, I did. Meat was always a no-no, which wasn't a big problem with me because I'm not a big meat eater. High-fat things bothered me quite a bit. And then I started vomiting—a lot. I had a lot of pain in my stomach, a lot of heartburn, reflux. It gradually grew worse and worse and I found I was unable to tolerate the anti-depressant that worked because I was just so nauseous....I was also having a lot of trouble with anemia. *Nothing* would work. I went to have my iron checked. I had to go as an outpatient to the surgical area to have my iron checked once a week for three weeks.... I was even considered bulimic at one point, because I couldn't keep stuff down. I wasn't losing weight though....What bothered me most was the anemia because I was so tired all the time. Lightheaded. My heart was racing. *That* was more bothersome to me (emphasis in original).

Jeanne, Doris and Yolande also threw up frequently, particularly after eating certain foods, although not to the same extent as Wanda and Renate. It has now been many years since their operations, and none of these women can still digest meat or other high-protein foods. Jeanne notes, that 14 years postoperative, "There's times when I can't eat for three or four days or two weeks at a time. I can't keep anything down. Even if I go back to mashed potatoes, I can't keep it." Joanne and Nadine, who also had VBGs, vomited frequently for three years after their surgery. The problem has since resolved itself, but fibrous meat remains a problem for Nadine.

Of all the sample members, Marcia's life has been the most negatively affected as a result of her weight loss surgery. Even though her surgeon had predicted she would soon be able to wear a size 9 after her JIB, Marcia only lost 70 pounds. For the first nine years after her surgery, she was plagued with frequent, foul-smelling bowel movements and flatulence, a common side effect of the JIB (Deitel 1998). The odor was so noxious that Marcia was too embarrassed to go to a public bathroom while there were other people there. Since she had approximately seven bowel movements a day, Marcia describes how going to the bathroom became an exercise in strategic planning:

The biggest problem there was the smell. The bowel movements and the gas were very, very malodorous. They were just horrible, horribly stinky. It was a problem for me at work because I would go to the bathroom when nobody else was in there. And then people started complaining to the building supervisor because that bathroom always had such a horrible, terrible odor and they had the building maintenance supervisor in there trying to figure out where that smell was coming from. They thought there was a

problem with the *drains*. And since I would only go when there was nobody else in there, nobody ever knew that it was me—that I know of. I was there the day they had the environmental people in trying to figure out where that smell was coming from. And it was very embarrassing. I started going to the bathroom on a different floor just so it would kind of maybe confuse them. And then people started reporting it from that floor, so they thought they had a building-wide problem. And it was just me!....If anybody had ever found out it was me, I would have just been mortified. It got so bad at work sometimes I would go to the Wendy's across the street and use the bathroom there rather than use it in our building because I didn't want to go to the bathroom in the building....You just can't believe the smell, it's just tremendously bad. You can't even be in the same room with it; it's almost asphyxiating. It's terrible. You just can't imagine how terrible it is (emphasis in original).

Later in her postoperative course, Marcia developed autoimmune problems, as evidenced by an eczematous rash and migratory arthritis. She has also sustained liver and kidney damage. Marcia has been advised that she may not live past the age of 55. She was 47 at the time of the interview. She knew numerous other people who also had a JIB and now almost all are dead. Marcia maintains her surgeon never advised her that the JIB was associated with serious, possibly life-threatening complications. The surgeon was surely aware of the complications associated with the JIB, as these were widely reported in the literature. The 1978 NIH Consensus Development Conference on surgery for obesity highlighted the adverse effects of the JIB and withdrew its support of the procedure as a treatment modality for the morbid obesity, and the JIB has rarely been performed since 1980 (Deitel 1998; Griffen, Bivins, and Bell 1983; NIH 1979; NIH Consensus Development Conference 1992). It is notable that Marcia had her JIB two years after most surgeons had stopped performing it.

Celeste is the only other sample member who had a JIB. Her operation was originally a success because she maintained a loss of 100 pounds for five years. Although she had watery, foul-smelling stools, "these were an appropriate price to pay for five anxiety-free years about my weight." This halcyon time came to an end, however, when Celeste experienced complications associated with her surgery:

Then in [January 1979], I started stiffening up in my body. I couldn't move my body. It was like being in a straitjacket. It was very painful. Right about that time, a surgeon from \_\_\_ called me and said, "You need to come to the hospital right now. I'm calling all the patients who had your surgery and we need to redo this."....It turned out that a lot of albumin had spilled into my interstitial spaces....While I was under, they did a liver biopsy and there had been some liver changes.

Marianne, Gisèle, Suzanne, and Juanita did not suffer deleterious side effects from their surgery, but they were not able to maintain permanent weight loss.

Marcia, Renate, Wanda, and Celeste are clearly worse off as result of the surgery. Their stories also indicate surgical success should not be determined by weight loss alone. Quality of life must be taken into consideration as well, and it would appear that at least some bariatric surgeons are aware of this (Baltasar et al. 1998; Halverson and Koehler 1981). Bariatric surgeons apparently trivialize or gloss over the inherent risks involved in these procedures (Fraser 1997). The inattention to possible surgically-induced morbidities may not be motivated by an intention to deceive patients but out of genuine conviction that the benefits of the surgery always outweigh the risks.

The women who experienced severe postoperative complications or who could not maintain weight loss managed this situation in a variety of ways. Yolande, Sherri, Valerie and Julie underwent further bariatric surgery, but for different reasons. Yolande, Valerie and Julie had more surgery because the prospect of returning to their pre-surgical weight was unacceptable to them, while Sherri decided to have another weight loss surgery in order to regain mobility. Yolande had her first VBG in 1979. She could not tolerate meat and vomited frequently. Despite her digestive problems, she was still able to eat a vast quantity of food, and her staples eventually burst. As a result, she regained her pre-surgical weight. Her surgeon offered her another type of gastroplasty, a procedure that was apparently more effective and associated with fewer problems. Despite this procedure's putative effectiveness, Yolande still vomited frequently and regained her pre-surgical weight after the second surgery. Her third bariatric procedure was an RNY, performed this time by another surgeon, in order to resolve the persistent vomiting and because the prospect of retaining the status of a morbidly obese woman was untenable to her.

Julie, who had an AGB as her primary surgery, lost weight rapidly but experienced numerous side effects as a result of the band and had to have it removed 15 months after it was inserted. As she describes:

I wanted the Adjustable Gastric Band which was still in the FDA trial at that point. In theory, it's a wonderful procedure. In reality, all but 20 of us had the band removed. I developed severe gastritis. I had a corrosion of my esophagus. I got into severe dehydration because I couldn't get anything to pass my band, it was twisted around my stomach....But I did very well with the band. I started out at almost 400 pounds; my pre-op weight was at 392. And I went down with the band to about 168. And with the band, which most people weren't doing anything with, I did very well. [The manufacturers of the band] did not want me to take the band out. I was one of the golden girls. They were doing an FDA study, and to get FDA approval, I was truly a golden case to them. They really wanted me to keep the band in. They didn't care about the fact that I was throwing up 12 times a day.

Julie's experience of a device while it is still in the experimental stage underscores the uncertainties involved in participating in clinical trials. Her account also exposes the murky ethics of manufacturers participating in FDA trials: The manufacturers of Julie's AGB obviously wanted to positively skew their results in order to obtain FDA approval.<sup>80</sup> Julie's account raises doubts as well as concerns about the extent to which the FDA is fully informed about the hazards of the AGB. Julie, who had been attracted to the gastric band because of its non-invasive properties, soon converted to a DS after the removal of her AGB because she quickly regained weight, and the prospect of returning to her pre-surgical weight was also unbearable:

The moment they released the restriction off the band, I immediately started gaining weight. I gained 20 pounds within five weeks. When they took the fluid out of the band, I was at 140 at that point. Then I was back up to 168. I was devastated. I saw 400 pounds coming back. I was there. In my head, I was, I can't go back there. I've worked too hard to get where I got. I would rather have died than to go back up to 400 pounds. I did not want to go back to that weight ever again. My body had gone into starvation mode because at that point my throat was so swollen, I couldn't eat. So once I could eat, I kept eating....I begged for a Duodenal Switch.

Valerie had another laparoscopic VBG performed four months after her first procedure. Her surgeon had promised her he would do an RNY if her VBG failed to work; despite this promise, however, he performed another VBG. He apparently has never outlined his reasons for his change of heart.

After the failure of her first surgery, Sherri decided her only viable option was to accept herself as a fat woman. She embraced the fat acceptance movement and became an outspoken critic of bariatric surgery. However, Sherri was forced to reconsider her position vis-à-vis the surgery when she became immobile as a consequence of her morbid obesity. She decided to have a second VBG in 1999 and has since lost 180 pounds. Although Sherri has experienced some mild surgical side effects, she is now ambulatory and has no regrets about having the surgery. As she says, "I'd have the surgery again tomorrow."

Renate, Wanda, and Celeste eventually had their primary procedures reversed and they regained—and in Wanda's case—greatly surpassed their pre-surgical weight (see Table 4.3). Marcia decided against

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<sup>80</sup> The FDA did indeed approve the use of the Adjustable Gastric Band in 2001.

getting her JIB reversed because she feared yet another surgery and because she was convinced it ultimately would not alleviate her problems.

### Problems with Long-Term Follow-Up

The bariatric surgery literature stresses the importance of life-long follow-up (Deitel 1998; Mason et al. 1997). According to Mason et al., “[s]urgical treatment of severe obesity deserves the same follow-up as is provided for the treatment of cancer (90% at yearly intervals following primary diagnosis)” (p. 196). Surgeons frequently note the difficulty of maintaining long-term follow-up of patients (Brolin 1992; Brolin et al. 1989; Choi et al. 1999; Powers and Rosemurgy 1989; Renquist et al. 1992). Surgeons commonly attribute this outcome to patients’ lack of motivation or embarrassment about weight regain (Hall et al. 1990; MacLean et al. 1990). However, my findings indicate that the surgeons themselves—the Canadian surgeons in particular—contribute to the problem of lack of follow-up, even during the period immediately following the surgery. For example, Nadine and Joanne were never once contacted by their surgeon’s office for a follow-up appointment after their surgery, nor did they contact the surgeon’s office themselves. Consequently, their surgeon has never seen them since their operation. Neither sister is concerned about the lack of follow-up but Nadine adds, “The surgeon really should have been more persistent. It was up to him to contact us, not us to contact him.” Valerie’s first follow-up appointment was canceled twice by her surgeon and it was two months before she was able to see him. During that period she gained weight, an occurrence she attributes to lack of guidance about a postoperative nutritional regimen. Gisèle, who experienced so many postoperative problems, was also never contacted by her surgeon for a follow-up visit after she had her umbilicus removed. She was so traumatized about her hemorrhage and removal of the umbilicus that she never saw her surgeon again. Jeanne recounts that when she was accepted as a candidate for the surgery, she was promised a 10-year follow-up by her surgeon. However, two years after her surgery, her surgeon informed her that he would not be following up bariatric patients any longer because the hospital had decided to terminate the weight loss surgery program. He advised her to consult her family doctor if she experienced problems related to the surgery, but Jeanne was not satisfied with that alternative:

He said the success rate wasn’t good enough for them so they weren’t seeing us anymore. If we had problems, go to our family doctor. But not any of us had ever consulted our family doctors so when you’d go back to them and say this is the kind of problem I’m

having, this is what's happening, [the family doctor would respond] "Don't tell me, go back and see the surgeon." So that's how we were left.

Similarly, Marcia and Doris were told by their surgeons that they had no reason to return to see them, even though they experienced problems associated with the surgery. Numerous women in the surgical failure sub-group also indicated that they refused further consultations with the operating surgeon because they mistrusted his competence.

I did note that life-long follow-up did not seem to be an issue of concern to my participants. Every woman who was longer than five years postoperative had not seen her surgeon in a number of years and expressed the opinion that it was not necessary to see him because her weight had stabilized and she was not experiencing any surgically related problems. Thus, it would seem that Grace (1992) and Higa, Boone, and Davies (2000) are correct in their speculation that patients may be reluctant to return to see the surgeon when they perceive there are no postoperative problems. The point remains, however, that surgeons are quick to blame patients for noncompliance with their directives for follow-up appointments. Yet, my findings show that the surgeons themselves are lax about maintaining long-term—and in some cases, short-term—follow-up.

### **EXPLAINING SURGICAL FAILURE**

In this section I explore the reasons why the surgery was unsuccessful for one third of the women in my sample. The literature frequently attributes failure to patient non-compliance with instructions regarding diet and exercise regimes following the surgery. These conclusions imply that the patient was a failure and not the surgery itself. My research challenges these assumptions. My participants' surgeries were not successful for various reasons; many of these are related directly to the surgical procedure as well as the surgeons themselves. For example, 12 of the 14 women's primary bariatric surgeries were gastric restrictive surgeries. The medical literature notes that the VBG and HBG are associated with high failure rates (Baltasar et al. 1998; Mun et al. 2001; Versélewel de Witt Hamer, Hunfeld, and Tuinebreijer 1999; Ramsey-Stewart 1995). The HBG is now considered an obsolete procedure (Deitel and Anand 1989; Kral 1992a). As mentioned earlier, the JIB, the only malabsorptive surgery to be included in this sub-sample, is

no longer performed because of the high incidence of serious complications (Balsiger et al 2000; Deitel 1998; Eckhout and Willbanks 1989; Mun et al. 2001).

Surgeon incompetence is clearly implicated in Wanda's case. Wanda became incapacitated as a result of the frequent vomiting and consulted another surgeon. This surgeon discovered her esophagus was completely obstructed and that her entire abdominal wall was herniated. The surgeon made another startling discovery: The band that was supposed to be sutured to Wanda's stomach, was actually sutured to her esophagus.<sup>81</sup> The band was removed during that operation and she has at least stopped vomiting. But she estimates she has between 15 to 20 bowel movements a day and suspects her current gastrointestinal difficulties are related to her surgeries.

Surgeon inexperience, tinged with indifference, is also implicated in one of the surgical failures. Valerie's surgeon was very inexperienced, apparently having started to perform bariatric surgeries just six months prior to Valerie's surgery. Since he was unknown, he had a very short waiting list for a consultation and the operation. Valerie admits she chose him on the basis of his short waiting list. As mentioned earlier, she received no immediate follow-up care from the surgeon, as his office canceled two appointments after her surgery. She saw him two months later when she wanted to advise him she had gained weight, instead of losing it. Her surgeon was very angry when she told him what she was eating, which was apparently contra-indicated for bariatric patients who are recovering from bariatric surgery. Valerie points out, however, that she was not provided with any guidance about what to eat.

High preoperative weight may also be a reason why the surgery failed to work for some participants. Five of the 10 women in the surgical failure group--Marcia, Wanda, Renate, Marianne, and Jeanne--had the highest preoperative weights among the women in the whole sample. The literature indicates that the heavier the patient, the lower the chances of achieving a significant weight loss (Brolin 2002).

There is yet another factor to consider in the case of the surgical failures. In Chapter 5, it was

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<sup>81</sup> Both Marcia and Wanda consulted attorneys about the possibility of initiating a lawsuit against their respective surgeons. They were advised against this action because the chances of winning a significant settlement from the surgeons were low.



revealed that some participants attributed their morbid obesity as a coping mechanism to stress, a phenomenon Bruch (1973) describes as “reactive obesity.” As drastic a measure as weight loss surgery is, it does not avert the occurrence of reactive obesity. Doris, Gisèle, and Suzanne feel they regained their pre-surgical weight in response to traumatic events in their lives. Doris, who suspects she originally became fat as a reaction to a childhood trauma, suffered an incapacitating stroke three years after her surgery. The stroke came as a blow to Doris who felt she was in the process of reconstructing her life. She had left a dysfunctional marriage, lost at least 100 pounds after her VBG, and earned a secretarial diploma. She was successful at her secretarial job. She feels she overate as a response to the insurmountable sense of injustice she felt after suffering her stroke. As she explains, “I was angry. I ate everything that wasn’t nailed down. In the space of one year, I had gone to 430 pounds. I was inactive too, I can’t do much, being hooked up to an oxygen tank.”

Gisèle and Suzanne each became depressed after their respective divorces and gained a considerable amount of weight after this event. Neither of these women attributes her weight regain entirely to emotional trauma following divorce, however. Both noted the metaphorically protective nature of fat and suspect they unconsciously sought to envelop themselves in a blanket of fat, albeit for different reasons:

Gisèle: I started gaining weight when I stopped smoking in 1991 or 1992. I stopped smoking because I couldn’t afford it anymore. I was on welfare because my ex-husband wouldn’t pay child support. I had started having panic attacks and could no longer work...When I stopped smoking, I put on an awful lot of weight then, back to where I was before the operation. You won’t believe this, I didn’t even notice that I had regained the weight....I had been estranged from my family for many years....I felt totally disassociated from society. I didn’t even notice that I was gaining weight....I’ve never understood that: Why didn’t I realize that I was gaining weight? I’ve analyzed it often. I figured I was erecting a barricade, a protective wall around myself. I don’t know if that was true or if it was laziness on my part. I’m under the impression that I’ll never know. I’ll never know because the state of mind that I was in then I’m no longer in now.

Glinski, Wetzler, and Goodman (2001) describe patients whose fears of intimacy unconsciously motivate them to create a “wall” which pushes others away. The authors observe, “[o]ne woman stated that her obesity allows her to “filter out” cruel people” (p. 585).<sup>82</sup> Gisèle, who was estranged from her family

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<sup>82</sup> See also Kral (1992a).

during this period of her life, may have sought to protect herself from further hurt by using fat as a filtering mechanism.

Her sister Suzanne explains how she also uses fat as a shield:

I realize now I became obese again to have peace. When I was thin and had perfect dimensions, 36-24-36, what did men see in me? My body. I could never have a discussion with a man. The only thing they thought about was my body. When I began to gain weight, men started having discussions with me because they weren't thinking about my body. They noticed that I had a brain. So now I wonder if I unconsciously became obese so I could be taken seriously by men.

Feminist psychotherapist Orbach (1978) suggests that some women unconsciously become fat to be considered as men's equals in a working context rather than as objects of sexual desire. Female fatness functions as a form of sexual neutering, thereby freeing men of distractions such as a woman's sexuality and forcing them to view her as a competent person (See Chapter 3). It was not clear to me whether Suzanne was specifically referring to male colleagues when she spoke about men viewing her as an engaging conversational partner. Suzanne frequently stated how happy she was living alone and that she would never again get involved in a romantic relationship. Her fatness is a signal to warn men to "keep out" and spares her the bother of unwanted male attention.

Finally, the women whose surgeries have failed share another significant commonality. Suzanne, Yolande, Sherri, and Julie had surgeries that were still in the experimental and developmental stages. Sherri was the first female patient in her county to undergo a VBG; Suzanne and Yolande were the second and thirteenth patients, respectively, to undergo the VBG in Quebec. Julie's AGB had not even been approved by the FDA. All persons who participate in a nascent medical treatment run the risk of being human guinea pigs; the medical practitioners are literally learning their craft on their bodies of their patients. Patients who have recently undergone the "more refined" bariatric surgical techniques must acknowledge these procedures are only refined because lessons were learned from the experiences of earlier patients.

## ADAPTING TO SURGICAL FAILURE: ACHIEVING RE-SELVEMENT THROUGH SELF-ACCEPTANCE

In this section, I describe how the sample members whose surgery was considered a failure by medical standards have adapted to the failed results. I argue that, in contrast to the surgical successes who have become re-embodied, these women have become re-selved. They may not have achieved success through surgery, but they did indicate a high degree of contentment with their lives.

The 10 women in the surgical failure group undertake various strategies to manage their failed bid to lose weight. Eight of these women are adamant that further bariatric surgery is not an option for them. They maintain they are not tempted by the apparent refinement in bariatric surgical techniques that increase the chances of a successful procedure because they are skeptical that bariatric surgery is safe or effective in the long term. These women are very critical of weight loss surgery, with Wanda and Juanita even referring to the surgery as “self-mutilation.” Marcia, in particular, has been very vocal in her criticism of bariatric surgeons and their slick marketing techniques in selling “the dream” to fat patients and has expressed her opinions in various media.

Renate and Celeste are the only members of the surgical failure group to have seriously considered having further bariatric surgery. After the reversal of her VBG, Renate regained her pre-surgical weight of 496 pounds. The steady weight gain has been agonizing for her, as she greatly fears gaining hundreds more pounds and becoming “a person who weighs 1,000 pounds and who needs a forklift to get to the hospital.” She reiterated this anxiety throughout the interview. Renate recently considered undergoing an RNY, but with her history of pulmonary embolism, she has been rejected by several surgeons on the grounds that she is an unacceptably high-risk patient. Renate described herself as devastated by these rejections, but added, “After hearing myself talk about everything, I’m afraid to have weight loss surgery again.”

Celeste was also tempted to undergo another weight loss surgical procedure. Her insurance plan had offered to cover the cost of an RNY, but she ultimately decided against it, even though “it would be wonderful to be thin,” after witnessing the surgical side effects experienced by others close to her:

My sister just had a Roux-en-Y and another good friend of mine just had a Roux-en-Y....They both look really good.....But [they] have to do all this weighing and measuring and considering every single bite they put into their mouths. If they eat this, they’ll get

sick. If they eat that, they get sick. We all went out for drinks and dinner one night and my friend spent 20 minutes pouring over the menu, figuring out what she could have that wouldn't make her sick. I don't want to do that. I thought to myself, I don't want to go through all that nonsense again.

However, Celeste, who was 61 at the time of the interview, has not given up on the idea of losing weight altogether—she just prefers to achieve this goal using nonsurgical means. During the interview, she extolled the virtues of a bestselling diet book which she claims has been very helpful in her recent modest weight loss. She also takes weight loss pills. Jeanne, who was 59 at the time of the interview, also expressed an intense desire to lose weight, although she is not currently dieting or pursuing other weight loss options. Celeste and Jeanne's accounts illustrate how unhappiness about weight preoccupation can last a woman's lifetime.<sup>83</sup>

The other eight women in the surgical failure group have foresworn diets, pills, and other weight loss measures. They explained that since the ultimate solution to morbid obesity had failed to work, they felt they had no other option but to accept the fact they would be fat for the rest of their lives. While the surgical successes describe their post-surgical bodies as "this is who I really am," ironically, all the women in the surgical failure group have also come to a similar conclusion: Their fat bodies are their "real" bodies, the bodies they are meant to have. They no longer think of themselves as future thin women. Their equanimity about this conclusion varies, with Celeste, Jeanne and Doris expressing more resignation and despair. These three women are profoundly disembodied and probably will remain so for the rest of their lives. There are various reasons why these particular women are so disconnected from their bodies. Celeste attributes her ongoing determination to lose weight as a byproduct of having been raised in Hollywood, California "where size is everything." Jeanne was verbally abused by her mother throughout her childhood and adult life. Her mother was relentless in her criticisms of her weight, and Jeanne may therefore make an exceptional association between obesity and deviance. Finally, Doris professed a life-long abhorrence of her fat body. As she puts it, "I don't like it. I never have liked it and I never will." Her

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<sup>83</sup> See also Grogan et al. (in Grogan 1999); Jackson (1992) and Pliner, Chaikin and Flett (1990). These authors conclude that weight and other appearance concerns are not limited to young women.

stroke, which has left her connected to an oxygen tank and barely capable of moving, can only have intensified her alienation from her body.

However, the other seven women have renegotiated the relationship between body, self and identity by severing the body from the self. Having come to accept their fatness, they are also no longer burdened by two dichotomous selves, the double identity described by Millman (1980:220). They have only one self, but they deny this is inherently a deviant self on the grounds that the body does not represent the character of the person residing in it:

Wanda: This is some body. It is what God gave me and this is what I have made it. It only houses what is inside me. It gives my heart and lungs a place to live. My spirit lives there and I think I'm a very nice person. I'm a loving person and if someone cannot see me through the fat, then that's their loss.

Marcia: I still wish I were thinner because life would be easier, but as far as it being any kind of reflection on what kind of character I might have or what kind of worth I might have to society or to the world in general, fatness isn't an issue.

Gisèle: You know, when it comes down to it, you can't judge someone's character by their weight. You should judge them by what they say or do, but not by their appearance....So I'm fat, so what? This doesn't mean I'm a bad person. Is a thin person good just because she's thin?....I don't let other people's opinions bother me anymore....A person can go ahead and dislike me if I've done something they don't like, but they can't dislike me because I'm fat. That's simply not a good reason not to like someone.

These women challenge the popular conception that the body is a physical manifestation of the self. Their bodies may be deviant, but *they* are not deviant by association. I infer from this argument that they view the body and the self as separate entities. Severing the body from the self allows them to reclaim their bodies and construct a more normative, or at least a non-deviant, identity by neutralizing the characterological stigma of fat (Goffman 1963). While the surgical successes have become re-embodied, the surgical failures have become re-selved. These women's renegotiated sense of self and identity and the equilibrium they now feel indicates that contentment, for fat women, is not only achievable by altering the body. Altering one's sense of self to accept one's fat body is also effective and may be many fat women's only option if they are to live free from emotional torment. Women who are able to achieve this state have also attained an admirable degree of success in resolving their weight issues and reducing the significance of weight in their lives. It would be grossly unfair to them to consider them solely as weight management

failures on the grounds their bariatric surgery did not result in the expected outcome. Success in the context of weight management, then, should not only be restricted to changes in the body but should expand to include positive changes in self and identity.

### The Role of the Size Acceptance Movement

The epiphany about the value of self-acceptance was not only achieved through an awareness of the futility of weight loss attempts. Marcia, Renate, Marianne, Juanita, and Wanda became involved—in varying degrees—in NAAFA after the failure of their surgeries.<sup>84</sup> For the first time in their lives, these women found a social group that welcomed them and accepted them *because* of their weight, not in spite of it. NAAFA provides a protective atmosphere where experiences of fat victimization are validated, as well as resources to help them come to terms with being fat (see *NAAFA Workbook* 1995). Marianne describes the benefits she has derived from her involvement in NAAFA:

It's made me more accepting of myself. I still feel different....That's always been a problem for me, but I feel certainly less isolated. It's helped me not to feel like I'm the only fat person in the world and that has helped a lot. I feel a little bit more empowered by it. Just being with people who go through the same things that I do...and I feel comfortable being with people closer to my size or to people who can appreciate my size—or at least not run me down because of it.

Gisèle and Suzanne feel they achieved size acceptance after reading books about fat women's body image and have attended—and later facilitated—workshops on this subject.

Self-acceptance has also given these women the strength to directly confront fatphobia. For instance, Renate, who was once victimized by doctors on account of her weight, now tells them her weight is off limits and that they are to treat her for her presenting condition. Wanda confronts the many teenage boys who harass her in malls and they invariably back down first. She has also warned her family not to admonish her about her weight. Suzanne, who weighs 405 pounds, reassures a person who comments on her size that she has an intelligence quotient that is commensurate to her weight.

The women in my sample whose surgeries were unsuccessful did not give me the impression they are happy being fat, although they do appear to have reached an impressive level of contentment with their

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<sup>84</sup> Sherri and Julie are also members of NAAFA, but since they eventually had successful surgeries, their NAAFA experiences are considered separately.

lives. Marcia, Marianne, and Juanita are single and never expect to become involved in a major relationship with a male partner. While they would like male companionship and express regret they never had children, they cherish their independence. Suzanne and Doris also enjoy living alone and vow they will never remarry. Gisèle, Celeste and Wanda are happily partnered with men who are accepting of their weight.

To summarize, the overwhelming majority of the women in the surgical failure group have concluded, with varying degrees of equanimity, that weight loss is not a possible pursuit for them. Most feel a more productive strategy vis-à-vis their weight is to simply accept themselves as fat women and to incorporate their body size as a neutral part of their identity. They achieved a sense of re-selvement once they were able to renegotiate their relationship between body and self. The women who accepted themselves appeared to be the most well adjusted of the surgical failure group.

#### **SELF-ACCEPTANCE VERSUS SURGERY: THE RIGHT TO CHOOSE**

Weight loss surgery and self-acceptance are the most extreme options for fat people, and the merits of each are furiously debated. I noted the same discourse among my sample members. It is worthwhile pointing out that the women whose surgeries failed are not the only supporters of NAAFA or other fat acceptance groups. Sherri and Julie were also members of NAAFA before their surgeries and highly involved in the organization's activities. Casey and Catherine also claim to have been influenced by the ideology of size acceptance, but their involvement is limited to reading books and perusing Internet sites on the subject. These women also maintain they feel greatly empowered by NAAFA's mission and accomplishments. NAAFA has been vociferous in its condemnation of bariatric surgery, citing the frequency of surgical complications and urges its members to not have the surgery (see *NAAFA Workbook* 1995). I asked Sherri and Julie if weight loss surgery was antithetical to participation in the fat acceptance movement, and both denied this suggestion, arguing weight loss surgery is legitimate when it is undergone for health reasons. They also condemn the organization's intransigent stance against the surgery. As they explain, surgery is necessitated in some cases and the person himself or herself is in the best position to choose whether surgery is a viable option:

Julie: NAAFA has a very negative view of weight loss surgery....They're like, radical fat women with attitude. I don't like negative people. Everything is negative and bad and they're coming to get us....NAAFA's position on weight loss surgery is cut and dried: weight loss surgery is bad for everyone. Weight loss surgery *isn't* bad for everyone. It is bad for certain people; it's great for certain people, but you can't make this blanket decision that being fat is healthy. When I see these women who are in a wheelchair, on oxygen, can't move, can't wash themselves--are you telling me they're healthy? *Come on* (emphasis in original).

Sherri: I would like to see NAAFA voice more support for weight loss surgery. It's not the panacea for all problems, but it's a good thing for some people to do. Sometimes people do it for their health, not to become a glamor girl. NAAFA has to recognize that.

Neither Sherri nor Julie was ostracized by other NAAFA members after they had their surgery, although many of them were not in favor of the surgery as a matter of principle. The members of Renate's chapter are aware she is considering further surgery, and although they tell her they are concerned she may experience more surgically related problems, they understand her reasons for wanting the surgery.

Ironically, Sherri, Renate and Julie observe that other members of their local chapters have had the surgery as well. In Gimlin's (2002) ethnographic study of a NAAFA chapter, she found that a substantial number of women in this group were trying to lose weight.

To my surprise, as much as the sample participants in the surgical failure group are critical of the surgery, all but one would not want the surgery to be discontinued. Even the most outspoken detractors of the surgery support women's right to have it, with the proviso that they are fully informed of the risks involved. Renate and Marianne also echo Julie and Sherri's frustration about NAAFA's stand that weight loss surgery is inadvisable under any circumstances:

Renate: I don't have to agree with everything NAAFA says....I don't feel bad about considering weight loss surgery, not at all. NAAFA argues that any obese person should be as healthy as they are. I don't agree with that. I think there are people who weigh 400 pounds and that are healthy, but there are some of us that aren't....Sometimes they go to an extreme with it. This can be a useful procedure for some people. I don't believe that it's the perfect answer for everybody, but it's good for some people....I have a hard time following any extremes....I want to make my own decisions based on my own needs and worries.

Marianne: I think of it, sort of like how some people feel about abortion, that it's a personal decision. If that's what a person wants and is willing to go through that to be at a size they feel more comfortable being, I certainly wouldn't condemn someone for doing that. If a person thinks that's the best thing for them, who am I to say whether they should have it done or not....I think even the people in NAAFA are starting to slowly come around to it [the surgery]. They're never going to support it, but I think that they're starting to understand that they need to respect people's opinions and their feelings. And



I'm not out going around telling people that they should have weight loss surgery or they should not. All I'm saying is, you should choose to do that for yourself and you need to make an informed decision. If you choose *not* to have it, you have the same rights as anyone else and you should be accepted the same as anyone else, if you should choose not to have it (emphasis in original).

Juanita is the only NAAFAn in the surgical failure group who is firmly convinced that the surgery should no longer be offered as a treatment modality for morbidly obese people:

It's not healthy and it's not necessary. Surgery should be done if we're sick or we have something wrong inside of us but not to make us lose weight. It's too drastic.

Juanita's antagonistic position is somewhat difficult for me to explain, as she herself did not suffer complications from her VBG. While she is a member of NAAFA, she does not appear to have taken leadership positions in her local chapter. Unlike Sherri, Julie, and Renate, she clearly does not believe surgery can alleviate obesity-related morbidities. The other NAAFANs in my sample, however, strongly advocate women's agency, including women's surgical agency. Those members who voiced complaints about NAAFA's policy on weight loss surgery focus on the organization's adoption of a standardized approach to weight loss surgery and argue the decision to undergo the surgery should be an individual decision. Successful bariatric surgery has not diminished Sherri, Julie, Casey and Catherine's commitment to fat-affirmative goals and values.

Elaine and Jennifer make a similar argument. They complain of overt hostility from size acceptance activists or by fat women who condemn the surgery in principle. Both of these women insist this antagonism is misplaced, as they do not advocate the surgery as a strategy for all fat people. As they explain, they are not pro-surgery, but pro-choice:

Elaine: They think that surgery is caving in to society's demands for a thin and beautiful body and it's like...they don't acknowledge the health reasons why people do this. I think they're their own worst enemy to a certain degree....I don't advocate surgery. What I advocate is people having the choice to make the choice that is best for them....I'm not saying that everyone that's morbidly obese *must* have the surgery. I disagree with that idea..... I'm more for everyone should have the right to make their own decision about this (emphasis in original).

Jennifer: It's really funny. If it wasn't for their militant attitude against weight loss surgery, we'd be on the same side. They can be very condescending to their own possible constituency. I appreciate what they've done for fat people's rights, to get restaurant accommodations, that sort of thing. That kind of movement has made people realize that fat people have rights too. As far as the movement saying that if you're fat, you should stay fat, that you're fine the way you are, well, I might not be fine the way I

am....They're very militant about weight loss surgery. They're not very accepting of you. I've experienced discrimination at [events sponsored by various size acceptance groups]. There's always a contingent that says you shouldn't do this....People ask you questions about it. I'm honest and I say it worked for me and I'm glad I did it, but I don't say surgery's the only way to go, you have to have it. Finally their hackles back down because they realize I'm not pro-surgery, I'm pro-choice.

However, a large number of my sample members, particularly those who comprised the surgical success group, were not influenced by the values of the fat acceptance movement and certainly did not view self-acceptance as a viable option for them. Although the majority of the women in this category are still fat themselves and express empathy for morbidly obese people, they do not identify with the activist goals of the fat acceptance movement. They indicated they admired fat women who accepted their bodies but maintained that this strategy was simply not a possibility for them. Many expressed doubts that it was actually possible for a fat woman to be truly happy with her weight:

Cinzia: I commend anybody who's happy being a large size. I say, more power to you if you got there. I couldn't go there. I know people who'd say, I'm happy being large, I'm just as healthy—I don't *buy* it. I don't think that if anybody could just have a magic wand and be thin, I can't see why that person would not do it (emphasis in original).

Cynthia: I don't know if I can agree with them that they're doing the self-acceptance thing and they accept their body. I have a hard time believing they're truly, deeply happy being fat. I've been there. I told people, Yeah I know I'm fat but I know I'm good looking. I always tried to portray myself as outgoing and that I loved myself. But when I came home at night, I'd be depressed in some aspects. Yeah, outwardly I wanted to tell everybody this is me, this is who I am, and if you don't like it, you can hit the highway kind of thing. But when I came home at night, it was, like, no. It was more of a denial. I have a hard time believing...If that's what they truly feel, deep down inside, then I would support that, but I have a really, really hard time believing that they're that proud of themselves. If they are, all the power to them. But I have a hard time believing they're really, truly happy with who they are.

Celeste: The fat pride movement is not an option for me, no *way*! I think they're crazy. [simplering voice] "Oh, look at how beautiful I am and look how big I am. Who cares if I have diabetes and who cares if my feet are going to dissolve underneath me because I'm so heavy?" [normal voice] That's just *nuts*! I think they want to mean what they say, but I think they have truly given up. If another woman feels fine about herself, fine, go for it. But I think it's delusional. I wouldn't have anything to do with it for myself (emphasis in original).

While these comments may suggest that these women are not supportive of women who elect self-acceptance, I argue this is not entirely the case. They profess admiration and respect for the self-accepting fat women. There is an implicit acknowledgement that it takes a great deal of courage to stand up to the

hegemonic weight ideal. In an earlier section I discussed the surgical success' recognition that surgery is not an optimal solution for every morbidly obese person.

For their part, the surgical failures—with the exception of one participant—do not want to see the surgery discontinued. They acknowledge that accepting oneself as a fat woman is not an option for every fat woman. They too support women's right to choose what is best for them.

Both weight loss surgery and self-acceptance elicit strong opinions from fat individuals. This debate does not promise to be resolved in a timely manner. Perhaps it can only be resolved by recognizing that fat people themselves—not their spouses, family members, doctors, or fellow NAAFA members--must have the right to choose how best to strategize their fatness.

### **SUMMARY OF FINDINGS**

This findings chapter examines my sample's lives after their bariatric surgery, from their hospital experiences onwards. More than three-quarters of the participants experienced unremarkable surgeries and perioperative periods. Some points of frustration were noted, however. Although two participants' surgeons were experienced in the field of bariatric surgery, the hospitals in which they operated did not have adequate facilities to meet the needs of morbidly obese patients. In four cases, fatphobic nurses also contributed to the atmosphere of insensitivity. Surgeons and nurses also trivialized the women's pre- and postoperative concerns.

Twenty women had successful bariatric surgeries, with four women undergoing more than one procedure before they could achieve surgical success. Ten women had unsuccessful surgeries. Five women in this category regained their pre-surgical weight, without experiencing deleterious surgical side effects. Five other women not only regained their excess weight, they also suffered—and in some cases continue to suffer--intolerable, surgical morbidities such as debilitating vomiting, frequent bowel movements and autoimmune dysfunction, among others. Three participants were so incapacitated by these morbidities they had to have their procedures reversed. Gastric restrictive operations dominated the surgical failure category.

As the women in the surgical success category lost weight, they reported marked improvements in the co-morbidities that plagued them before their operation. Many of these medical conditions were alleviated by the weight loss. Psychosocial improvements such as greater self-esteem and self-confidence were also correlated with weight loss. The sample participants felt their bodies were more attractive by virtue of becoming more normative and in alignment with their sense of self. Their lifestyles changed dramatically as they became more mobile and outgoing. The majority of the participants reported the quality of their relationship with their spouses, as well as their sex lives improved as a result of their greater self-confidence. They also felt their employability was enhanced. Sixteen women were involved in a surgical support group and credit this experience as having greatly helped them in the transition from pre- to postsurgery. Perhaps more important than anything else, these women attained a sense of normalcy that had long been denied to them.

Weight loss also resulted in a change of embodied experience for the surgical successes, a process that I refer to as re-embodiment. They had been acutely alienated from their bodies prior to their surgery, not only in an aesthetic sense but because they felt it did not reflect who they “really” were. These women were re-embodied once they felt their postoperative body (the authentic body) more closely conformed to the authentic self.

There were some negative aspects to the bariatric surgical experience besides failure. While most of the women in the sample considered these side effects to be tolerable and “an okay price to pay,” bariatric surgery is major abdominal surgery and is never incurred without risk.

Negative non-medical events were also associated with the surgery. Five women reported their weight loss acted as a stressor to their marriages; four of these women are now divorced or separated and all attribute their former husbands’ insecurities over their weight loss as a factor in the rupture. The participant who remains with her husband complains he tries to make her insecure about other aspects of her appearance and does not foresee a long-term future with him. Some women noted their relationships with other morbidly obese women were also disrupted. These events illustrate that weight can serve as a key component in maintaining the balance of power in intimate relationships.

Surgical failure is managed in different ways. All ten women in this group accept they will always be fat. Nine are no longer attempting to lose weight. The three oldest women in the surgical failure category are resigned, more than accepting, of their weight and continue to feel detached from their bodies. The other women take a more active approach to acceptance. They shrug off others' negative opinions of fatness and deny the body is an indicator of personal characteristics. They maintain their worth as people should not be evaluated on the basis of the cultural acceptability of their bodies. These women therefore challenge the popular conception that the body is a physical manifestation of the self. This challenge involves the severing of the self from the body and positioning the self of the fat woman as non-deviant. I refer to this process as re-selvment because it involves the re-adjustment of their sense of self to accommodate the realities of their current body. To summarize, the surgical successes have become re-embodied, while the surgical failures have become re-selved.

In view of these findings, I argue self-acceptance and re-selvment should be considered as successful adaptive measures to the stigma of fatness. While weight loss has been the conventional means of addressing fat stigma, it is simply not possible for every fat person to lose weight. In this context, self-acceptance is under-recognized as a viable option. A fat person's self-acceptance may be widely interpreted as evidence of an admission of failure: It is an outcome achieved only when everything else has failed. However, it takes a high degree of courage and inner strength to accept oneself as a fat person, particularly as a fat woman. A fat woman who is self-accepting and who demands respect from others is successful by virtue of the difficulty of this feat. The definition of success and failure should be expanded to include the extent to which women are able to effectively address their weight issues.

The fat acceptance movement proved to be very influential for participants in both groups. Seven sample participants are involved in NAAFA and their involvement in this organization has helped them come to terms with their fatness. Two other participants have read material on this subject which inspired them to think of themselves in a more positive manner. All the women who are involved with NAAFA feel greatly empowered by its mission to confront fatphobia and the succor that it provides them from a hostile world. However, most objected to NAAFA's negative view of weight loss surgery, indicating they felt the organization was too closed-minded about this procedure.

The overwhelming majority of my sample members agree that weight loss surgery or self-acceptance is an individual choice and every fat person must be given the space within which to make that choice and have it respected by others.

### **AGENCY REVISITED**

The theme of agency is predominant throughout the last two chapters. It first became evident when the women in my sample decided to undergo surgery: They had an overwhelming problem and took a measure to actively address it, rather than passively accepting the status quo. With few exceptions, the sample participants maintained they underwent the surgery for themselves, not to please significant others.

The women whose surgery was successful clearly believe the procedure allowed them to become more agentic in every aspect of their lives. However, most of the women whose surgeries resulted in failure should also be viewed as agents. The majority of the women in this category accept their fatness as a permanent state. Unlike most fat women they do not live their lives in abeyance to the time when they will lose weight. They are agentic in that they refuse to be oppressed by fatphobia and normative standards of femininity.

Both groups have created spaces of empowerment for themselves, and by participating in this dissertation work, they have created spaces of empowerment for fat women who seek bariatric surgery and for women who want to manage surgical failure.

## CHAPTER EIGHT

### CONCLUSION

This dissertation has focused on the experiences of 30 women who have undergone bariatric surgery. I have described and analyzed why the participants in this research came to have the surgery and what impact the surgery had on their lives, as well as their sense of self. The analysis of the women's surgical odysseys goes beyond description of their points of view, to provide a sociological explanation of personal experience in terms of the social organizations and social processes that shape this experience. In this concluding chapter, I tie together the threads of the arguments I have made in the preceding chapters.

### SUMMARY OF FINDINGS

My study of women's experiences of weight loss surgery suggests that they view it as a radical solution to a severe problem. Their morbidly obese status cast a shadow on virtually every aspect of their lives prior to their surgery. The excess weight was a physical, emotional, and medical burden that appeared impossible to overcome. They were perceived by others as deviants and suffered the social sanctions commonly meted out to deviants. My sample members internalized the perception of their bodies as aberrant, as evidenced by their descriptions of their pre-surgical bodies as "ugly," "gross," and "disgusting." As a result of this negative body image, they distanced themselves from their bodies, avoiding mirrors and cameras and focused mainly on their faces—a strategy Millman (1980:195) describes as "living from the face up." They were also distressed by the incongruence between the pre-surgical body and the flawed self it allegedly represented.

Despite this intense bodily dissatisfaction, half the sample underwent bariatric surgery for "medical reasons," that is, their decision to have the surgery was motivated more by the desire to alleviate the discomfort of obesity comorbidities than to reshape their bodies to conform to dominant cultural ideals. They did not want a slender body as much as they wanted a functioning body. Thus, these findings refute

the claims of fat feminists (MacInnis 1993; Wolfe 1983) that women undergo this procedure *purely* for cosmetic reasons.

Overall, my sample members are satisfied with the results of the surgery or are happy they at least underwent it. Bariatric surgery, even in the cases where the effects were short lived, enabled these women to live their lives in the moment, rather than in the mythical future. Not surprisingly, all of the 20 women whose surgery was successful declared they were highly pleased with the surgical outcome. Success, in this context, is not related to the attainment of an ideal weight as defined by clinical or cultural standards, but to a substantial weight loss, improved health, and an enhanced quality of life. I refer to these women as “surgical successes.”

However, this research also reveals that weight loss surgery is not always a permanent solution to morbid obesity, nor is it incurred without risk. Four women in the surgical success group only achieved this status after additional operations subsequent to a failed primary procedure. Ten women in my sample, whom I refer to as “surgical failures,” did not maintain a significant weight loss or suffered such extreme side effects that the operation had to be reversed. These women had procedures that are associated with high rates of complications and failure to maintain weight loss. For various reasons they did not have further bariatric surgery.

Reactions towards the surgical experience varied amongst this sub-sample. For instance, Marcia and Wanda deeply regret having had their surgeries, while Celeste and Doris are happy they had a few years where morbid obesity was not the central focus of their lives. Gisèle is bitter about her treatment at the hands of the medical profession, but she credits her weight loss as enabling her to improve her employment prospects. Greater financial autonomy, in turn, enabled her to leave a violent marriage. Not surprisingly, the severity and duration of adverse side effects positively or negatively influenced opinions about the operation.

It must also be stressed that the women in the surgical failure group demonstrate surgical failure is not synonymous with disempowerment. Seven of these 10 women indicate they are no longer ashamed of their weight or bothered by the stigmatization of obesity. While their physical health has been compromised by weight loss surgery and by obesity comorbidities, their mental health (as indicated by self-



esteem, self-confidence, and satisfaction with life) appears to mirror the status of the women in the surgical success group. These women credit their contentment to self-acceptance of themselves as fat women. Five of the seven women in this sub-group achieved self-acceptance through involvement in the size acceptance movement.

The women's experiences of embodiment and sense of self changed in the aftermath of bariatric surgery—regardless of the surgical results. The women in the surgical success group reported they are “new” people, not only because of the dramatic physical transformation of their bodies, but also because of the greatly increased self-confidence that accompanied their weight loss. While they felt they had not changed fundamentally as people since their surgery, they felt their excess weight obscured the real self from others, and the surgery whittled away the layers of fat to reveal the “real” body and the “real” self. The surgical successes thought that weight loss surgery established a congruency between the body and the self. The integration between body and self enabled these women to establish a connection to their bodies that had been hitherto unknown, a process I describe as “re-embodiment.”

The seven women in the surgical failure group who now accept the permanence of their fatness have also experienced an identity change, but they view the body and the self as entirely distinct entities. Whereas the surgical successes may position their bodies as a reflection of the self, these women strenuously argue against that view. In particular, they do not accept the popular conclusion that the fat body is overt evidence of an anomalous self, and that by extension, they are anomalous people. Rather, they argue the body is a casing for the self, not a mirror of it. The self of a very fat woman cannot be inferred from her body; more importantly, it is not necessarily deviant. I propose that these women have become re-selved because they have comfortably integrated their fatness in their identities.

This research has also demonstrated that bariatric surgeons are ambivalent towards their patients. Surgeons tended to vary widely in their approach to patient education, assistance in decision making, and preoperative testing. Some sample members described receiving detailed information packets containing booklets, diagrams, and videos, while others received no supplemental information to that provided by the surgeon. The Canadian surgeons, in particular, appeared to be remiss in their efforts to educate their patients about the rigors of the surgery.

Counseling about the advisability of undergoing the surgery also varied from the unmitigated conviction that morbid obesity required immediate surgical action to suggesting a one-month "cooling-off" period. The surgeons who advocated deliberation before decision making tended to also suggest attendance at surgical support group meetings, as well as speaking to patients who were not satisfied with the surgery.

The variability in preoperative testing was particularly striking; in particular, the guideline set by the Task Force of the American Society for Clinical Nutrition (1985) of a thorough psychological evaluation before the surgery was ignored altogether or implemented only very loosely. For example, some patients met with a therapist in person, others had a telephone consultation or filled out short questionnaires. Seventeen participants did not have any psychological examination at all. Virtually all the sample members who consulted the therapist suggested by the surgeon were derisive of the experience and felt it had no value to their recovery and adjustment.

Surgeon ambivalence was also demonstrated by the lack of adequate furniture, examining equipment, and accessories in the care of the morbidly obese patient. This is noteworthy, as bariatric surgeons' patients are restricted to the morbidly obese.

Despite these issues, my sample members voiced few criticisms of their surgeons, although the women whose surgery ended in failure were more critical. With the exception of Catherine, all the women in the surgical success group indicated that their assessment of their surgeon was primarily based on the surgical results. The surgeons themselves stressed the anticipated weight loss to the exclusion of other aspects of the surgery, such as morbidity risks and proper postoperative dietary regimen. This is a disturbing finding because outcome of treatment is an inadequate criterion for assessing the performance of medical practitioners. Since weight loss surgery patients are typically desperate by the time they meet with a surgeon, they are not likely to question their quality of care. Their vulnerability allows the surgeons to maintain extraordinary authority and power in their interactions with their patients. The focus on weight loss also suggests that the surgeons view their patients as inadequate bodies, rather than as whole persons with social, emotional, cultural and other facets to their lives.

Bariatric surgery is a ubiquitous topic in the medical literature; however, little is substantively known about the subjective experience of the surgery. Thus, this research sheds needed empirical light on

terrain that has been under-researched by medical practitioners and by academics. A number of contributions have emerged from this research, and these will be described in detail.

### CONTRIBUTION TO THE LITERATURE

*The Role of Stigma.* This study both extends and challenges Goffman's (1963) insights into stigma and what it means to be stigmatized. Prior to their surgery, the women reported an all-pervasive stigmatization related to their obesity. For some women, obesity stigma served as the primary thrust behind their decision to have weight loss surgery. Even after a successful surgery, most of the women in the successful group have remained obese—and in some cases, morbidly obese. The women in the surgical failure group are, of course, all morbidly obese. Interestingly, the stigma of obesity is a greatly diminished factor in the postoperative lives of both groups of sample members. It is possible that the surgically successful women actually quantitatively experience fewer incidents of obesity-related prejudice and discrimination. It is also possible that these participants' greater social involvement and increased self-esteem and feelings of efficacy could mitigate their perceptions of prejudice and discrimination and allow them to interpret reactions of other people as being more positive. I suggest that the surgical successes are content that they are not as fat as they were before and this contentment neutralizes the effects of stigma.

While the women in the surgical failure group continue to experience obesity-related prejudice and discrimination, the majority of the women in this group at least resist their stigmatization. These women neutralize obesity stigma by no longer readily accepting their devalued status.

These findings indicate that the presence of stigmatizers is not enough to initiate the process of stigmatization. For stigmatization to occur, the stigma has to be internalized; that is, the feature has to be devalued by the bearer himself or herself. The effects of stigma are neutralized when the bearer does not internalize the devalued status.

The results of my study also challenge Goffman's suggestion that those who have corrected a stigma never fully acquire the status of normal; rather, they will be known as individuals who once had a blemish but who corrected it. My findings indicate that the women considered themselves as normal by virtue of having achieved a more normative weight and were viewed as being within an acceptable weight

range by those with whom they had regular interaction. As for the women for whom the surgery was a failure but who have since become self accepting, they are not making the argument they are normal, but rather argue they are not abnormal by virtue of their fatness. Thus, they reject the suggestion that fatness is indicative of bad character and aberrance. They contend that women's identities and moral worth are not defined by the outer body's appearance. Normalcy, for them, is not defined by the shape and size of one's body, and they challenge those who define them according to those standards.

*Surgery and Feminine Appearance Norms.* This study also adds to the extensive feminist literature on women and their relationships to their bodies, particularly in the context of weight and body image (Chernin 1981; Gimlin 2002; Grogan 1999; Hesse-Biber 1996; Millman 1980; Spitzack 1990). Feminists have long recognized and politicized the salience of weight for women (Chernin 1981; Orbach 1978, 1983; Rothblum 1994; Wolf 1991). This research supports the view that overweight plays an overarching role in women's lives and limits their life chances. Fat women must not only contend with the popular assumption that overweight is the result of character defects, but also with the norms of a patriarchal society in which restrictions on desirable physical appearance are much stronger for women than for men. The feminization of bariatric surgery is reflective of a strongly gendered society in which appearance is pivotal for success in the female gender role. Success in the male gender role, on the other hand, is more likely to be influenced by educational, financial, and vocational accomplishments (Rodin et al. 1984). As Millman (1980:224) notes, "[b]ecause physical appearance is so consequential for women, we attempt to change our looks in order to change our lives, while in our places men would think about their work or achievements in the world."

There is some evidence that the surgical successes have internalized the dominant cultural beliefs about women, weight, and appearance. Although these sample members were troubled by the ambivalence of compliments suggesting they "looked so much better" since their surgery, they themselves appeared to equate weight loss with enhanced attractiveness. However, my data also indicate that fat women, including the surgical successes, negotiate and resist the thin ideal as the only standard of attractiveness for women. The women in the surgical success group, most of whom were over 200 pounds, declared they were happy at their current weight and spoke disparagingly of the women in their support groups who expected to lose

a very great deal of weight. They were also critical of the more radical bariatric surgical procedures which promote higher rates of weight loss, yet are associated with a higher frequency of metabolic complications. To the extent that the women in my study accept themselves as fat women, they pose a challenge to the patriarchal construction of the ideal woman as the woman who is thin. Thus, my findings contradict the popular feminist presumption that women cannot be satisfied with their bodies unless they closely approximate the current cultural standard of extreme thinness (Grogan 1999; Hesse-Biber 1996; Orbach 1986; Wolf 1991).

*Exploring Fat Women's Agency.* The surgical stories recounted in this study reveal two competing visions of agency for fat women; both of which are empowering and problematic. The surgical successes position themselves as individuals who exercised control over an unbearable situation and who view having bariatric surgery as an act of self-determination. The decision to have the surgery was a watershed moment in these women's lives. Up until then they had been paralyzed, emotionally and in some cases, physically, by their morbid obesity.

Their accounts of agency are strengthened by their insistence that they did this "for health reasons"—both current and anticipated—rather than cosmetic reasons. They staunchly maintain that they did this "for themselves," or made the decision independent of coercion. The surgical successes enhance their agency by speaking of surgery as a choice; presumably, the choice was between passively continuing to suffer as a morbidly obese woman or to change her circumstances.

Yet there are contradictions and tensions in the characterization of weight loss surgery as a choice. For one, their narratives (as well as those of the surgical failures) indicate the decision to undergo the surgery was informed more by desperation than a perceived choice. For another, choices are shaped by the cultural context in which we live. Fat women's decision-making power is constrained by the norms of a patriarchal and capitalist society which teaches women from childhood that physical attractiveness is their most precious asset and can be purchased or achieved through the expenditure of time, discipline, and financial resources. Thus, the extent that weight loss surgery can be totally positioned as a free choice is questionable.

The women in the surgical failure group who have become self-accepting offer an alternative vision of agency for fat women. While the surgical successes defined themselves as agents largely on the basis of their choice to change their circumstances through bodily intervention, the self-accepting women promote agency that is based on resistance. These women's refusal to accept the negative definitions of fatness and their refusal to allow others to define them negatively personally empowers them and creates spaces of empowerment for other fat women. By not apologizing for their size (to use McKinley's phrase [1999:110]), they challenge the structure and ideology of fatphobia, and by extension, patriarchy and capitalism. Their self-acceptance frees them of the burden of trying to attain the sociocultural standard of the ideal feminine body type. They refuse to be labeled as deviant on the basis of their fatness and reject the patriarchal and capitalist prescription that women must expend time, energy and resources to make their bodies acceptable to men. The concept of choice also features prominently in these women's discourse, although in this context choice is configured as the fat woman's right to choose not to lose weight and to have that choice respected by others. This notion is particularly significant for women who live in a society where fatness is automatically considered a condition to be eradicated using any means.

In some cases, however, this determination to fight cultural oppression has not been without cost. Three of the women in this group expressed disappointment at the absence of male companionship and the opportunity to have children. While NAAFA organizes social events which provide its mostly female constituency with the opportunity to meet men who are attracted to fat women, the phenomenon of the Fat Admirer (FA) needs to be critically examined. Millman's (1980) and Gimlin's (2002) interviews with women who meet FAs at NAAFA social events indicate that FAs often objectify and exploit them. According to these accounts, relationships with FAs tend to be sexual and short lived. This is not particularly surprising, as FAs appear to value women solely on the basis of their bodies—hardly a foundation for a long-term relationship. Thus, FAs are not the solution to fat women's loneliness and isolation.

The impact of severe obesity on health is also another serious consideration. Apart from the health problems incurred by bariatric surgery, the women in the surgical failure group suffer from obesity comorbidities such as diabetes, immobility, arthritis, and sleep apnea. While they may have achieved a

personal contentment with their lives, the impairment of their health and their functional quality of life remains. Self-acceptance may promote the mental health of fat women but does not address these issues. This point is illustrated by the experiences of three women in the surgical success category who had advocated self-acceptance until their size became an over-riding issue affecting their health and quality of life. The health risk and inconvenience associated remaining at their current weight were primary factors in leading them to the conclusion that surgery was their best option.

Furthermore, the blanket recommendation of self-acceptance may not be relevant to most severely obese women because they do not see this counsel as a constructive one that makes a tangible improvement in their lives. A woman who has to struggle for breath to perform the simplest actions, who cannot walk or stand for more than a few minutes, and who cannot fit into standardized seating may feel her problems are trivialized by the advice to just accept herself. As Grimshaw (1999:99) argues, “[t]o suggest, simply, that women should be ‘happy’ with their bodies is in its way as problematic as aiming to tackle issues concerning age or disability by saying that the old or those who are not able-bodied should be ‘happy’ with their bodies as well.”

Lastly, self-acceptance simply does not appear to be an option for most fat women. This is reflected in the fact that 90 percent of the clients in weight loss programs are female (Cogan and Rothblum 1992). NAAFA, which has been in existence since 1969, has low membership rates considering that most of the US population is overweight. The surgical successes and one of the surgical failures expressed strong skepticism about fat women who maintain they are self accepting. This incredulity may be a function of a fatphobic culture and industries that have structural interests in maintaining this culture, such as the fashion, dieting, fitness and media industries (Germov and Williams 1999:121). Nonetheless, the deeply entrenched belief that a woman can never be truly happy if she is fat serves as a powerful inhibitor against fat women adopting their fatness as an integral part of their identity.

These competing discourses of agency are persistent themes in the feminist literature on body politics. Women’s active, voluntary involvement in the alteration of their appearance through make-up, dieting, exercise, and surgery is the source of recent feminist debate, and there is some controversy about whether these activities are representative of agency or subordination. Early second wave feminists called

for women to escape the tyranny of appearance norms by celebrating the unadorned, unadulterated female body. However, this is a call that most women have not heeded, as the multimillion-dollar cosmetic and cosmetic surgery industries illustrate (Wolf 1991). Until recently, feminists portrayed women who were involved with their appearance as victims of patriarchal oppression (Chapkis 1986; Freedman 1986; Morgan 1991; Wolf 1991). However, this stance has also become problematized in the literature on women's bodies (Bordo 1993; Davis 1995; Frost 1999; Germov and Williams 1999; Grimshaw 1999). For instance, Germov and Williams describe this position as "patronizing and simplistic formulations that posit women as 'brainwashed' subjects of a patriarchal society" (p. 118). Davis (1995) refers to the description of women's engagement with their appearance as victims as "the problem of the cultural dope." While it is important to acknowledge both the cultural and structural constraints imposed by patriarchy, it is also essential to view women as active subjects who create spaces of empowerment within a repressive system. This approach would more accurately portray the complexities of women's body practices and also avoids the patriarchal presumption where women are viewed as objects, rather than subjects. This position also highlights the feelings of competency, pleasure, and satisfaction women derive from their involvement in body practices (Beausoleil 1994; Frost 1999; Gimlin 2002; Grimshaw 1999).

The participants in this study demonstrate that agency is a subjective concept. For some women in this sample, agency for fat women is presented as the wherewithal to choose a surgical solution to a problem that had been hitherto unsolvable. For others, agency is manifested in their demand for the right to live as fat women, free of discrimination and ostracization. The commonality these seemingly disparate notions of agency share is the right of fat women to choose the option that is best for them.

*Fatness and Feminism.* Feminists can empower fat women by providing them with more discursive space. Fat women's subjective experiences have been marginalized in the academic literature, including the feminist literature. As I noted in Chapter 3, mainstream feminists are ambivalent towards fat women. This ambivalence is reflected in the feminist empirical literature which, to date, can boast of only two in-depth examinations of fat women's lives (Gimlin 2002; Millman 1980). Although feminists are very critical of the current dieting culture, noting its vise-like grip on women of all ages and its relationship to eating disorders, they do not comment about the association between dieting and the exacerbation of



obesity. Dieting behavior in obese women has not been problematized by feminists. A thin woman who diets obviously has a body image problem if not an eating disorder, while a fat woman who diets is only doing what she is supposed to do. In other words, diets are pathologized when they are undertaken by normal-weight or thin women and normalized when they are undertaken by fat women. Feminists must address this contradiction in terms of the implications it has for fat women.

Feminists must also contextualize the thin ideal in the fertile ground of fat hatred. Women are not held in the thrall of thinness as much as they are imprisoned by the hatred of fat. The hatred of fat has thrived in our patriarchal culture and enriched the coffers of capitalism. The stigmatization of fat women as ugly and physically and mentally unhealthy (McKinley 1999) has implications for all women by continually reminding them how they must regulate their bodies if they are to avoid the social sanctions meted out to women who do not conform to the dominant cultural standards of beauty.

This study has demonstrated the usefulness of integrating the insights from both stigma theory and feminist theory in analyzing women's experiences of weight loss surgery. Goffman and other stigma theorists illuminate how a feature, behavior, or group membership becomes stigmatized and the impact stigmatization can have on an individual. However, while obesity is an extremely stigmatizing attribute, stigma theory is not sufficient in itself to explain why women so overwhelmingly dominate the bariatric surgical population. Feminist theory supplements stigma theory by pointing out that some stigmas are not gender neutral—particularly when these pertain to a socially acceptable body. While both obese men and women suffer from anti-fat prejudice and discrimination, the evidence unequivocally indicates that women suffer harsher penalties. Feminists have shown how the primacy of women's appearance in patriarchal society dominates women's lives and how women who transgress the bounds of normative femininity are penalized. Not surprisingly, women are more likely than men to seek surgical solutions to physical stigmas (Davis 1995). One of the main contributions I make with this work is to generate an integrated theoretical model with which to understand the experience of women who have undergone bariatric surgery.

*Contribution to the Medical Literature.* Virtually every participant in this study reported a longstanding history of weight loss attempts, often begun in childhood. A substantial proportion of the sample identified a lifetime of chronic weight loss attempts as having been a factor in becoming morbidly

obese. Until their surgery they had engaged in numerous weight loss attempts, and each diet cycle resulted in weight gain. Although dieting is widely promoted as a solution for obesity, research is increasingly revealing that chronic dieting may actually be a causal factor in the genesis of obesity (Brownell et al. 1986; Korkeila et al. 1999). Physicians and other health professionals interested in obesity must seriously re-consider the wisdom of routinely counseling overweight persons to go on diets, as the 'cure' may be actually worsening the situation. Diets are linked to other adverse health conditions as well (McFarlane, Polivy, and McCabe 1999; Polivy and Herman 1976, 1995; Stunkard and Rush 1974; Wadden, Stunkard, and Smoller 1986).

This study has also expanded bariatric surgeons' understanding of their patients' perspectives, as well as the professional conduct of their colleagues, two aspects of the surgery which are overlooked in the medical literature. The main focus of the surgical consultation appeared to be anticipated weight loss. While patients obviously consult bariatric surgeons because they want to lose weight, the focus on potential weight loss is extremely reductionist and obscures other important aspects associated with bariatric surgery. For instance, none of the surgeons asked the women if they were being coerced into having the operation by husbands, partners or other significant individuals. Although the mortality risks of the operation appeared to be stressed, the morbidity risks were not. For example, none of the surgeons asked the women if she thought she could live with a particular complication, should it happen to her. By failing to bring up these salient issues, surgeons are effectively precluding their patients from adopting a holistic approach to this surgery and making the decision that is best for them.

Postoperative problems in the interactions between health care practitioners and patients were noted as well. The majority of the women in this sample reported that health care professionals belittled or trivialized symptoms they experienced after the operation. In numerous instances, this indifference had devastating consequences for them. Besides compromising patient health, this condescending attitude suggests that medical practitioners do not involve patients as participants in their own care.

Patient education also appeared to be a neglected issue, particularly for the Canadian sample members. Eight of these women were not provided with written material about the proper dietary regimen

following bariatric surgery. Additionally, the Canadian women were unaware at the time of their operation that health insurance coverage for plastic surgery was limited, or in some cases, not covered at all.

The problem of long-term follow-up of bariatric surgery patients is frequently noted in the medical literature and is apparently a source of frustration to surgeons (Brolin 1992; Brolin et al. 1989; Choi et al. 1999; Fisher and Barber 1999). However, seven sample members reported it was the bariatric surgeons themselves who were negligent about maintaining both short-term and long-term follow-up; again, this trend was more noticeable among the Canadian surgeons.

Why do Canadian surgeons appear to be less committed to their patients than their American counterparts? The differences in each country's health care models provide insights into the disparity in quality of care. Bariatric surgery is a very expensive procedure, costing at least \$20,000 (Gawande 2001). Under the United States' market model of health care, American surgeons are reimbursed by private health care insurance companies and thus have the resources to offer a wide range of services to their patients. Patients are viewed as consumers who expect good value for their money, so obesity surgery centers compete with each other for their patronage. Bariatrics is gaining recognition as a lucrative specialty and obesity surgery centers are proliferating in the United States (Gawande 2001). This is not a broad-based comparison of the two health care systems, but Canada has placed limits on the amount of money that can be claimed by doctors for this type of surgery, and the net effect appears to be better service in the United States.

Canada's socialized health care system, on the other hand, is impoverished and not able to support large numbers of these bariatric operations. One Canadian participant recounted that her surgeon told her he was only being reimbursed \$500 for a procedure. In a June 2001 interview with Shelagh Rogers, Ontario surgeon David Michael Grace complained that he has difficulty getting access to operating rooms and that he has to pay a dietician out of pocket.<sup>85</sup> The Canadian doctors have to maintain a practice with few resources, and this is perhaps why they provide their patients with little supplemental information about the surgery. Year-long (and sometimes longer) waiting lists are further evidence of the strain these

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<sup>85</sup> Quebec bariatric surgeons have also publicly complained about the lack of availability of operating rooms.

physicians are experiencing. Pressure to meet increasing demand may result in less vigilance about scheduling follow-up visits. As a result of these systemic deficiencies, Canadian patients are clearly disadvantaged relative to American patients in nearly every aspect of the surgery.

### CONSIDERATIONS FOR FUTURE RESEARCH

The lived experience of morbid obesity and bariatric surgery in the context of a sociological analysis has been a surprisingly under-studied area in feminist scholarship on the body. Even though the bariatric patient population is disproportionately made up of white women, other populations are seeking the surgery as well and their experiences must also be investigated. As much as female bariatric patients' voices are not heard in the academic and medical literatures, the voices of men and racial minorities who have had bariatric surgery are even more muted.

As mentioned in Chapter 1, men make up only a very small part of the bariatric surgical population. Morbid obesity is more common among women than men (Balsiger et al. 2000a; Freedman et al. 2002; MacDonald et al. 1997; Rand and Kuldau 1993). Additionally, men's experience of obesity appears to be less traumatizing than that of women. The literature shows that men appear to be less preoccupied and less depressed with their weight, experience less discrimination than fat women, and are less likely to diet or engage in other weight loss pursuits (Khan et al. 2001; MacDonald et al. 1997; Millman 1980; Rand and Kuldau 1993).

Little information about the racial composition of the bariatric patient population is available, but it would appear that blacks and other minorities are less likely to undergo weight loss surgery (Bufalino et al. 1989; Hildebrandt 1998; Rand and Kuldau 1993). A combination of racial, cultural, and economic factors may explain this phenomenon. More black women are morbidly obese than white women, but fatness is not as derogated in the black community (Hebl and Heatherston 1998; Klesges et al. 1996; Stearns 1997). Rand and Kuldau (1993) suggest that black women and white men delay bariatric surgery until they are physically impaired by their obesity. Physician racism, and for those living in the United States,

inaccessibility to insurance companies who cover the procedure may be other reasons why black women view surgery as a last resort.

White men's and minority women's experiences of morbid obesity and bariatric surgery are surely different from those of white women. Research into their motivations for having weight loss surgery and the impact the surgery has on their lives would yield further insights into the multifaceted phenomenon of bariatric surgery and body issues faced by fat people.

### **CONCLUSION**

This study has provided us with a glimpse into the lives of very fat women who have undergone weight loss surgery. Their experiences demonstrate that morbid obesity is not only a physical and medical condition, it is also a social and political condition. Weight loss surgery is a unique operation; unlike most other surgeries designed to address medical conditions, this surgery resulted in women experiencing a major metamorphosis. This feminist qualitative examination of bariatric surgery provides a sociocultural context that helps us understand the social factors influencing individual decisions to undergo the surgery. My participants' surgical stories provide insights into the physical and personal transformation induced by bariatric surgery, revealing that surgical intervention is not only a bodily intervention but also an intervention in the self.

CONVENTIONAL (NONSURGICAL) TREATMENTS OF OBESITY

The cause of excess weight appears to be obvious. Weight gain occurs when the body ingests more calories than it expends. Until recently, health professionals, lay people, and obese people themselves have assumed that the only barrier between fatness and desirable weight was the regulation of appetite and/or increase in physical activity. Accordingly, conventional weight loss treatments, e.g., dieting, exercise, behavioral modification, and drugs are predicated on these assumptions. While weight loss occurs when calories are restricted and/or physical activity is increased, “weight maintenance has been the most difficult element in all approaches to the therapy of obesity” (National Task Force on the Prevention and Treatment of Obesity 1993:969). Each of these treatments will be discussed in detail below.

*Diets.* Dieting is the most popular weight loss strategy (NIH Technology Assessment Conference Panel 1992). There are hundreds of different types of diets, and most are not medically sponsored (Stunkard 1992). These range from caloric restriction to changes in dietary proportions of fat, protein, and carbohydrates (e.g., “Dr. Atkins Diet,” “The Zone Diet”). Two levels of caloric restriction are commonly used. The low-calorie diet (LCD) involves about 1,000 to 1,200 calories per day (Blackburn 1993; Mun et al. 2001; NIH Technology Assessment Conference Panel 1992; NHLBI Obesity Education Initiative 1998; Powers and Rosemurgy 1989). LCDs are typically offered by commercial weight loss programs and diet books (NIH Technology Assessment Conference Panel 1992; Stunkard 1992). Very low calorie diets (VLCDs), consisting of 800 or fewer calories a day, are restricted to severely overweight persons and are conducted under physician supervision (National Task Force on the Prevention and Treatment of Obesity 1993; NIH Technology Assessment Conference Panel 1992). LCDs produce a loss of about 8 percent of total body weight over a period of six months to a year, whereas VLCDs produce a loss of 20 to 25 kilograms (20 to 25 percent of initial weight in 12 to 16 weeks) (Wadden 1999). However, after a year, the weight loss incurred is not different from that of the LCD (Jeffery et al. 2000; National Task Force on the

Prevention and Treatment of Obesity 1993; NIH Technology Assessment Conference Panel 1992; NHLBI Obesity Education Initiative 1998).

Both LCDs and VLCDs are associated with high failure rates. The NIH Technology Assessment Conference Panel (1992:944) notes that “there is a strong tendency to regain weight, with as much as two thirds of the weight lost regained within 1 year of completing the program and almost all by 5 years.” The panel also noted that weight loss programs are marked by dropout rates as high as 80 percent.

These results are consistent, whether the diet program is administered by a physician or conducted under the auspices of a commercial program such as Weight Watchers. Only 5 percent of dieters manage to lose weight and maintain the weight loss (Rothblum 1992). Although this low figure has been highly publicized recently, it is not a new discovery. In 1958, Stunkard observed that less than 5 percent of dieters lost large amounts of weight and that even fewer maintained this weight loss.

Ironically—and sadly—the prospect of failure does not appear to deter individuals who want to lose weight. They simply try another diet, convinced that this one will be the key to losing weight. They can easily spend their lives following one diet plan after the other, losing weight, regaining it and then trying another diet—a process known in the dieting nomenclature as “weight cycling” or “yo-yoing” (Brownell et al. 1986).

There are other drawbacks to dieting besides chronic failure and its attendant feelings of inadequacy. Frequent dieting is associated with personality and mood disorders such as depression, irritability, lassitude and general feelings of inefficiency (Polivy and Herman 1976; Stunkard and Rush 1974; Wadden et al. 1986). Sudden and dramatic weight loss can cause gallstone formation (Klawansky and Chalmers 1992; Sichieri, Everhart, and Roth 1991; Spirt et al. 1995). The earlier forms of VLCDs, the commercial liquid protein diets popular in the 1970s (e.g., the “Cambridge Diet”), have been associated with severe nutritional deficiencies, as well as dehydration. Numerous deaths have also been attributed to these diets (Berg 1999; Van Itallie 1978; Van Itallie and Yang 1984; Wadden et al. 1983; Wadden et al. 1990). The quality and safety of the current generation of VLCDs has improved greatly, particularly when these are administered under the supervision of a trained physician (Blackburn 1993; National Task Force on the Prevention and Treatment of Obesity 1993; Wadden et al. 1990). However, adverse effects are

associated with these regimens as well. VLCDs are very stressful on the body; these diets put the body in semi-starvation mode so that it will burn its fat stores, making its primary energy source fat, rather than the simple carbohydrate, glucose (Scanlon 1991:53). Side effects range from fatigue, dizziness, and hair loss to gallbladder disease, gout, and cardiac complications (Berg 1999; Blackburn 1993; National Task Force on the Prevention and Treatment of Obesity 1993; Scanlon 1991; Wadden et al. 1990). Scanlon (1991:55) notes, “[a]ll diets assume some degree of risk; VLCDs assume the most.”

Chronic dieting is also associated with additional weight gain (Coakley et al. 1998; French et al. 1994; Korkeila et al. 1999). Brownell et al. (1986) showed that rats took 21 days to lose a specific amount of weight and 46 days to regain it when they were returned to a normal caloric intake. But in the next diet cycle, the same diet took 40 days to accomplish the weight loss goal, while the rats regained the weight in only 14 days. At the same time, their bodies got progressively fatter because in losing weight, they lost both muscle and fat but they gained back proportionately more body fat than they had lost. The authors suggest that yo-yo dieting increased the activity of lipoprotein lipase, an enzyme that promotes the storage of body fat. With each diet cycle, the rats' daily caloric needs dropped and they gained weight on fewer calories. The authors concluded that yo-yo dieting increases body fatness and may ultimately result in an inability to lose weight, even on a very low caloric intake. They suggest that the body zealously guards its fat stores and protects itself from the next “famine” (i.e., diet) by storing calories more efficiently.<sup>86, 87</sup>

Chronic dieting and high levels of body dissatisfaction are believed to be associated in the genesis of eating disorders such as anorexia nervosa and bulimia which primarily afflict women more than men by a ratio of 9:1 (Hesse-Biber 1996; Seid 1989). The precise prevalence rate of eating disorders is difficult to determine because of the furtiveness involved in these diseases, but conservative estimates are believed to be 0.5 to 1 percent for anorexia and 4 percent for bulimia (Gordon 1990). On college campuses, eating disorders are virtually epidemic among young women. Estimates suggest that 4 to 15 percent of college women suffer from bulimia (Crandall 1988).

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<sup>86</sup> See also Brownell (1995).

<sup>87</sup> Other studies have failed to confirm Brownell et al.'s conclusion that weight cycling causes weight gain in the long term. See National Task Force on the Prevention and Treatment of Obesity (1993).



*Exercise.* According to Mun et al. (2001:672-673), “[a]lthough physical activity and exercise are key factors in successful weight reduction programs, the contribution of exercise to weight loss is modest at best.” A review of the literature conducted by the authors found that most studies on the effect of exercise on weight loss concluded exercise generates only a small reduction of weight (approximately 2 kilograms) or none at all. Compared with changes in diet, exercise is not a very effective way to reduce weight because few calories are burned by even quite vigorous exercise (Epstein and Wing 1980). According to Bray (1986), even under heavy exertion (such as running), most people expend around 7.5 calories per minute. An average lunch of 500 calories would take over an hour’s running to burn off.

The benefits of exercise cannot be disputed; regular exercise lowers cholesterol levels and increases lean body mass (NIH Technology Assessment Conference Panel 1992; Jeffery et al. 2000). A regular exercise regimen is involved in the maintenance of weight loss (National Task Force on the Prevention and Treatment of Obesity 1993; Wadden and Foster 2000). However, if exercise alone is promoted as a weight reduction tool, then participants need to understand that weight loss will be very minimal (Calles-Escandon and Horton 1992).

*Behavior Therapy.* According to Wadden and Foster (2000:442), “[t]he behavioral treatment of obesity refers to a set of principles and techniques designed to help overweight individuals reverse... maladaptive eating and activity habits.” Current behavioral approaches are based on the classic conditioning model but also include measures such as “self-monitoring, nutrition, stimulus control, slowing eating, exercise, problem solving and cognitive restructuring” (Wadden and Foster 2000:444).<sup>88</sup> While some researchers have reported weight losses of up to 14 kilograms, behavioral treatment of obesity generally results in an average loss of 8.5 kilograms (equal to 9 percent reduction in initial weight) after 21 weeks of treatment (National Task Force on the Prevention and Treatment of Obesity 1996; Wadden 1999; Wadden and Foster 2000). Brownell and Kramer (1989:195) note, “[e]ven the best behavioral programs produce weight losses of no greater than 30 pounds on the average.” Weight regain is common after cessation of treatment (Ciliska 1993; Cogan and Rothblum 1992; Douketis et al. 1999; NIH Technology

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<sup>88</sup> See also Stuart (1967).

Assessment Conference Panel 1992; Wadden and Foster 2000). For example, studies show that patients typically regain about 30 to 35 percent of their weight loss in the year following treatment. By five years, 50 percent or more of patients are likely to have returned to their original weight (NIH Technology Assessment Conference Panel 1992; Wadden and Foster 2000:448).

Long-term group behavioral treatment (e.g., six months to one year) appears to generate higher weight losses than short-term treatment (e.g., three months) (Brownell and Kramer 1989; Jeffery et al. 2000; Wadden and Foster 2000). These losses also appear to be maintained over a longer period of time (Wadden and Foster 2000). However, long-term behavioral treatment programs are not widely available, and attrition rates increase substantially after the first six months of treatment (Jeffery et al. 2000; Wadden 1999; Wadden and Foster 2000).

Since behavior therapy produces relatively insignificant weight losses when used on its own, results are more favorable when it is accompanied by other weight loss strategies such as exercise, strict dieting, and drugs (Brownell and Kramer 1989; Wadden 1999; Wadden and Foster 2000; Wing 1992). Even in these cases, weight losses tend to be modest.

*Drug Therapy.* Most diet drugs can be classified into three major groups by their mechanisms of action: suppress the appetite, increase the metabolic rate, and reduce the absorption of fat (National Task Force on the Prevention and Treatment of Obesity 1996; Powers and Rosemurgy 1989).

In the 1950s and 1960s, the primary drug prescribed to treat obesity was amphetamine, a central nervous system stimulant. The use of amphetamine, or "speed" as it is popularly known, as a weight loss mechanism was "widespread and often indiscriminate" (National Task Force on the Prevention and Treatment of Obesity 1996:1907). The drug suppressed the appetite, and large weight losses were reported. However, amphetamine fell out of favor when it was discovered that its users suffered from severe side effects such as insomnia, irritability, ulcers, cardiovascular collapse, strokes, and in some cases, death (Schroeder 1992:137). Furthermore, amphetamine is highly addictive (Bray 1993). Following the negative publicity regarding this drug, the Food and Drug Administration (FDA) reclassified amphetamines as

dangerous drugs in 1979 and doctors have been since forbidden to prescribe it as a weight control agent (Fraser 1997:193).<sup>89</sup>

After the amphetamine debacle, prescription diet drugs fell out of favor as a weight loss strategy until 1992, when Weintraub and his colleagues published the results of a series of studies which combined the diet drugs fenfluramine and phentermine. Subjects lost an average of 14 kilograms (16 percent of initial weight) within six months. The patients who remained on medication for three years maintained approximately two-thirds of their weight loss. Fenfluramine (“Pondimin” in U.S.; “Ponderal” in Canada) is a serotonergic reuptake inhibitor—that is, it triggers the release of serotonin and prevents its rapid reuptake or reabsorption by the brain (Fraser 1997; Hensrud 2000; Lemonick 1996, 1997). Serotonin is a neurotransmitter, that, among other things, regulates mood and satiety. Increased levels of serotonin seem to reduce hunger by sending a message to the brain that the stomach is full. Both drugs were approved separately by the FDA for short-term use but not the combination of the two (Berg 1999; National Task Force on the Prevention and Treatment of Obesity 1996). Doctors, however, exercised their rights to prescribe off label (prescribing other than as approved by the FDA) and gave the drugs in combination to their patients who wanted to lose weight. This practice—and the public’s demand for it—launched what came to be known as the “fen-phen” phenomenon (Lemonick 1996).

The pharmaceutical treatment of obesity was given a further boost in 1996, when the FDA approved dexfenfluramine (“Redux”) for long-term use as a diet drug. Dexfenfluramine, a chemical cousin of fenfluramine, also elevates serotonin levels (Lemonick 1996). Dexfenfluramine was also approved for use in Canada in 1996, and marketing of the drug to doctors and the general public began in January 1997 (Kalbfleisch 1996; Zacharias 1997). The FDA approval was not without controversy. Animal studies showed that both fenfluramine and dexfenfluramine causes brain damage in rats and primates (McCann et al. 1994; Molliver and Molliver 1990; Ricaurte et al. 1991; Seiden, cited in Fraser 1997:196). Shortly after the approval of dexfenfluramine by the FDA, a study conducted on patients living in Western Europe where dexfenfluramine has long been available, found they face increased risk in contracting primary

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<sup>89</sup> Non-prescription diet pills are also widely used as a weight loss tool. See Blanck, Khan, and Serdula (2001).

pulmonary hypertension after taking the drug for more than three months (Abenhaim et al. 1996).<sup>90</sup>

Moreover, adverse side effects were experienced with these drugs, and fen-phen's effectiveness tended to be temporary.

Despite these problems, the public demand for Redux and fen-phen appeared insatiable. More than 18 million fen-phen prescriptions were written in the United States alone in 1996 (Gorman 1997).<sup>91</sup> It is estimated that Canadian doctors wrote at least 1.4 million prescriptions for fenfluramine and dexfenfluramine (Mitrovica 2001). The popularity of these drugs plummeted sharply, however, when a series of studies reported an association between valvular heart disease and fen-phen or fenfluramine/dexfenfluramine (Connolly et al. 1997; Graham and Green 1997; Mark et al. 1997).<sup>92</sup> In September 1997, the FDA requested the voluntary withdrawal of fenfluramine and dexfenfluramine from the market. Phentermine alone does not appear to increase valvular heart disease and is still prescribed for weight loss (Hensrud 2000; Mun et al. 2001).

Sibutramine ("Meridia"), approved in 1997, is the latest candidate in the appetite suppressant generation of drugs.<sup>93</sup> It inhibits the reuptake of both serotonin and the neurotransmitter norepinephrine to suppress appetite (Berg 1999:280; Mun et al. 2001; NHLBI Obesity Education Initiative Expert Panel 1998). Sibutramine is also only mildly effective, inducing a loss of about 5 to 8 percent of excess body weight, or 3 to 5 kilograms (Berg 1999; Fanghänel et al. 2000; NHLBI Obesity Education Initiative 1998; Wadden and Foster 2000). Weight is regained once the drug is discontinued (NHLBI Obesity Education Initiative 1998). The side effects of Sibutramine are increase in heart rate and blood pressure, and the drug should not be taken for more than one year (Fanghänel et al. 2000; NHLBI Obesity Education Initiative 1998).

The most recent diet drug is Orlistat ("Xenical"), approved by the FDA and Health Canada in 1999. It too has proved to be widely popular among weight loss seekers (Lemonick 1999; Poulton 1999). Unlike all previous diet drugs, however, Orlistat does not suppress the appetite. Instead, it interferes with

<sup>90</sup> See also Atanassoff et al. (1992); Roche et al. (1992).

<sup>91</sup> See also Khan et al. (2001).

<sup>92</sup> See also Curfman (1997); Jick et al. (1998); Khan et al. (1998); Weissman et al. (1998).

<sup>93</sup> Sibutramine has been available in Canada since 2001.

fat absorption in the intestine by blocking pancreatic lipase, the enzyme that breaks down fat, allowing it to pass through the intestinal walls and into the bloodstream where it is either used as energy or stored. Orlistat prevents the digestion of approximately one-third of fat ingested during a meal and the fat is excreted. This drug has been shown to achieve a weight loss of about 3 to 4 kilograms, or 8.5 to 10 percent of excess weight (Finer et al. 2000; Hensrud 2000; Mun et al. 2001; Sjöström et al. 1998; Wadden and Foster 2000). Orlistat can be used on a long-term basis (Halpern 1999), but adverse side effects are also occur with the use of this drug. More fat in the intestine results in more fat in the stool; hence, oily and loose stools are common (Finer et al. 2000; Halpern 1999; Sjöström et al. 1998). Moreover, since fat is not absorbed in the body, fat-soluble vitamins (A, D, E, K) are also not absorbed (Finer et al. 2000; Halpern 1999; Mun et al. 2001; NHLBI Obesity Education Initiative 1998).

Adverse effects have been noted with all weight loss drugs. The drugs cannot be taken on a long-term basis, yet paradoxically, must be taken long-term to maintain weight loss. Most patients regain weight once any drug therapy is discontinued.

In sum, conventional weight loss therapies produce modest results at best and do not appear to be sustainable over the long term. Their success rates are only in the 2 to 5 percent range (Douketis et al. 1999; Garner and Wooley 1991). Diets and weight loss drugs have also been found to compromise health in many instances, rather than promote it.

THE COMPLEX AND CONFOUNDING ETIOLOGY OF OBESITY

Physicians, dieticians and other weight loss experts have traditionally—and still do—dismiss the high failure rate of weight loss regimens as an indication of willful disobedience of specific instructions or, more likely, a lack of self-discipline. However, the exceedingly low success rates demonstrated by all weight management programs can no longer be accounted for by a lack of will power on the dieter's part. Obesity researchers are increasingly recognizing that the cause of obesity is much more complex than a simple “calories in, calories out” imbalance. There is no consensus in the literature about the etiology of obesity, but researchers are deviating from focusing on obesity as a purely one-dimensional phenomenon to considering the probability that there may be a multiplicity of factors at work. Recent studies have been directed toward investigating the genetic, metabolic, and environmental components involved in the development of obesity.

*Genetic Factors.* Familial studies have shown that weight is highly correlated among first-degree relatives. For example, 50 percent of children born to two obese parents will be overweight. These children have an 80 percent chance of becoming obese adults (Angel et al. 1989). However, it is not certain whether this outcome is the result of genetic or environmental influences. Stronger support for the role of genetics in obesity comes from twin studies, in which weight has consistently been shown to be similar between twins, with the similarity being greater in identical than fraternal twins. A study on 34 sets of identical twins raised apart found them to be within a few pounds of each other's weight (Price and Gottesman 1991). Another twin study was conducted by Stunkard et al. (1990), although these researchers studied both identical and fraternal twins, reared apart as well as together. Identical twins had very similar BMIs, regardless of whether they shared the same house. The fraternal twins, on the other hand, showed more differences even if they were raised together.

Adoption studies have also shown evidence of the contribution of genetics to body weight. The results of a number of studies on children adopted during the first year of life indicate that their BMI can be

predicted by their biological parents and that the BMI of the adoptive parents has relatively little influence (Stunkard et al. 1986; Teasdale and Sorensen 1983). It is estimated that the role of genetics in obesity can vary from 25 percent to 70 percent (Bouchard 1989; Bouchard 1990; Bouchard et al. 1990; Bray and Gray 1988; Hill et al. 2000).

*Metabolic Factors.* There is also evidence to suggest that an individual's weight is influenced by the rate at which food is metabolized. Metabolism, the rate at which the body burns calories, determines how much fat a person burns and how much is stored. Research with human subjects has shown that by measuring basal metabolism, it is possible to predict with reasonable precision who will gain weight and that the metabolic rate is heritable.

Roberts et al. (1988), working in Cambridge, England, tracked the infants born to six thin and 12 obese mothers. Close to half of the babies born to the obese mothers had lower metabolic rates than the other babies, burning 20.7 percent fewer calories. The babies with low metabolisms were overweight by the time they were a year old, while those with higher metabolic rates were not. The babies who had lower metabolic rates at the age of three months gained more weight by the age of one year than did those with higher rates. None of the babies born to thin mothers had low metabolisms, nor did any of them become fat. According to Roberts and her colleagues, the overweight babies did not eat more than the normal-weight babies.

Ravussin and his associates (1988) focused on 95 adult Pima Indians in Arizona. The Pimas were chosen for this four-year study because 80 to 85 percent of their population is obese.<sup>94</sup> Most subjects had family members participating in the study, thereby giving the researchers information on familial connections. The researchers noted that adults with low metabolic rates gained more weight over both a two- and four-year period than did those with higher rates. Furthermore, the researchers found similar 24-hour metabolic rates among family members. Ravussin et al. speculate that the tendency to fatness is an inherited trait. These studies show weight differences occur because some people's bodies are more

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<sup>94</sup> See also Gladwell (1998).

efficient at storing calories than others and thus the amount of eating necessary for weight gain is considerably less for them than it is for others.<sup>95</sup>

*Environmental Factors.* Noting that our genes have not changed substantially in the past two decades, numerous researchers attribute the current obesity epidemic to changes in the environment which promotes behaviors that cause obesity (Bray and Gray 1988; Flegal and Troiano 2000; Hill and Peters 1998; Hill et al. 2000). While genes and metabolism may make one susceptible to becoming obese, a permissive environment such as sedentariness in conjunction with the widespread availability of calorie-dense foods is necessary for excessive fat accumulation to occur (Garn and Clark 1976; Hill et al. 2000). Researchers studying the rapidly increasing prevalence of obesity in Canada and the United States note our increasingly sedentary lives. The advent of the automobile and labor-saving devices as well as the popularity of television watching, video games and computer interactions contribute to low levels of physical activity. The ascendance of a diet dominated by high-fat, high-sugar foods, as well as larger portion sizes in restaurants are also believed to be factors in the rapid, widespread development of obesity.<sup>96</sup> High-fat diets also increase the risk of overeating (Hill et al. 2000).<sup>97</sup>

At the present time, the cause of obesity is incompletely understood but there is a consensus that it is a multifactorial phenomenon, involving an interaction of genes and environment (Hill et al. 2000; NIH Technology Assessment Conference Panel 1992).

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<sup>95</sup> Set Point Theory also offers an explanation as to why some people become obese and others do not. See Bennett and Gurin (1982); Fallon (1994); Keesey (1980, 1995); Nisbett (1972).

<sup>96</sup> See also Schlosser (2001).

<sup>97</sup> See also Fraser (1997).



## APPENDIX C

### WEIGHT LOSS SURGERY: AN OVERVIEW

According to Mun et al. (2001:674), “[b]ariatric procedures for weight reduction share two major designs: intestinal malabsorption and gastric restriction.” Malabsorptive procedures involve rearrangement of the small intestine to decrease the intestinal tract, thereby decreasing nutrient and caloric absorption. Restrictive operations involve the creation of a small gastric pouch and outlet to decrease food intake. Various procedures have evolved from combinations of these two principles, and these will be briefly described below. (See Table C).

Table C--Major Bariatric Surgical Procedures

Malabsorptive	Restrictive	Combination Malabsorptive/Restrictive
Jejunioileal Bypass	Vertical Banded Gastroplasty	Roux-en-Y Gastric Bypass
	Silastic Ring Vertical Gastroplasty	Biliopancreatic Diversion
	Horizontal Banded Gastroplasty	Duodenal Switch
	Adjustable Gastric Band	

It is important to emphasize that “[t]here has been no agreement to date regarding the best outcome measure to use when evaluating the results of results of... bariatric surgery” (Fisher and Barber 1999:96). Surgeons report results in terms of change in BMI, total weight lost, percentage excess weight lost and percentage total weight lost (Brolin et al. 1989; Halverson and Koehler 1981; MacLean et al. 1990; MacLean, Rhode, and Shizgal 1981; Reinhold 1982; Versélewel de Witt Hamer et al. 1999).<sup>98</sup> According to Brolin (1992:577S), most bariatric surgeons report results in terms of mean percent excess weight lost (weight above ideal weight). Balsiger et al. (2000a:485) argue, “[t]o date, a realistic goal of bariatric surgery is that most (70%) patients should be able to attain a target loss of at least 50% of excess weight.”<sup>99</sup>

<sup>98</sup> See also Hell et al. (2000) and Hildebrandt (1998).

<sup>99</sup> See also Baltasar et al. (1998); Brolin (1992); Deitel (1998); Hall et al. (1990).

Long-term follow-up of patients has proved difficult for bariatric surgeons. “[m]ost surgeons have encountered great difficulty in obtaining a high percentage of patient follow-up, with the percentage lost to follow-up increasing rapidly with time following surgery” (Fisher and Barber 1999:96).<sup>100</sup> The International Bariatric Surgery Registry reported a follow-up of only 5.1 percent at five years for 1,359 patients eligible for that time interval (Renquist et al. 1992). The reasons for patient dropout are not well known (Brolin 1992). Some surgeons interpret patient dropout as a result of weight regain (Hall et al. 1990; MacLean et al. 1990); others suspect that patients may be reluctant to return when they perceive there are no postoperative problems (Higa et al. 2000).<sup>101</sup> As Fisher and Barber (1996:96) observe, “[t]his loss of patient follow-up affects the denominator of any statistical analysis, reducing the validity of any conclusions drawn.”<sup>102</sup>

### **Malabsorptive Procedures**

*Jejunioileal Bypass (JIB)*. (Also known as *intestinal bypass*). The JIB was the first operation that was widely used for severe obesity and dominated the field of bariatric surgery in the 1960s and 1970s (Deitel 1998; Griffen, Bivins, and Bell 1983; Kral 1992b; Mun et al. 2001). The JIB involves bypassing most of the small intestine, anastomosing 14 inches of jejunum (second segment) to the last four inches of ileum (third segment) (Balsiger et al. 2000a; Castelnovo-Tedesco 1987; DeWind and Payne 1976; Kral 1992a; O’Leary 1980, 1992). Thus, this operation exerts weight loss effects through malabsorption. Patients could eat large amounts of food, which would be poorly digested or passed along too fast for the body to absorb many calories. The idea was appealing because a change in eating habits was not necessarily imposed; the patient could eat as much as he or she wanted and still lose weight.

Although weight losses with this procedure proved to be satisfactory, the JIB was associated with a high incidence of severe complications, including acute hepatic failure, late development of cirrhosis, oxalate nephropathy, immune arthritis and various metabolic deficiencies (Balsiger et al. 2000a; Deitel 1998; Griffen et al. 1983; Kolanowski 1997; Kral 1992a; O’Leary 1980). The 1978 NIH Consensus

<sup>100</sup> See also Brolin et al. (1989); Choi et al. (1999); Powers and Rosemurgy (1989).

<sup>101</sup> See also Grace (1992).

<sup>102</sup> See also Choi et al. (1999).

Development Conference reviewed the complications associated with the JIB and determined that this procedure should no longer be performed (NIH Consensus Development Conference 1979). The JIB fell out of favor as a bariatric surgical technique and has rarely been performed since 1980 (NIH Consensus Development Conference 1992).<sup>103</sup>

### Restrictive Procedures

*Vertical Banded Gastroplasty (VBG)*. (Also known as “stomach stapling”). The VBG, introduced by Mason in 1980 is the most commonly performed gastric restriction operation worldwide (Grace 1992; Hell et al. 2000; Mason et al. 1998). This operation reduces food intake by closing off part of the stomach. A small pouch (size depends on surgeon’s preference but varies between 15 to 30 milliliters) is created at the top of the stomach, using up to four vertical staple lines (Ashley et al. 1993; Balsiger et al. 2000a; Kral 1992a; Mason et al. 1998). The pouch initially holds about one ounce of food and expands to two or three ounces with time. The pouch empties into the remainder of the stomach through a narrow channel (usually about 10 millimeters in diameter) known as the *stoma* (Kral 1992a). The stoma delays the emptying of food from the pouch and enhances satiety (Mason 1982). It is reinforced by a band or collar of polypropylene mesh to prevent it from enlarging over time. The VBG can now be performed laparoscopically (Deitel 1998; Lonroth and Dalenback 1998).

This operation is technically simple to perform and the normal digestive and absorptive process is maintained (Ashley et al. 1993; Grace 1992; Mason et al. 1998). Complications of the VBG include gastric leak, staple line disruption, erosion of staples or band, stomal obstruction, and incisional hernias (Ashley et al. 1993; Baltasar et al. 1998; Belachew and Legrand 1999; Choi et al. 1999; Deitel 1998; Grace 1992; MacLean et al. 1990; Papakonstantinou et al. 1998). A common side effect of the VBG is persistent vomiting, particularly if food is inadequately chewed or rapidly ingested (Baltasar et al. 1998; Grace 1992; Nightengale et al. 1991; Kolanowski 1997; Kral 1992a). Intolerance of solid food such as meat, fresh fruit and vegetables is also problematic (Belachew and Legrand 1999; Bufalino et al. 1989; Deitel 1998; Grace 1992; Nightengale et al. 1991).

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<sup>103</sup> Some specialized centers in Canada and the United States are currently performing safer variants of the JIB. See Deitel (1998) and O’Leary (1992).

Patients who have undergone a VBG can initially lose 60 percent of their excess weight (Ashley et al. 1993; Brolin 2002; Deitel et al. 1986). However, long-term weight maintenance after VBG is disappointing. Nightengale et al. (1991) found that only 38 percent of their VBG patients had lost and maintained at least 50 percent of their excess weight at three-year follow-up. Other researchers have reported similar figures at three- and five-year follow-ups (Ramsey-Stewart 1994; Sugerman et al. 1987; Versélewel de Witt Hamer et al. 1999). Kral (1992a) estimates that VBG patients can lose about 40 percent of their excess weight. According to Brolin (2002:2793), “[g]astroplasty has recently fallen into disfavor due to poor weight loss maintenance and a 15% to 20% rate of reoperation.”

*Silastic Ring Vertical Gastroplasty (SRVG).* This is a variant of the VBG, except that a 5-centimeter silastic ring (made of wire and covered with polypropylene) is used to prevent dilatation of the stoma (Baltasar et al. 1998; Deitel 1998; Eckhout and Willbanks 1989; Eckhout, Willbanks, and Moore 1986; Sjöström 2000). The complications associated with the VBG are essentially the same for SRVG, and the results of SRVG are similar to the VBG (Deitel 1998).

*Horizontal Banded Gastroplasty (HBG).* The HBG was first performed in 1971 (Mason 1998; Pace et al. 1979). A single or double staple row or plastic collar was applied horizontally across the upper part of the stomach, creating a 30 to 60-milliliter pouch with a 9- to 11-millimeter stoma (MacLean et al. 1981; Salmon 1984).<sup>104</sup> The stoma between the pouch and the remainder of the stomach dilated rapidly, and thus long-term results were poor (Deitel 1984; Deitel et al. 1986; Deitel and Anand 1989; Grace 1984, 1987, 1992; Kolanowski 1997; Mason 1982; Näslund 1986; Salmon 1984; Sjöström 2000). This procedure is now considered obsolete (Brolin et al. 1989; Kral 1992a).

*Adjustable Gastric Band (AGB).* (Also known as *Adjustable Silicone Gastric Band* or *ASGB*.) The AGB has only recently been approved for use in Canada and the United States, but has been used in Europe, Asia and Australia since 1993 (Belachew et al. 1998). This surgery is most often done laparoscopically. A hollow, silicone band, connected through a tube to a saline reservoir (known as an access port), is placed around the upper stomach (Allen et al. 2001; Belachew et al. 1998; Deitel 1998; Mun

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<sup>104</sup> See also Gomez (1980).

et al. 2001; Sjöström 2000). The band squeezes the stomach, causing it to be divided into two sections. The small part lies above the band and is known as the pouch. The pouch has a capacity of 10 milliliters while the remaining part of the stomach lies below the band (Allen et al. 2001). Like the other forms of restrictive surgery, the AGB helps the patient eat less by limiting the amount of food that can be eaten at one time and increasing the time it takes for food to be digested. Depending on the person's weight loss trajectory, the stoma size can be adjusted by inflating or deflating the hollow band on an outpatient basis (Belachew et al. 1998; Belachew and LeGrand 1999). Inflating the band makes the opening smaller, causing food to pass more slowly. Deflating the band makes it wider, causing food to pass more quickly. This adjustment is made by adding or removing fluid inside the hollow band. The surgeon does this by injecting or removing the fluid through the access port, which is placed under the skin in a muscle in the chest wall. The port is connected to the band by the tubing (Belachew et al. 1998; Busetto et al. 1996; Deitel 1998; Forsell and Hellers 1997; Sjöström 2000).

The AGB is technically simple to perform and is minimally invasive; it does not involve cutting or stapling the stomach (Belachew et al. 1998). It is easily reversible, as the device can simply be removed (Allen et al. 2001; Belachew et al. 1998). Studies that have been conducted indicate that weight loss results vary, but patients typically lose between 50 to 70 percent of their excess weight (Allen et al. 2001; Belachew et al. 1998; Forsell and Hellers 1997; Hell et al. 2000; Nehoda et al. 2001; O'Brien et al. 1999; Rubenstein 2002). The percentage of complications associated with the AGB is low and these include frequent vomiting, food intolerance, band erosion; pouch dilatation and stomach slippage (Allen et al. 2001; Belachew et al. 1998; Busetto et al. 1996; Rubenstein 2002).

#### **Combination Restrictive/Malabsorptive Surgeries**

*Roux-en-Y Gastric Bypass (RNY)*. The RNY is the most common gastric bypass procedure (Kolanowski 1997).<sup>105</sup> In the RNY gastric bypass, a 20-milliliter stomach pouch is created by vertical rows of stapling (Fisher and Barber 1999). It is also completely stapled shut and the outlet of the pouch opens, through a stoma, into the small intestine rather than into the rest of the stomach. This is done by dividing

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<sup>105</sup> The RNY is rarely performed in Europe (Hell et al. (2000).

the jejunum and connecting the distal end up to the pouch. The other open end of the bowel is sewn back into the side of the Roux limb of the intestine; this segment is known as the Roux-en-Y limb. Ingested food will bypass 90 percent of the stomach, the whole duodenum, and 15 to 20 centimeters of the jejunum (Brolin 2002; Kral 1992a). Hence, this technique induces weight loss by combining restricted intake and a moderate degree of malabsorption of calories and nutrients (Kolanowski 1997; Kral 1992a). The RNY can be performed laparoscopically (Deitel 1998; Higa et al. 2000; Lonroth and Dalenback 1998).

The Roux-en-Y limb can vary in lengths (Fisher and Barber 1999). The more jejunum that is bypassed, the more malabsorption that occurs. If the remaining jejunum is 101 inches or more (255 centimeters or more), it is referred to as a proximal RNY. A remaining jejunum length of 61 to 100 inches (153 to 254 centimeters) is a medial RNY, while a remaining jejunum length of 40 to 60 inches (101 to 152 centimeters) is a distal RNY. The smaller jejunum reduces the amount of food that can be absorbed by the body. It also reduces the absorption of vitamins and minerals. Patients with a medial or distal procedure are at higher risk of developing vitamin and mineral deficiencies and have to take a greater amount of vitamin and mineral supplements than the proximal patient.

Patients can lose between 60 and 75 percent of excess weight with the RNY (Balsiger et al. 2000b; Brolin 2002; Hall et al. 1990; Hell et al. 2000; Pories et al. 1995; Sugerman et al. 1987; Sugerman et al. 1992). Surgeons who perform this procedure have reported complications ranging from pulmonary embolism; osteomalacia; intestinal obstruction; electrolyte imbalance, and malnutrition among others (Balsiger et al. 2000b; Crowley, Seay, and Mullin 1984; Grace 1992; Hall et al. 1990; MacLean 1984; Sugerman et al. 1992; Waters et al. 1991). Since the contents of the stomach enter the small bowel rapidly, patients sometimes experience “dumping syndrome” or feelings of weakness, sweating, palpitations, diarrhea and nausea after ingesting foods with a high sugar content (Brolin 2002; Kolanowski 1997; Kral 1992a; Sugerman et al. 1992). Additionally, since the duodenum, the site of vitamin and mineral absorption, is bypassed, the RNY may cause malabsorption of iron and calcium, increasing the risk of anemia, osteoporosis and hip fracture (Brolin 2002; Kolanowski 1997; Kral 1992b; O’Leary 1992; Sugerman et al. 1992). Nutritional supplementation is mandatory for RNY patients (Sugerman et al. 1992).

*Biliopancreatic Diversion (BPD)*. This more drastic operation involves removal of approximately two-thirds to three-quarters of the stomach to moderately restrict the amount of food that can be consumed at one time. The volume of the remaining gastric pouch is much larger than other procedures and may vary from 200 to 500 milliliters, depending on the weight of the patient (Kolanowski 1997; O'Leary 1992; Scopinaro et al. 1996). The loss of weight is mainly produced by intestinal malabsorption. The intestinal tract is rearranged so that bile and pancreatic juices, which are necessary for the absorption of fat, are diverted away from the food stream until very late in their passage through the intestine (Balsiger et al. 2000a; Deitel 1998; Mun et al. 2001; O'Leary 1992; Scopinaro et al. 1998; Sjöström 2000). Separating the flow of food from the flow of bile and pancreatic juices inhibits the absorption of calories and some nutrients.

After the partial removal of the stomach, the ileum is then divided with the distal end attached to the stomach pouch to create an *alimentary limb*. All the food moves through this segment; however, little is absorbed. The bile and pancreatic juices move separately through the *biliopancreatic limb*, which is created by connecting the jejunioileal segment to the side of the distal ileum 50 cm from the ileocecal valve (Deitel 1998; O'Leary 1992; Scopinaro et al. 1996; Sjöström 2000). This supplies digestive juices to the last 50 centimeters of the ileum (the *common limb* or *common channel*). Most of the digestion and absorption of nutrients will take place in the common channel. This last part of the bowel is too short to absorb all of the ingested fat; thus, the effect is to selectively reduce absorption of fats and starches (Deitel 1998).

This procedure is highly effective in inducing weight loss. Scopinaro et al. (1996) report that after 18 years of follow-up, their patients have maintained an excess weight loss of 72 percent. Although this operation is very powerful, it is also complicated and extreme. Patients are subject to increased risk of nutritional deficiencies of protein, vitamins and minerals and require life-long nutritional supplements (Brolin 2002; Kolanowski 1997; Mun et al. 2001; Scopinaro et al. 1996; Vanuystel et al. 1993). Abdominal bloating, loose, malodorous stools and flatus are also a problem (Marceau et al. 1998; Scopinaro et al. 1996).

While this operation has been performed extensively in specialized centers in Europe, particularly in Italy where it was pioneered, it is not widely performed in North America.

*Biliopancreatic Diversion with Duodenal Switch (DS).* (Also known as the *Distal Gastric Bypass with Duodenal Switch* or *Duodenal Switch*). This surgical technique is a modified form of the BPD (Marceau et al. 1998). As with the BPD, a portion of the stomach is removed, although more of the stomach is left intact. However, unlike the BPD, the pylorus (the valve at the outlet of the stomach which regulates the emptying of the stomach contents into the duodenum) is preserved, as is a small part of the duodenum (Sjöström 2000). Like the BPD, malabsorption is accomplished by rerouting the path of pancreatic and bile secretions so that food travels an abridged pathway and does not meet up with the digestive juices until the common channel. In the DS, however, the common channel is 75 to 100 centimeters in length.

The DS appears to produce weight loss comparable or greater than the BPD. On average, patients lose 70 to 80 percent of their excess weight (Baltasar et al. 2001; Marceau et al. 1998; Rabkin 1998). Patients may eat normal-sized portions of food, and the diet is unrestricted. Since the pylorus is preserved, there is no dumping syndrome (Rabkin 1998). Unpleasant side effects include frequent foul-smelling bowel movements and foul smelling flatus (Baltasar et al. 2001). This operation also has the potential to cause protein malnutrition and vitamin and mineral deficiencies, albeit not to the same degree as the BPD (Balsiger et al. 2000a; Marceau et al. 1998).

#### Caveats about Bariatric Surgery

While bariatric surgery may be the most effective treatment modality for morbid obesity, patients rarely attain ideal weight (Balsiger et al. 2000a; NIH Consensus Development Conference 1992). Moreover, according to the NIH Consensus Development Conference (1992:617S), “[s]ome weight regain is common by 2 to 5 years after operation.” Most long-term studies show a tendency for modest weight gain (5 to 7 kilograms) after the initial postoperative years (Balsiger et al. 2000a:480; Brodin 2002).

Studies also reveal that the various surgeries are associated with numerous complications, which vary from unpleasant to life threatening.



INTERVIEW SCHEDULE

1. When did you undergo your surgery?
2. What type of surgery did you have?
3. Have you had any other weight loss surgery?
4. Can you describe your life prior to your [first] surgery?
5. Do you think you experienced any weight-related discrimination?
6. Did you have any weight-related health problems?
7. How did you feel about your body when you were overweight? I.e., did you feel you “owned” your body?
8. What weight loss measures did you undertake prior to your [initial] surgery?
9. What brought you to the decision to undergo the [initial] surgery?
10. How did you hear about this type of operation?
11. Did you make the decision to undergo the surgery on your own, or in consultation with anyone else?
12. How did your partner/other family members feel when you told them about your decision?
13. Can you describe the process involved in undergoing weight loss surgery?
14. Were you seen by a mental health worker before the operation?
15. Did you have any fears about the possible consequences of the surgery? That is, were you afraid of permanent, severe side effects or even dying during the operation?
16. What degree of risk were you prepared to accept? For instance, would you have accepted a 10 percent mortality risk? Twenty percent? Higher?
17. How would you describe your relationship with your surgeon?
18. Can you describe the surgical experience and the immediate aftermath?
19. Can you describe the pattern of your weight since the [initial] operation? For example, how much weight did you lose? Have you regained any? Has your weight stabilized?
20. How did you feel about the changes taking place in your body after your [first] surgery?
21. What was your partner/family’s reaction when they observed the changes in your body?

22. Do you feel your life has changed in any significant way as a result of the [first] operation? If so, how?
23. Are there any side effects that occurred as a result of the operation? If so, could you tell me what these are? How much do you feel they impact on your quality of life?
24. Overall, how would you describe the operation in terms of success or failure? What is your definition of success? Failure?
25. You mentioned earlier that you have had other surgery since the initial procedure. Can you tell me what this is?
26. What factors led up to the subsequent surgery?
27. Can you tell me a little bit about the consequences of this other surgery?
28. How do you feel about your body now?
29. Would you say you are a “different” person since your surgery?
30. Can you tell me which body type reflects you as you really are—the heavier body or the slimmer body?
31. Do you “own” your body now?
32. How do you feel towards very overweight people since you’ve had your surgery?
33. How did you come to be involved with the size acceptance movement?
34. What impact, if any, has the size acceptance movement had on your life?
35. What is your general opinion of weight loss surgery?
36. Support groups for people who have undergone weight loss surgery exist in some regions. There are also numerous groups on the Internet. Were you ever advised of such a group during the time you had your surgery(ies)?
37. When was that, exactly? Did you ever join the group?
38. If you did, how would you describe the experience?
39. If there was no support group in place at the time of your surgery, do you wish there had been?
40. Do you participate in support groups organized on the Internet?
41. What do you think of the size acceptance movement?
42. How would you describe your quality of life now?
43. How do you feel, now, about your decision to have the surgery?
44. Based on your own experiences, what advice would you give to other women who are considering this operation?

WEIGHT LOSS SURGICAL RECIPIENT STUDY 2001

**LETTER OF INFORMATION**

My name is Leanne Joannis. I am a Ph.D. student in the Department of Sociology at McMaster University, in Hamilton, Ontario, Canada. The focus of my doctoral dissertation is the experience of people who have undergone weight loss surgery. My supervisor is Dr. Rhonda Lenton, who is also affiliated with the Department of Sociology.

While doctors have written extensively on the techniques and success rates of various weight loss surgeries, little is known about how the patients themselves feel about this operation. My research attempts to fill in this gap in our knowledge by talking to surgical recipients about their experience of the surgery, how and why to chose to undergo it, how they feel about their bodies since the operation, what impact, if any, it has had on their lives, etc.

Data will be gathered by means of in-depth, face-to-face interviews, lasting approximately 1½ hours in length. Examples of the questions that may be asked are, When did you have your operation? Where did it take place? Why did you decide to have the surgery? Are you pleased with the results? The interview will take place at your convenience, at a location of your choice. With your permission, the interview will be tape recorded.

You may decline to answer any questions asked in the interview and/or you may also withdraw from the research study at any point. In the event that you do withdraw from the study, any notes or tapes pertaining to your interview will be returned to you.

The information you provide will be kept strictly confidential and will be used for research purposes only. All identifying information will be removed from the interview material. The tapes will be stored in a locked cabinet and will be destroyed after a period of three years.

There are no anticipated physical risks as a result of participating in this research study. If, however, you experience any emotional upset, you should feel free to terminate the interview.

Your participation in this study is greatly appreciated. If you are interested, you will be provided with a transcript of the interview as well as a summary of the research findings once the study is completed.

This research study has been reviewed and granted ethics clearance by the McMaster Research Ethics Board. Participants with concerns or questions about their involvement in the study may contact:

McMaster Research Ethics Board Secretariat, c/o Office of Research Services

Or:

Dr. Rhonda Lenton  
Department of Sociology

CONSENT FORM TO PARTICIPATE IN RESEARCH

I have read the Letter of Information provided by Leanne Joannis. I understand that this is a study about the experience of weight loss surgery.

I understand that my participation is completely voluntary and that I can withdraw from the study at any time and/or refuse to answer specific questions. If I do withdraw, then I may request that all materials associated with my interview will be returned to me.

I understand the interview will be approximately 1½ hours in length and that this will be tape- recorded. All materials relating to the interview will be stored in a secure location and will be destroyed after a period of three years.

The information I provide will be treated with the utmost confidence. No information concerning my identity will be released or included in any publication from this research.

I understand that Leanne Joannis will provide me with a brief summary of the research findings.

Name \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

\_\_\_\_\_  
Leanne Joannis, M.A.  
Research Investigator

Date \_\_\_\_\_

INVITATION TO PARTICIPATE - NAAFA

Subject: Study on effects of weight loss surgery

Dear Friends and Colleagues:

Dr. Donna Ciliska, author of *Beyond Dieting* and faculty member at McMaster University in Ontario, Canada, has asked my (and possibly your) assistance. She has a doctoral student who is doing a qualitative study (feminist analysis) of women and how they experience the results of gastroplasty or bypass surgery, for up to many years later. She is conducting in-depth interviews and so far she has 7 participants. Her student would like a way to contact other possible participants.

She is willing to do the interviews by phone. If anyone is interested in being interviewed for this study, please contact the student directly. Her name is Leanne Joannis.

Thanks in advance for your help.

Cheri Erdman

APPENDIX H

INVITATION TO PARTICIPATE – OSSG-CANADA

My name is Leanne Joannis and I am a Ph.D. student in sociology at McMaster University in Hamilton, Ontario. My interest in the politics of weight is longstanding. For my masters degree I studied large people's experience of social and economic discrimination and its consequences on their lives. For my Ph.D., I decided to focus my research on women's experiences with weight loss surgery: their decisions to undergo it, their descriptions of the surgical experience itself and its impact on their quality of life, etc.

Participation in the study would involve an in-depth, telephone interview lasting approximately an hour in length—although it could go on a bit longer. It would just depend on what you have to say. You are free to refuse to answer any questions asked in the interview. With your permission, the interview will be tape-recorded.

The information you provide me will be treated with the utmost confidentiality and will be used for research purposes only. All identifying information will be removed from the interview material. I will pay for the long-distance call.

If you would prefer to correspond with me via e-mail before you feel comfortable enough to give me your home phone number, I quite understand. My supervisor, Dr. Rhonda Lenton, can vouch for the legitimacy of my study.

## BIBLIOGRAPHY

- Abenhaim, Lucien, Yola Moride, François Brenot, Stuart Rich, Jacques Benichou, Xavier Kurz, Tim Higenbottam, Celia Oakley, Emil Wouters, Michel Aubier, Gérald Simmoneau and Bernard Bégaud. 1996. "Appetite-Suppressant Drugs and the Risk of Primary Pulmonary Hypertension." *New England Journal of Medicine* 335:609-616.
- Abrams, Kay Kosak, La Rue Allen and James J. Gray. 1993. "Disordered Eating Attitudes and Behaviors, Psychological Adjustment, and Ethnic Identity: A Comparison of Black and White Female College Students." *International Journal of Eating Disorders* 14(1):49-57.
- Adami, Gian Franco, Anna Meneghelli, Annalisa Bressani and Nicola Scopinaro. 1999. "Body Image in Obese Patients Before and After Stable Weight Reduction Following Bariatric Surgery." *Journal of Psychosomatic Research* 46(3):275-281.
- Adams, Cynthia H., Nancy J. Smith, David C. Wilbur and Kathleen E. Grady. 1993. "The Relationship of Obesity to the Frequency of Pelvic Examinations: Do Physician and Patient Attitudes Make a Difference?" *Women and Health* 20(2):45-57.
- Agell, Gladys and Esther D. Rothblum. 1991. "Effects of Clients' Obesity and Gender on the Therapy Judgments of Psychologists." *Professional Psychology, Research and Practice* 22(3):223-229.
- Algazi, Linda P. 2000. "Transactions in a Support Group Meeting: A Case Study." *Obesity Surgery* 10:186-191.
- Allen, Jeff W., Mark G. Coleman and George Fielding. 2001. "Lessons Learned From Laparoscopic Gastric Banding for Morbid Obesity." *American Journal of Surgery* 182:10-14.
- Allison, David B., Kevin R. Fontaine, JoAnn Manson, June Stevens and Theodore Van Itallie. 1999. "Annual Deaths Attributable to Obesity in the United States." *JAMA* 282(16):1530-1538.
- Allison, David B. and Suzanne E. Saunders. 2000. "Obesity in North America: An Overview." *Medical Clinics of North America* 84(2):305-332.
- Allon, Natalie. 1973a. "The Stigma of Overweight in Everyday Life." Pp. 83-102 in *Obesity in Perspective*, edited by George A. Bray. Bethesda, MD: National Institutes of Health Publication No. 75-708.
- Allon, Natalie. 1973b. "Group Dieting Rituals." *Society* 10:36-42.
- Allon, Natalie. 1975. "Latent Social Services in Group Dieting." *Social Problems* 23:59-69.
- Allon, Natalie. 1976. "Tensions in Interactions of Overweight Adolescent Girls." *Women and Health* 1:14-15, 18-23.
- Allon, Natalie. 1979. "Self-Perceptions of the Stigma of Overweight in Relationship to Weight-Losing Patterns." *American Journal of Clinical Nutrition* 32:470-480.

- Allon, Natalie. 1982. "The Stigma of Overweight in Everyday Life." Pp. 130-174 in *Psychological Aspects of Obesity: A Handbook*, edited by Benjamin B. Wolman. New York: Van Nostrand Reinhold.
- American Society for Bariatric Surgery. "Membership Listing." Retrieved February 21, 2003 (<http://www.asbs.org/>).
- Andersen, Ross E. 2000. "The Spread of the Childhood Obesity Epidemic." *Canadian Medical Association Journal* 163(11):1461-1462.
- Angel, Aubie, Janis T. Winocur and Daniel A.K. Roncari. 1989. "Morbid Obesity—The Problem and its Consequences." Pp. 19-26 in *Surgery for the Morbidly Obese Patient*, edited by Mervyn Deitel. Philadelphia, PA: Lea and Febiger.
- Ashley, S., D.L. Bird, G. Sugden and C.M.S. Royston. 1993. "Vertical Banded Gastroplasty for the Treatment of Morbid Obesity." *British Journal of Surgery* 80:1421-1423.
- Atanassoff, Peter G., Branko M. Weiss, E.R. Schmid and M. Tornic. 1992. "Pulmonary Hypertension and Dexfenfluramine." *Lancet* 339:436.
- Austin, S. Bryn and Steven L. Gortmaker. 2001. "Dieting and Smoking Initiation in Early Adolescent Girls and Boys: A Prospective Study." *American Journal of Public Health* 91(3):446-450.
- Averett, S. and S. Korenman. 1999. "Black-White Differences in Social and Economic Consequences of Obesity." *International Journal of Obesity* 23:166-173.
- Babbie, Earl. 2001. *The Practice of Social Research*. 9<sup>th</sup> Ed. Belmont, CA: Wadsworth/Thomson Learning.
- Bagley, C.R., D.N. Conklin, R.T. Isherwood, D.R. Pechiulis and L.A. Watson. 1989. "Attitudes of Nurses Toward Obesity and Obese Patients." *Perceptual and Motor Skills* 68:954.
- Balsamo, Anne. 1996. *Technologies of the Gendered Body*. Durham, NC: Duke University Press.
- Balsiger, Bruno M., Michel M. Murr, Juan Lucas Poggio and Michael G. Sarr. 2000a. "Bariatric Surgery: Surgery for Weight Control in Patients with Morbid Obesity." *Medical Clinics of North America* 84(2):477-489.
- Balsiger, Bruno M., Frank P. Kennedy, Haitham S. Abu-Lebdeh, Maria Collazo-Clavell, Michael D. Jensen, Timothy O'Brien, Donald D. Hensrud, Sean F. Dinneen, Geoffrey B. Thompson, Forencia G. Que, Donald E. Williams, Matthew M. Clark, Jeanne E. Grant, Marsha S. Frick, Roger A. Mueller, Jane L. Mai and Michael G. Sarr. 2000b. "Prospective Evaluation of Roux-en-Y Gastric Bypass as Primary Operation for Medically Complicated Obesity." *Mayo Clinic Proceedings* 75:673-680.
- Baltasar, Aniceto, Rafael Bou, Francisco Arlandis, Rosa Martinez, Carlos Serra, Marcelo Bengochea and Javier Miro. 1998. "Vertical Banded Gastroplasty at More Than 5 Years." *Obesity Surgery* 8:29-34.
- Baltasar, A., R. Bou, M. Bengochea, F. Arlandis, C. Escrivá, J. Miró, R. Martínez and N. Pérez. 2001. "Duodenal Switch: An Effective Therapy for Morbid Obesity—Intermediate Results." *Obesity Surgery* 11:54-58.



- Barlow, Kate. 1998a. "Surgery Causes Coma." *The Hamilton Spectator*, April 1, A1, A6.
- Barlow, Kate. 1998b. "Surgery Nightmare II." *The Hamilton Spectator*, April 3, A1, A5.
- Barlow, Kate. 1998c. "Surgeons Feel Gastroplasty not Worth Health Risk." *The Hamilton Spectator*, April 6, A3.
- Bar-Tal, Daniel and Leonard Saxe. 1976. "Physical Attractiveness and its Relationship to Sex-Role Stereotyping." *Sex Roles* 2(2):123-133.
- Bartky, Sandra Lee. 1990. *Femininity and Domination: Studies in the Phenomenology of Oppression*. New York: Routledge.
- Beausoleil, Natalie. 1994. "Makeup in Everyday Life: An Inquiry into the Practices of Urban American Women of Diverse Backgrounds." Pp. 33-57 in *Many Mirrors: Body Image and Social Relations*, edited by Nicole Sault. New Brunswick, NJ: Rutgers University Press.
- Belachew, Mitiku, Marc Legrand, Vernon Vincent, Michel Lismonde, Nicole Le Docte and Veronique Deschamps. 1998. "Laparoscopic Adjustable Gastric Banding." *World Journal of Surgery* 22:955-963.
- Belachew, M. and M. Legrand. 1999. "Update on Laparoscopic Surgery for Morbid Obesity." Pp. 789-793 in *Progress in Obesity Research: 8*, edited by Bernard Guy-Grand and Gérard Ailhaud. London: John Libbey.
- Bell, Judith. 1993. *Doing Your Research Project*. 2<sup>nd</sup> Ed. Bristol, PA: Open University Press.
- Bennett, William and Joel Gurin. 1982. *The Dieter's Dilemma: Eating Less and Weighing More*. New York: Basic Books.
- Benson, Peter L., Drew Severs, John Tatgenhorst and Nancy Loddengaard. 1980. "The Social Costs of Obesity: A Non-Reactive Field Study." *Social Behavior and Personality* 8(1):91-96.
- Berg, Frances M. 1999. "Health Risks Associated with Weight Loss and Obesity Treatment Programs." *Journal of Social Issues* 55(2):277-297.
- Birmingham, C. Laird, Jennifer L. Muller, Anita Palepu, John J. Spinelli and Aslam H. Anis. 1999. "The Cost of Obesity in Canada." *Canadian Medical Association Journal* 160(4):483-488.
- Blackburn, George L. 1993. "Comparison of Medically Supervised and Unsupervised Approaches to Weight Loss and Control." *Annals of Internal Medicine* 119(7 pt 2):714-718.
- Blanck, Heidi Michels, Laura Kettel Khan and Mary K. Serdula. 2001. "Use of Nonprescription Weight Loss Products: Results from a Multistate Survey." *JAMA* 286(8):930-935.
- Blumberg, Phyllis and Linda P. Mellis. 1985. "Medical Students' Attitudes Toward the Obese and the Morbidly Obese." *International Journal of Eating Disorders* 4(2):169-175.
- Bordo, Susan. 1993. *Unbearable Weight: Feminism, Western Culture, and the Body*. Berkeley, CA: University of California Press.
- Bouchard, Claude. 1989. "Genetic Factors in Obesity." *Medical Clinics of North America* 73:67-81.

- Bouchard, Claude. 1990. "Heredity and the Path to Overweight and Obesity." *Medicine and Science in Sports and Exercise* 23(3):285-291.
- Bouchard, Claude, Angelo Tremblay, Jean-Pierre Desprès, André Nadeau, Paul J. Lupien, Germain Thériault, Jean Dussault, Sital Moorjani, Sylvie Pinault and Guy Fournier. 1990. "The Response to Long-Term Overfeeding in Identical Twins." *New England Journal of Medicine* 322:1477-1482.
- Bovey, Shelley. 1994. *The Forbidden Body: Why Being Fat is not a Sin*. London: Pandora Press.
- Boyd, L.M. 1981. "Grab-Bag." *San Francisco Chronicle*, January 17, 33.
- Braet, C. and K. Wydhooge. 2000. "Dietary Restraint in Normal Weight and Overweight Children: A Cross-Sectional Study." *International Journal of Obesity* 24:314-319.
- Brand, Pamela A., Esther D. Rothblum and Laura J. Solomon. 1992. "A Comparison of Lesbians, Gay Men and Heterosexuals on Weight and Restrained Eating." *International Journal of Eating Disorders* 11(3):253-259.
- Bray, George A. 1986. "Effects of Obesity on Health and Happiness." Pp. 3-44 in *Handbook of Eating Disorders: Physiology, Psychology and Treatment of Obesity, Anorexia, and Bulimia*, edited by Kelly D. Brownell and John P. Foreyt. New York: Basic Books.
- Bray, George A. 1993. "Use and Abuse of Appetite-Suppressant Drugs in the Treatment of Obesity." *Annals of Internal Medicine* 119(7 pt 2):707-713.
- Bray, George A. and David S. Gray. 1988. "Obesity. Part I—Pathogenesis." *Western Journal of Medicine* 149:429-441.
- Breseman, Betsy Covell, Sharron J. Lennon and Theresa L. Schulz. 1999. "Obesity and Powerlessness." Pp. 173-197 in *Appearance and Power*, edited by Kim K.P. Johnson and Sharron J. Lennon. New York: Berg.
- Breyspraak, Linda M., Jeanne McGee, Judy Cohen Conger, Judith L. Whatley and James T. Moore. 1977. "Sensitizing Medical Students to Impression Formation Processes in the Patient Interview." *Journal of Medical Education* 52:47-54.
- Brink, Pamela J. 1989. "The Fattening Room Among the Annang of Nigeria." *Medical Anthropology* 12:131-143.
- Brolin, Robert E. 1987. "Results of Obesity Surgery." *Gastroenterological Clinics of North America* 16(2):317-338.
- Brolin, Robert E. 1992. "Critical Analysis of Results: Weight Loss and Quality of Data." *American Journal of Clinical Nutrition* 55:577S-581S.
- Brolin, Robert E. 2002. "Bariatric Surgery and Long-Term Control of Morbid Obesity." *JAMA* 288(22):2793-2796.
- Brolin, Robert E., Hallis A. Kenler, Robert C. Gorman and Ronald P. Cody. 1989. "The Dilemma of Outcome Assessment After Operations for Morbid Obesity." *Surgery* 105:337-346.

- Brown, Catrina and Karin Jasper. 1993. "Why Weight? Why Women? Why Now?" Pp.16-35 in *Consuming Passions: Feminist Approaches to Weight Preoccupation and Eating Disorders*, edited by Catrina Brown and Karin Jasper. Toronto: Second Story Press.
- Brown, Peter J. and Melvin Konner. 1987. "An Anthropological Perspective on Obesity." *Annals of the New York Academy of Sciences* 499:29-46.
- Brownell, Kelly D. 1991. "Dieting and the Search for the Perfect Body: Where Physiology and Culture Collide." *Behavior Therapy* 22:1-22.
- Brownell, Kelly D. 1995. "Effects of Weight Cycling on Metabolism, Health, and Psychological Factors." Pp. 56-60 in *Eating Disorders and Obesity: A Comprehensive Handbook*, edited by Kelly D. Brownell and Christopher G. Fairburn. New York: Guilford Press.
- Brownell, Kelly D., M.R.C. Greenwood, Eliot Stellar and E. Eileen Shrager. 1986. "The Effects of Repeated Cycles of Weight Loss and Regain in Rats." *Physiology and Behavior* 38:459-464.
- Brownell, Kelly D. and F. Matthew Kramer. 1989. "Behavioral Management of Obesity." *Medical Clinics of North America* 73(1):185-201.
- Brownmiller, Susan. 1984. *Femininity*. New York: Fawcett Columbine.
- Bruch, Hilde. 1957. *The Importance of Overweight*. New York: W.W. Norton.
- Bruch, Hilde. 1973. *Eating Disorders: Obesity, Anorexia Nervosa, and the Person Within*. New York: Basic Books Inc.
- Brugman, E., J.F. Meulmeester, A. Spee-van der Wekke, R.J. Beuker, B.M. Zaadstra, J.J. Radder and P.S. Verloove-Vanhorick. 1997. "Dieting, Weight and Health in Adolescents in the Netherlands." *International Journal of Obesity* 21:54-60.
- BuFalino, Joan, Lynn Kolisetty, Gretchen Wagle McCaskey and Karen L. Stratton. 1989. "Surgery for Morbid Obesity: The Patients' Experiences." *Applied Nursing Research* 2(1):16-22.
- Burgard, Debora and Patricia Lyons. 1994. "Alternatives in Obesity Treatment: Focusing on Health for Fat Women." Pp. 212-230 in *Feminist Perspectives on Eating Disorders*, edited by Patricia Fallon, Melanie A. Katzman and Susan C. Wooley. New York: Guilford Press.
- Busetto, L., P. Valente, C. Pisent, G. Segato, F. de Marchi, F. Favretti, M. Lise and G. Enzi. 1996. "Eating Pattern in the First Year Following Adjustable Silicone Gastric Banding (ASGB) for Morbid Obesity." *International Journal of Obesity* 20:539-546.
- Cahnman, Werner J. 1968. "The Stigma of Obesity." *The Sociological Quarterly* 9:283-299.
- Callaghan, Karen A. 1994. "Introduction." Pp. vii-xv in *Ideals of Feminine Beauty: Philosophical, Social, and Cultural Dimensions*, edited by Karen A. Callaghan. Westport, CT: Greenwood Press.
- Calles-Escandon Jorge and Edward S. Horton. 1992. "The Thermogenic Role of Exercise in the Treatment of Morbid Obesity: A Critical Evaluation." *American Journal of Clinical Nutrition* 55:533S-557S.
- Canning, Helen and Jean Mayer. 1966. "Obesity--Its Possible Effect on College Acceptance." *New England Journal of Medicine* 275(21):1172-1174.

- Carter, Kathy Barrett. 1989. "Obese Worker Upheld on Biased Firing Based on Appearance Alone." *The Star-Ledger*, April 21, 27.
- Cash, Thomas F. 1990. "The Psychology of Physical Appearance: Aesthetics, Attributes, and Images." Pp. 51-79 in *Body Images: Development, Deviance and Change*, edited by Thomas F. Cash and Thomas Pruzinsky. New York: Guilford Press.
- Cash, Thomas F. and Robin E. Roy. 1999. "Pounds of Flesh: Weight, Gender and Body Images." Pp. 209-228 in *Interpreting Weight: The Social Management of Fatness and Thinness*, edited by Jeffery Sobal and Donna Maurer. New York: Aldine de Gruyter.
- Caskey, Sheila R. and Donald W. Felker. 1971. "Social Stereotyping of Female Body Image by Elementary School Age Girls." *Research Quarterly* 42(3):251-255.
- Cassidy, Claire M. 1991. "The Good Body: When Big is Better." *Medical Anthropology* 13:181-213.
- Castelnuovo-Tedesco, Pietro. 1987. "Bypass Surgery for Superobesity: The Patient's Experience." Pp. 161-193 in *The Psychological Experience of Surgery*, edited by Richard S. Blacher. New York: John Wiley and Sons.
- Chandarana, Praful C., M.B. Patrick Conlon, Ronald L. Holliday, Timothy Deslippe and Victoria A. Field. 1990. "A Prospective Study of Psychological Aspects of Gastric Stapling Surgery." *Psychiatry Journal of University of Ottawa* 15(1):32-35.
- Chapkis, Wendy. 1986. *Beauty Secrets: Women and the Politics of Appearance*. Boston, MA:South End Press.
- Charmaz, Kathy. 1995. "Grounded Theory." Pp. 27-49 in *Rethinking Methods in Psychology*, edited by Jonathan A. Smith, Rom Harré, Luk Van Langenhove. London: Sage.
- Chernin, Kim. 1981. *The Obsession: Reflections on the Tyranny of Slenderness*. New York: Parker and Row.
- Choi, Yong, James Frizzi, Anthony Foley and Michael Harkabus. 1999. "Patient Satisfaction and Results of Vertical Banded Gastroplasty and Gastric Bypass." *Obesity Surgery* 9:33-35.
- Ciliska, Donna. 1993. "Why Diets Fail." Pp. 80-90 in *Consuming Passions: Feminist Approaches to Weight Preoccupation*, edited by Catrina Brown and Karin Jasper. Toronto: Second Story Press.
- Cnattingius, Sven, Reinhold Bergström, Loren Lipworth and Michael S. Kramer. 1998. "Prepregnancy Weight and the Risk of Adverse Pregnancy Outcomes." *New England Journal of Medicine* 338(3):147-152.
- Coakley, E.H., E.B. Rimm, G. Colditz, I. Kawachi, W. Willett. 1998. "Predictors of Weight Change in Men: Results from The Health Professionals Follow-Up Study." *International Journal of Obesity* 22:89-96.
- Cogan, Jeanine C., Satish K. Bhalla, Araba Sefa-Dedeh and Esther D. Rothblum. 1996. "A Comparison Study of United States and African Students on Perceptions of Obesity and Thinness." *Journal of Cross-Cultural Psychology* 27(1):98-113.
- Cogan, Jeanine C. and Paul Ernsberger. 1999. "Dieting, Weight, and Health: Reconceptualizing Research and Policy." *Journal of Social Issues* 55(2):187-205.

- Cogan, Jeanine C. and Esther D. Rothblum. 1992. "Outcomes of Weight-Loss Programs." *Genetic, Social and General Psychology Monographs* 118:387-415.
- Connolly, Heidi M., Jack L. Crary, Michael D. McGoan, Donald D. Hensrud, Brooks S. Edwards, William D. Edwards and Hartzell V. Schaff. 1997. "Valvular Heart Disease Associated with Fenfluramine-Phentermine." *New England Journal of Medicine* 337(9):581-518.
- Cook, Judith A. and Mary Margaret Fonow. 1990. "Knowledge and Women's Interests: Issues of Epistemology and Methodology in Feminist Sociological Research." Pp. 69-93 in *Feminist Research Methods: Exemplary Readings in the Social Sciences*, edited by Joyce McCarl Nielsen. Boulder, CO: Westview Press.
- Coontz, Stephanie and Peta Henderson, eds. 1986. *Women's Work, Men's Property: The Origins of Gender and Class*. London: Verso.
- Cordell, Gina and Carol Rambo Ronai. 1999. "Identity Management Among Overweight Women: Narrative Resistance to Stigma." Pp. 29-47 in *Interpreting Weight: The Social Management of Fatness and Thinness*, edited by Jeffery Sobal and Donna Maurer. New York: Aldine de Gruyter.
- Council on Scientific Affairs. 1988. "Treatment of Obesity in Adults." *JAMA* 260(17):2547-2551.
- Cowley, Geoffrey. 1990. "Made to Order Babies." *Newsweek* Winter/Spring, 96-100.
- Crandall, Christian S. 1988. "Social Contagion of Binge Eating." *Journal of Personality and Social Psychology* 55(4):588-598.
- Crandall, Christian S. 1991. "Do Heavy-Weight Students Have More Difficulty Paying for College?" *Personality and Social Psychology Bulletin* 17(6):606-611.
- Crandall, Christian S. 1994. "Prejudice Against Fat People: Ideology and Self-Interest." *Journal of Personality and Social Psychology* 66(5):882-894.
- Crandall, Christian S. 1995. "Do Parents Discriminate Against Their Overweight Daughters?" *Personality and Social Psychology Bulletin* 21:724-735.
- Crandall, Christian and Monica Biernat. 1990. "The Ideology of Anti-Fat Attitudes." *Journal of Applied Social Psychology* 20(3):227-243.
- Crandall, Christian S. and Rebecca Martinez. 1996. "Culture, Ideology, and Anti-Fat Attitudes." *Personality and Social Psychology Bulletin* 22:1165-76.
- Crocker, Jennifer, Beth Cornwell and Brenda Major. 1993. "The Stigma of Overweight: Affective Consequences of Attributional Ambiguity." *Journal of Personality and Social Psychology* 64(1):60-70.
- Crocker, Jennifer and Brenda Major. 1989. "Social Stigma and Self-Esteem: The Self-Protective Properties of Stigma." *Psychological Review* 96:608-630.
- Crowley, Leonard V., James Seay and Gerald Mullin. 1984. "Late Effects of Gastric Bypass for Obesity." *American Journal of Gastroenterology* 79:850-859.

- Curfman, Gregory D. 1997. "Diet Pills Redux." *New England Journal of Medicine* 337(9): 629-630.
- Daly, Mary. 1990. *Gyn/Ecology: The Metaethics of Radical Feminism*. Boston: Beacon Press.
- Dam, Julie K.L. and Ulrica Wihlberg. 2001. "Weigh to Go!" *People*, January 15, pp. 86-93.
- Davis, Jennifer and Robert Oswalt. 1992. "Societal Influences on a Thinner Body Size in Children." *Perceptual and Motor Skills* 74:697-698.
- Davis, Kathy. 1995. *Reshaping the Female Body*. London: Routledge.
- Davison, Kristen Krahnstoever and Leann Lipps Birch. 2001. "Weight Status, Parent Reaction, and Self-Concept in Five-Year-Old Girls." *Pediatrics* 107(1):46-53.
- Deaux, Kay and Randel Hanna. 1984. "Courtship in the Personals Column: The Influence of Gender and Sexual Orientation." *Sex Roles* 11(5/6):363-375.
- Deitel, Mervyn. 1984. "Horizontal Gastric Partitioning for Morbid Obesity." *Canadian Journal of Surgery* 27(3):237-238.
- Deitel, Mervyn. 1989. "Indications for Surgery for Morbid Obesity." Pp. 69-79 in *Surgery for the Morbidly Obese Patient*, edited by Mervyn Deitel. Philadelphia: Lea and Febiger.
- Deitel, Mervyn. 1998. "Overview of Operations for Morbid Obesity." *World Journal of Surgery* 22:913-918.
- Deitel, Mervyn and Sundaram V. Anand. 1989. "Horizontal Gastric Partitionings: An Historical Overview." Pp. 135-143 in *Surgery for the Morbidly Obese Patient*, edited by Mervyn Deitel. Philadelphia, PA: Lea and Febiger.
- Deitel, Mervyn, Beverly A. Jones, Ivan Petrov, Stanislaw R. Wlodarczyk and Surinder Basi. 1986. "Vertical Banded Gastroplasty: Results in 233 Patients." *Canadian Journal of Surgery* 29(5):322-324.
- DeJong, William. 1980. "The Stigma of Obesity: The Consequence of Naïve Assumptions Concerning the Causes of Physical Deviance." *Journal of Health and Social Behavior* 21:75-87.
- DeJong, William. 1993. "Obesity as a Characterological Stigma: The Issue of Responsibility and Judgments of Task Performance." *Psychological Reports* 73:963-970.
- DeJong, William and Robert E. Kleck. 1986. "The Social Psychological Effects of Overweight." Pp. 65-87 in *Physical Appearance, Stigma, and Social Behavior: The Ontario Symposium, Volume 3*, edited by C. Peter Herman, Mark P. Zanna, and E. Tory Higgins. Hillsdale, NJ: Lawrence Erlbaum.
- DeVault, Marjorie. 1999. *Liberating Method*. Philadelphia, PA: Temple University Press.
- DeWind, Loren and J. Howard Payne. 1976. "Intestinal Bypass Surgery for Morbid Obesity." *Journal of the American Medical Association* 236(20):2298-2301.
- Diamond, Nicky. 1985. "Thin is the Feminist Issue." *Feminist Review* 19:45-64.

- Dietz, William H. 1998. "Childhood Weight Affects Adult Morbidity and Mortality." *Journal of Nutrition* 128(Suppl II):411S-414S.
- Douketis, James D., John W. Feightner, John Attia, William Feldman and the Canadian Task Force on Preventive Health Care. 1999. "Periodic Health Examination, 1999 Update: 1. Detection, Prevention and Treatment of Obesity." *Canadian Medical Association Journal* 160(4):513-525.
- Dworkin, Sari H. 1988. "Not in Man's Image: Lesbians and the Cultural Oppression of Body Weight." *Women and Therapy* 8:27-39.
- Dyrenforth, Sue R., Orland W. Wooley and Susan C. Wooley. 1980. "A Woman's Body in a Man's World: A Review of the Findings on Body Image and Weight Control." Pp. 30-57 in *A Woman's Conflict: The Special Relationship Between Women and Food*, edited by Jane Rachel Kaplan. Englewood Cliffs, NJ: Prentice-Hall.
- Eckhout, Gifford V. and Otto L. Willbanks. 1989. "Silastic Ring Vertical Gastroplasty." Pp. 217-224 in *Surgery for the Morbidly Obese Patient*, edited by Mervyn Deitel. Philadelphia, PA: Lea and Febiger.
- Eckhout, Gifford V., Otto L. Willbanks and John T. Moore. 1986. "Vertical Ring Gastroplasty for Morbid Obesity: Five Year Experience with 1,463 Patients." *American Journal of Surgery* 152:713-716.
- Eichler, Margrit. 1988. *Nonsexist Research Methods*. New York: Routledge.
- Eichler, Margrit. 1990. "The Relationship Between Sexist, Non-Sexist, Woman-Centred and Feminist Research in the Social Sciences." Pp. 21-53 in *Women and Men: Interdisciplinary Readings on Gender*, edited by Greta Hoffmann Nemiroff. Toronto: Fitzhenry and Whiteside.
- Eichler, Margrit. 1997. "Feminist Methodology." *Current Sociology* 45(2):9-36.
- Elder, Glen H. 1969. "Appearance and Education in Marriage Mobility." *American Sociological Review* 34:519-533.
- Engels, Frederick. 1972. *The Origin of the Family, Private Property and the State*. New York: International Publishers.
- English, Cliff. 1993. "Gaining and Losing Weight: Identity Transformations." *Deviant Behavior* 14:227-241.
- Epstein, Leonard H. and Rena R. Wing. 1980. "Aerobic Exercise and Weight." *Addictive Behaviors* 5:371-388.
- Ernsberger, Paul. 1991. "Surgery Risks Outweigh Its Benefits." *Obesity and Health March/April*:24-25.
- Etoff, Nancy. 1999. *Survival of the Prettiest: The Science of Beauty*. New York: Doubleday.
- Evers, Susan. 1987. "Economic and Social Factors Associated with Obesity in Adult Canadians." *Nutrition Research* 7:3-13.
- Fabian, L.J. and J.K. Thompson. 1989. "Body Image and Eating Disturbances in Young Females." *International Journal of Eating Disorders* 8(1):63-74.

- Fallon, April E. 1990. "Culture in the Mirror: Sociocultural Determinants of Body Image." Pp. 80-109 in *Body Images: Development, Deviance, and Change*, edited by Thomas F. Cash and Thomas Pruzinsky. New York: Guilford Press.
- Fallon, April E. 1994. "Body Image and the Regulation of Weight." Pp. 127-180 in *Psychological Perspectives on Women's Health*, edited by Vincent J. Adesso, Diane M. Reddy and Raymond Fleming. Washington, DC: Taylor and Francis.
- Faludi, Susan. 1991. *Backlash: The Undeclared War Against American Women*. New York: Crown.
- Fanghänel, G., L. Cortinas, L. Sánchez-Reyes and A. Berber. 2000. "A Clinical Trial of the Use of Sibutramine for the Treatment of Patients Suffering Essential Obesity." *International Journal of Obesity* 24:144-150.
- Featherstone, Mike. 1991. "The Body in Consumer Culture." Pp. 170-196 in *The Body: Social Process and Cultural Theory*, edited by Mike Featherstone, Mike Hepworth and Bryan S. Turner. London: Sage.
- Feldman, W., E. Feldman and J.T. Goodman. 1988. "Culture Versus Biology: Children's Attitudes Toward Thinness and Fatness." *Pediatrics* 81(2):190-194.
- Fettes, Patricia and Donald E. Williams. 1996. "Assessment and Treatment of Morbid Obesity." Pp. 441-459 in *Body Image, Eating Disorders, and Obesity*, edited by J. Kevin Thompson. Washington, DC: American Psychological Association.
- Field, Alison E., Eugenie H. Coakley, Aviva Must, Jennifer L. Spadano, Nan Laird, William H. Dietz, Eric Rimm and Graham A. Colditz. 2001. "Impact of Overweight on the Risk of Developing Common Chronic Diseases During a 10-Year Period." *Archives of Internal Medicine* 161:1581-1586.
- Finer, N., W.P.T. James, P.G. Kopelman, M.E.J. Lean and G. Williams. 2000. "One-Year Treatment of Obesity: A Randomized, Double-Blind, Placebo- Controlled, Multicentre Study of Orlistat, A Gastrointestinal Lipase Inhibitor." *International Journal of Obesity* 24:306-313.
- Fisher, Barry L. and Annabel E. Barber. 1999. "Gastric Bypass Procedures." *European Journal of Gastroenterology and Hepatology* 11:93-97.
- Fisher, Jennifer Orlet and Leann Lipps Birch. 1999a. "Restricting Access to a Palatable Food Affects Children's Behavioral Response, Food Selection and Intake." *American Journal of Clinical Nutrition* 69:1264-1272.
- Fisher, Jennifer Orlet and Leann Lipps Birch. 1999b. "Restricting Access to Foods and Children's Eating." *Appetite* 32:405-419.
- Flegal, K.M., M.D. Carroll, R.J. Kuczmarski and C.L. Johnson. 1998. "Overweight and Obesity in the United States: Prevalence and Trends, 1960-1994." *International Journal of Obesity* 22:39-47.
- Flegal, Katherine M., Margaret D. Carroll, Cynthia L. Ogden and Clifford L. Johnson. 2002. "Prevalence and Trends in Obesity Among US Adults, 1999-2000." *JAMA* 288 (14): 1723-1727.



- Flegal, K.M. and R.P. Troiano. 2000. "Changes in the Distribution of Body Mass Index of Adults and Children in the US Population." *International Journal of Obesity* 24:807-818.
- Fonow, Mary Margaret and Judith A. Cook. 1991. "Back to the Future: A Look at the Second Wave of Feminist Epistemology and Methodology." Pp. 1-15 in *Beyond Methodology: Feminist Scholarship as Lived Research*, edited by Mary Margaret Fonow and Judith A. Cook. Bloomington, IA: Indiana University Press.
- Fontaine, Kevin R., Myles S. Faith, David B. Allison and Lawrence J. Cheskin. 1998. "Body Weight and Health Care Among Women in the General Population." *Archives of Family Medicine* 7:381-384.
- Forsell, Peter and Göran Hellers. 1997. "The Swedish Adjustable Gastric Banding (SAGB) for Morbid Obesity: 9-Year Experience and a 4-year Follow-up of Patients Operated with a New Adjustable Band." *Obesity Surgery* 7:345-351.
- Foucault, Michel. 1979. *Discipline and Punish: The Birth of the Prison*. Trans. Alan Sheridan. New York: Vintage Books.
- Fouts, Gregory and Kimberley Burggraf. 2000. "Television Situation Comedies: Female Weight, Male Negative Comments, and Audience Reactions." *Sex Roles* 42(9/10):925-932
- Frank, Arthur W. 1991. "For a Sociology of the Body: An Analytical Review." Pp. 36-102 in *The Body: Social Process and Cultural Theory*, edited by Mike Featherstone, Mike Hepworth and Bryan S. Turner. London: Sage.
- Fraser, Laura. 1997. *Losing It: America's Obsession With Weight and the Industry That Feeds on It*. New York: Penguin.
- Freedman, David S., Laura Kettel Khan, Mary K. Serdula, Deborah A. Galuska and William H. Dietz. 2002. "Trends and Correlates of Class 3 Obesity in the United States from 1990 Through 2000." *JAMA* 288(14):1758-1761.
- Freedman, Rita Jackaway. 1986. *Beauty Bound*. Lexington, MA: D.C. Heath.
- Freiberg, Arnis. 1989. "Plastic Surgery After Weight Loss. Pp. 365-383 in *Surgery for the Morbidly Obese Patient*, edited by Mervyn Deitel. Philadelphia, PA: Lea and Febiger.
- French, Glenna, Janet L. Galbraith and Mervyn Deitel. 1989. "The Nurses' Role in Bariatric Surgery." Pp. 319-326 in *Surgery for the Morbidly Obese Patient*, edited by Mervyn Deitel. Philadelphia, PA: Lea and Febiger.
- French, S.A., R.W. Jeffery, J.L. Forster, P.G. McGovern, S.H. Kelder and J.E. Baxter. 1994. "Predictors of Weight Change Over Two Years Among a Population of Working Adults: The Healthy Worker Project." *International Journal of Obesity* 18:145-54.
- Friedman, Michael A. and Kelly D. Brownell. 1995. "Psychological Correlates of Obesity: Moving to the Next Research Generation." *Psychological Bulletin* 117(1):3-20.
- Frieze, Irene Hanson, Josephine E. Olson and Deborah Cain Good. 1990. "Perceived and Actual Discrimination in the Salaries of Male and Female Managers." *Journal of Applied Social Psychology* 20(1):46-67.

- Frisch, Rose E. and J.W. McArthur. 1974. "Menstrual Cycles: Fatness as a Determinant of Minimum Weight for Height Necessary for their Maintenance or Onset." *Science* 185:949-951.
- Frost, Liz. 1999. "Doing Looks': Women, Appearance and Mental Health." Pp. 117-136 in *Women's Bodies: Discipline and Transgression*, edited by Jane Arthurs and Jean Grimshaw. London: Cassell.
- Fuller, Mary Louise and Stephen B. Groce. 1991. "Obese Women's Responses to Appearance Norms." *Free Inquiry in Creative Sociology* 19(2):167-174.
- Furnham, Adrian and N. Alibhai. 1983. "Cross-Cultural Differences in the Perception of Female Body Shapes." *Psychological Medicine* 13:829-837.
- Furnham, Adrian and Peter Baguma. 1994. "Cross-Cultural Differences in the Evaluation of Male and Female Body Shapes." *International Journal of Eating Disorders* 15(1):81-89.
- Gaesser, Glenn. 1996. *Big Fat Lies: The Truth About Your Weight and Your Health*. New York: Fawcett Columbine.
- Gagnard, Alice. 1986. "From Feast to Famine: Depiction of Ideal Body Type in Magazine Advertising: 1950-1984." Pp. R46-R50 in *Proceedings of the 1986 Conference of the American Academy of Advertising*, edited by E.F. Larkin. Norman, OK: School of Journalism, University of Oklahoma.
- Garn, Stanley M., Stephen M. Bailey, Patricia E. Cole and Ian T.T. Higgins. 1977. "Level of Education, Level of Income, and Level of Fatness in Adults." *American Journal of Clinical Nutrition* 30:721-725.
- Garn, Stanley M. and Diane C. Clark. 1976. "Trends in Fatness and Origins of Obesity." *Pediatrics* 57:443-456.
- Garn, Stanley M. and Alan S. Ryan. 1981. "Replicating the Income Related Reversal of Fatness." *Ecology of Food and Nutrition* 10:237-239.
- Garn, Stanley M., Timothy V. Sullivan and Victor M. Hawthorne. 1989a. "Educational Level, Fatness, and Fatness Differences Between Husbands and Wives." *American Journal of Clinical Nutrition* 50:740-745.
- Garn, Stanley M., Timothy V. Sullivan and Victor M. Hawthorne. 1989b. "The Education of One Spouse and the Fatness of the Other Spouse." *American Journal of Human Biology* 1:223-238.
- Garner, David M., Paul E. Garfinkel, Donald Schwartz and Michael Thompson. 1980. "Cultural Expectations of Thinness in Women." *Psychological Reports* 47:48-491.
- Garner, David M. and Susan C. Wooley. 1991. "Confronting the Failure of Behavioral and Dietary Treatments for Obesity." *Clinical Psychology Review* 11:729-780.
- Gawande, Atul. 2001. "The Man Who Couldn't Stop Eating." *The New Yorker*, July 9, pp. 66-75.
- Germov, John and Lauren Williams. 1999. "Dieting Women: Self-Surveillance and the Body Panopticon." Pp. 117-132 in *Weighty Issues: Fatness and Thinness as Social Problems*, edited by Jeffery Sobal and Donna Maurer. New York: Aldine de Gruyter.

- Giddens, Anthony. 1991. *Modernity and Self-Identity: Self and Society in Late Modern Age*. Stanford, CA: Stanford University Press.
- Gimlin, Debra L. 2002. *Body Work: Beauty and Self-Image in American Culture*. Berkeley, CA: University of California Press.
- Gittelsohn, Joel, Stewart B. Harris, Andrew L. Thorne-Lyman, Anthony J.G. Hanley, Annette Barrie and Bernard Zinman. 1996. "Body Image Concepts Differ by Age and Sex in an Ojibway-Cree Community in Canada." *Journal of Nutrition* 126:2990-3000.
- Gladwell, Malcolm. 1998. "The Pima Paradox." *The New Yorker*, February 2, pp. 42-57.
- Glaser, Barney G. and Anselm L. Strauss. 1967. *The Discovery of Grounded Theory: Strategies for Qualitative Research*. New York: Aldine de Gruyter.
- Glinski, Juliet, Scott Wetzler and Elliot Goodman. 2001. "The Psychology of Gastric Bypass Surgery." *Obesity Surgery* 11:581-588.
- Goble, Larry K., Colleen S.W. Rand and John M. Kuldau. 1986. "Understanding Marital Relationships Following Obesity Surgery." *Family Therapy* 13(2): 195-202.
- Goffman, Erving. 1963. *Stigma: Notes on the Management of Spoiled Identity*. Englewood Cliffs, NJ: Prentice Hall.
- Goldblatt, Phillip, Mary E. Moore and Albert J. Stunkard. 1965. "Social Factors in Obesity." *Journal of the American Medical Association* 192(12):97-102.
- Goldfield, Amanda and Joan C. Chrisler. 1995. "Body Stereotyping and Stigmatization of Obese Persons by First Graders." *Perceptual and Motor Skills* 81:909-910.
- Gomez, Cesar A. 1980. "Gastroplasty in the Surgical Treatment of Morbid Obesity." *American Journal of Clinical Nutrition* 33:406-415.
- Goode, Erich and Joanne Preissler. 1983. "The Fat Admirer." *Deviant Behavior* 4:175-202.
- Goodman, Norman, Sanford M. Dornbusch, Stephen A. Richardson and Albert H. Hastorf. 1963. "Variant Reactions to Physical Disabilities." *American Sociological Review* 28:429-435.
- Goodman, W. Charisse. 1995. *The Invisible Woman: Confronting Weight Prejudice in America*. Carlsbad, CA: Gürze Books.
- Gordon, Richard A. 1990. *Anorexia and Bulimia: Anatomy of a Social Epidemic*. Cambridge, MA: Blackwell.
- Gorman, Christine. 1997. "Danger in the Diet Pills?" *Time*, July 21, p. 39.
- Gortmaker, Steven L., William H. Dietz, Arthur M. Sobol and Cheryl A. Wehler. 1987. "Increasing Pediatric Obesity in the United States." *American Journal of Diseases of Children* 141:535-540.

- Gortmaker, Steven L., Aviva Must, James M. Perrin, Arthur M. Sobol and William H. Dietz. 1993. "Social and Economic Consequences of Overweight in Adolescence and Young Adulthood." *New England Journal of Medicine* 329(14):1008-1012.
- Grace, D. Michael. 1984. "Use of Marlex in Horizontal Gastroplasty." *Canadian Journal of Surgery* 27(3):231.
- Grace, D.M. 1987. "Recognition and Management of Marlex Erosion After Horizontal Gastroplasty for Morbid Obesity." *Canadian Journal of Surgery* 30(4):282-285.
- Grace, David Michael. 1992. "Gastric Restriction Procedures for Treating Severe Obesity." *American Journal of Clinical Nutrition* 55:556S-559S.
- Grace, David Michael. 2001. Interview by Shelagh Rogers. "Gastric Bypass Surgery." *This Morning*, CBC Radio 1, June 18.
- Graham, David J. and Lanh Green. 1997. "Further Cases of Valvular Heart Disease Associated with Fenfluramine-Phentermine." *New England Journal of Medicine* 337(9):635.
- Green, Kathryn L., Roy Cameron, Janet Polivy, Karen Cooper, Liyan Liu, Lawrence Leiter, Todd Heatherton and the Canadian Heart Health Surveys Research Group. 1997. "Weight Dissatisfaction and Weight Loss Attempts Among Canadian Adults." *Canadian Medical Association Journal* 157:S17-S25.
- Griffen, Ward O., Jr., Brack A. Bivins and Richard M. Bell. 1983. "The Decline and Fall of the Jejunioileal Bypass." *Surgery Gynecology and Obstetrics* 157(4):301-308.
- Grilo, Carlos M., Denise E. Wilfley, Kelly D. Brownell and Judith Rodin. 1994. "Teasing, Body Image and Self-Esteem in a Clinical Sample of Obese Women." *Addictive Behaviors* 19(4):443-450.
- Grimshaw, Jean. 1999. "Working Out with Merleau-Ponty." Pp. 91-116 in *Women's Bodies: Discipline and Transgression*, edited Jane Arthurs and Jean Grimshaw. London: Cassell.
- Grogan, Sarah. 1999. *Body Image: Understanding Body Dissatisfaction in Men, Women and Children*. London: Routledge.
- Guillen, Eileen O. and Susan I. Barr. 1994. "Nutrition, Dieting, and Fitness Messages in a Magazine for Adolescent Women, 1970-1990." *Journal of Adolescent Health* 15:464-472.
- Gustafson-Larson, Ann M. and Rhonda Dale Terry. 1992. "Weight-Related Behaviors and Concerns of Fourth-Grade Children." *Journal of the American Dietetic Association* 92(7):818-822.
- Hafner, R. Julian. 1991. "Morbid Obesity: Effects on the Marital System of Weight Loss after Gastric Restriction." *Psychotherapy and Psychosomatics* 56:162-166.
- Hall, John C., James McK. Watts, Paul E. O'Brien, Richard E. Dunstan, John F. Walsh, Anthony Slavotnick and Ronald G. Elmslie. 1990. "Gastric Surgery for Morbid Obesity." *Annals of Surgery* 211:419-427.
- Halpern, Alfredo. 1999. "Trends in Pharmacology for Treatment of Obesity: The Point of View of a Clinician." Pp. 721-730 in *Progress in Obesity Research* 8, edited by Bernard Guy-Grand and Gérard Ailhaud. London: John Libbey.

- Halpern, Carolyn Tucker, J. Richard Udry, Benjamin Campbell and Chirayath Suchindran. 1999. "Effects of Body Fat on Weight Concerns, Dating and Sexual Activity: A Longitudinal Analysis of Black and White Adolescent Girls." *Developmental Psychology* 35(3):721-736.
- Halverson, John D. and Robert E. Koehler. 1981. "Gastric Bypass: Analysis of Weight Loss and Factors Determining Success." *Surgery* 90:446-455.
- Hammersley, Martyn. 1992. *What's Wrong With Ethnography?* London: Routledge.
- Harding, Sandra, ed. 1987. *Feminism and Methodology*. Bloomington, IA: Indiana University Press.
- Harris, Mary B. 1990. "Is Love Seen as Different for the Obese?" *Journal of Applied Social Psychology* 20(15):1209-1224.
- Harris, Mary B., Richard J. Harris and Stephen Bochner. 1982. "Fat, Four-Eyed, and Female: Stereotypes of Obesity, Glasses and Gender." *Journal of Applied Social Psychology* 12: 503-516.
- Harris, Mary B., Laurie C. Walters and Stefanie Waschull. 1991. "Gender and Ethnic Differences in Obesity-Related Behaviors and Attitudes in a College Sample." *Journal of Applied Social Psychology* 21(19):1545-1566.
- Harris, Shanette M. 1994. "Racial Differences in Predictors of College Women's Body Image Attitudes." *Women and Health* 21(4):89-104.
- Harrison, Albert A. and Laila Saeed. 1977. "Let's Make a Deal: An Analysis of Revelations and Stipulations in Lonely Hearts Advertisements." *Journal of Personality and Social Psychology* 35(4):257-264.
- "He Dreaded Teasing." 1996. *Montreal Gazette*, August 27, B1.
- Hebl, Michelle R. and Todd F. Heatherton. 1998. "The Stigma of Obesity in Women: The Difference is Black and White." *Personality and Social Psychology Bulletin* 24(4):417-426.
- Hell, Emanuel, Karl A. Miller, Melodie K. Moorehead and Norman Samuels. 2000. "Evaluation of Health Status and Quality of Life After Bariatric Surgery: Comparison of Standard Roux-en-Y Gastric Bypass, Vertical Banded Gastroplasty and Laparoscopic Adjustable Silicone Gastric Banding." *Obesity Surgery* 10:214-219.
- Hensrud, Donald D. 2000. "Pharmacotherapy for Obesity." *Medical Clinics of North America* 84(2):463-476.
- Hesse-Biber, Sharlene. 1991. "Women, Weight and Eating Disorders: A Socio-Cultural and Political-Economic Analysis." *Women's Studies International Forum* 14:173-191.
- Hesse-Biber, Sharlene. 1996. *Am I THIN Enough Yet?* New York: Oxford University Press.
- Higa, Kelvin D., Keith B. Boone and Orland G. Davies. 2000. "Laparoscopic Roux-en-Y Gastric Bypass for Morbid Obesity: Technique and Preliminary Results of our First 400 Patients." *Archives of Surgery* 135:1029-1034.
- Hildebrandt, Sallie E. 1998. "Effects of Participation in Bariatric Support Group After Roux-en-Y Gastric Bypass." *Obesity Surgery* 8:535-542.

- Hill, Andrew J., Edwina Draper and Judith Stack. 1994. "A Weight on Children's Minds: Body Shape Dissatisfactions at 9-Years Old." *International Journal of Obesity* 18:383-389.
- Hill, Andrew J. and Victoria Pallin. 1998. "Dieting Awareness and Low Self-Worth: Related Issues in 8-Year-Old Girls." *International Journal of Eating Disorders* 24:405-413.
- Hill, A.J. and E.K. Silver. 1995. "Fat, Friendless and Unhealthy: 9-Year-Old Children's Perception of Body Shape Stereotypes." *International Journal of Obesity* 19:423-430.
- Hill, James O. and John C. Peters. 1998. "Environmental Contributions to the Obesity Epidemic." *Science*, May 29, pp. 1371-74.
- Hill, James O., Holly R. Wyatt and Edward L. Melanson. 2000. "Genetic and Environmental Contributions to Obesity." *Medical Clinics of North America* 84(2):333-346.
- Hooper, Malcolm S.H. and David M. Garner. 1986. "Application of the Eating Disorders Inventory to a Sample of Black, White, and Mixed Race Schoolgirls in Zimbabwe." *International Journal of Eating Disorders* 5(1):161-168.
- Hubbard, Van S. 2000. "Defining Overweight and Obesity: What are the Issues?" *American Journal of Clinical Nutrition* 72:1067-8.
- Jackson, Linda A. 1992. *Physical Appearance and Gender: Sociobiological and Sociocultural Perspectives*. Albany, NY: State University of New York Press.
- Jasper, Cynthia R. and Michael L. Klassen. 1990a. "Stereotypical Beliefs About Appearance: Implications for Retailing and Consumer Issues." *Perceptual and Motor Skills* 71:519-528.
- Jasper, Cynthia R. and Michael L. Klassen. 1990b. "Perceptions of Salespersons' Appearance and Evaluation of Job Performance." *Perceptual and Motor Skills* 71:563-566.
- Jayarathne, Toby Epstein and Abigail J. Stewart. 1991. "Quantitative and Qualitative Methods in the Social Sciences." Pp. 85-106 in *Beyond Methodology: Feminist Scholarship as Lived Research*, edited by Mary Margaret Fonow and Judith A. Cook. Bloomington, IA: Indiana University Press.
- Jeffery, Robert W., Leonard H. Epstein, G. Terence Wilson, Adam Drewnowski, Albert J. Stunkard, Rena R. Wing and Dana Robin Hill. 2000. "Long-Term Maintenance of Weight Loss: Current Status." *Health Psychology* 19(1):5-16.
- Jick, Hershel, Catherine Vasilakis, Larry A. Weinrauch, Christoph R. Meier, Susan S. Jick and Laura E. Derby. 1998. "A Population-Based Study of Appetite-Suppressant Drugs and the Risk of Cardiac-Valve Regurgitation." *New England Journal of Medicine* 339(11):719-724.
- Joanisse, Leanne and Anthony Synnott. 1999. "Fighting Back: Reactions and Resistance to the Stigma of Obesity." Pp. 49-70 in *Interpreting Weight: The Social Management of Fatness and Thinness*, edited by Jeffery Sobal and Donna Maurer. New York: Aldine de Gruyter.
- Johnson, Allan G. 1988. *Statistics*. New York: Harcourt Brace Jovanovich.
- Jones, Jennifer M., Susan Bennett, Marion P. Olmsted, Margaret L. Lawson and Gary Rodin. 2001. "Disordered Eating Attitudes and Behaviors in Teenaged Girls: A School-Based Study." *Canadian Medical Association Journal* 165(5):547-552.

- Kalbfleisch, John. 1996. "Obesity Drugs Linked to Artery Illness." *The Montreal Gazette*, August 29, A3.
- Kaminsky, Josephine and Dominick Gadaleta. 2002. "A Study of Discrimination Within the Medical Community as Viewed by Obese Patients." *Obesity Surgery* 12:14-18.
- Karris, Lambros. 1977. "Prejudice Against Obese Renters." *Journal of Social Psychology* 101:159-160.
- Katzmarzyk, Peter T. 2002. "The Canadian Obesity Epidemic, 1985-1998." *Canadian Medical Association Journal* 166(8):1039-1040.
- Keesey, Richard E. 1980. "A Set-Point Analysis of the Regulation of Body Weight." Pp. 144-165 in *Obesity*, edited by Albert J. Stunkard. Philadelphia, PA: W.B. Saunders.
- Keesey, Richard E. 1995. "A Set-Point Model of Body Weight Regulation." Pp. 46-50 in *Eating Disorders and Obesity: A Comprehensive Handbook*, edited by Kelly D. Brownell and Christopher G. Fairburn. New York: Guilford Press.
- Kelman, Suanne. 1993. "Fat in a Thin Society." *Chatelaine*, September, pp. 58-61, p. 144.
- Khan, Laura Kettel, Mary K. Serdula, Barbara A. Bowman and David F. Williamson. 2001. "Use of Prescription Weight Loss Pills Among U.S. Adults in 1996-1998." *Annals of Internal Medicine* 134:282-286.
- Khan, Mehmood A, Charles A. Herzog, John V. St. Peter, Guilford G. Hartley, Richard Madlon-Kay, Candace D. Dick, Richard W. Asinger and John T. Vessey. 1998. "The Prevalence of Cardiac Valvular Insufficiency Assessed by Transthoracic Echocardiography in Obese Patients Treated With Appetite-Suppressant Drugs." *New England Journal of Medicine* 339(11):713-718.
- Kilbourne, Jean. 1994. "Still Killing Us Softly: Advertising and the Obsession With Thinness." Pp. 395-418 in *Feminist Perspectives on Eating Disorders*, edited by Patricia Fallon, Melanie A. Katzman, and Susan C. Wooley. New York: Guilford Press.
- Kincey, J., H. Neve, C. Soulsby and T.V. Taylor. 1996. "Psychological State and Weight Loss After Gastroplasty for Major Obesity—Some Outcomes and Inter-relationships." *Psychology, Health and Medicine* 1(1):113-118.
- Kirby, Sandra and Kate McKenna. 1989. *Experience, Research, Social Change: Methods from the Margins*. Toronto: Garamond Press.
- Kirk, Jerome and Marc L. Miller. 1986. *Reliability and Validity in Qualitative Research*. Newbury Park, CA: Sage.
- Klawansky, Sidney and Thomas C. Chalmers. 1992. "Fat Content of Very Low-Calorie Diets and Gallstone Formation." *JAMA* 268(7):873.
- Klesges, Robert C., Margaret DeBon and Andrew Meyers. 1996. "Obesity in African American Women: Epidemiology, Determinants, and Treatment Issues." Pp. 461-477 in *Body Image, Eating Disorders, and Obesity*, edited by J. Kevin Thompson. Washington, DC: American Psychological Association.

- Kolanowski, J. 1997. "Surgical Treatment for Morbid Obesity." *British Medical Bulletin* 53(2):433-444.
- Korkeila, Maarit, Aila Rissanen, Jaakko Kaprio, Thorkild I.A. Sørensen and Markku Koskenvuo. 1999. "Weight-Loss Attempts and Risk of Major Weight Gain: A Prospective Study in Finnish Adults." *American Journal of Clinical Nutrition* 70(6):965-975.
- Kral, John G. 1992a. "Surgical Treatment of Obesity." Pp. 496-506 in *Treatment of the Seriously Obese Patient*, edited by Thomas A. Wadden and Theodore B. Van Itallie. New York: Guilford Press.
- Kral, John G. 1992b. "Overview of Surgical Techniques for Treating Obesity." *American Journal of Clinical Nutrition* 55:552S-555S.
- Kral, John G., Lars V. Sjöström and M.B.E. Sullivan. 1992. "Assessment of Quality of Life Before and After Surgery for Severe Obesity." *American Journal of Clinical Nutrition* 55:611S-614S.
- Kuczmarski, Robert J. and Katherine M. Flegal. 2000. "Criteria for Definition of Overweight in Transition: Background and Recommendations for the United States." *American Journal of Clinical Nutrition* 72:1074-1081.
- Kuczmarski, Robert J., Katherine M. Flegal, Stephen M. Campbell and Clifford L. Johnson. 1994. "Increasing Prevalence of Overweight Among US Adults: The National Health and Nutrition Examination Surveys, 1960 to 1991." *JAMA* 272:205-211.
- Kurscheid, T. and K. Lauterbach. 1998. "The Cost Implications of Obesity for Health Care and Society." *International Journal of Obesity* 22(Supplement 1):S3-S5.
- Kvale, Steinar. 1996. *Interviews: An Introduction to Qualitative Research Interviewing*. Thousand Oaks, CA: Sage.
- Lake, J.K., C. Power and T.J. Cole. 1997. "Women's Reproductive Health: The Role of Body Mass Index in Early and Adult Life." *International Journal of Obesity* 21:432-438.
- Larkin, Judith Candib and Harvey A. Pines. 1979. "No Fat Persons Need Apply." *Sociology of Work and Occupations* 6(3):312-327.
- Lau, David C.W. 1999. "Call for Action: Preventing and Managing the Expansive and Expensive Obesity Epidemic." *Canadian Medical Association Journal* 160(4):503-505.
- Laurence, Leslie and Beth Weinhouse. 1994. *OutRAGEous Practices: How Medicine Mistreats Women*. New York: Fawcett Columbine.
- Lederer, E.M. 1997. "British Teen Takes Fatal Overdose After 'Fatty' Taunts." *Toronto Star*, October 2, A22.
- Lemonick, Michael D. 1996. "The New Miracle Drug?" *Time*, September 23, pp. 39-45.
- Lemonick, Michael D. 1997. "The Mood Molecule." *Time*, September 29, pp. 55-62.
- Lemonick, Michael D. 1999. "Viagra for the Thighs?" *Time*, May 10, pp. 44-45.
- Lerner, Richard M. and E. Gellert. 1969. "Body Build Identification, Preference, and Aversion in Children." *Developmental Psychology* 5:456-462.



- Loewy, Michael I. 1998. "Suggestions for Working with Fat Children in the Schools." *Professional School Counseling* 1(4):18-22.
- Lonroth, H. and Jan Dalenback. 1998. "Other Laparoscopic Procedures." *World Journal of Surgery* 22:964-968.
- Louderback, Llewellyn. 1970. *Fat Power: Whatever you Weigh is Right*. New York: Hawthorn Books.
- Lynch, Dennis M. 1996. "The Heavy Issue: Weight-Based Discrimination in the Airline Industry." *Journal of Air Law and Commerce* 62:203-242.
- MacDonald, Sharon M., Bruce A. Reeder, Yue Chen, Jean-Pierre Després, and The Canadian Heart Health Surveys Research Group. 1997. "Obesity in Canada: A Descriptive Analysis." *Canadian Medical Association Journal* 157 (Suppl 1):S3-S9.
- MacInnis, Beth. 1993. "Fat Oppression." Pp. 69-79 in *Consuming Passions: Feminist Approaches to Weight Preoccupation*, edited by Catrina Brown and Karin Jasper. Toronto: Second Story Press.
- MacLean, Lloyd D. 1984. "Nutrition Following Intestinal Bypass and Gastric Operations for Morbid Obesity." *Canadian Journal of Surgery* 27:134-135.
- MacLean, Lloyd D., Barbara M. Rhode and Harry M. Shizgal. 1981. "Gastroplasty for Obesity." *Surgery Gynecology and Obstetrics* 153:200-208.
- MacLean, Lloyd D., Barbara M. Rhode and R. Armour Forse. 1990. "Late Results of Vertical Banded Gastroplasty for Morbid and Super Obesity." *Surgery* 107: 20-27.
- Maddox, George L. and Veronica Liederman. 1969. "Overweight as a Social Disability with Medical Implications." *Journal of Medical Education* 44:214-220.
- Maddox, George L., Kurt W. Back and Veronica R. Liederman. 1968. "Overweight as Social Deviance and Disability." *Journal of Health and Social Behavior* 9: 287-298.
- Maiman, Lois A., Virginia Li Wang, Marshall H. Becker, Jack Finlay and Maria Simonson. 1979. "Attitudes Toward Obesity and the Obese Among Professionals." *Journal of the American Dietetic Association* 74:331-336.
- Manson, JoAnn, Walter C. Willett, Meir J. Stampfer, Graham A. Colditz, David J. Hunter, Susan E. Hankinson, Charles H. Hennekens and Frank E. Speizer. 1995. "Body Weight and Mortality Among Women." *New England Journal of Medicine* 333(11):677-685.
- Marceau, P., F.-S. Hould, S. Simard, S. Lebel, R.-A. Bourque, M. Potvin and S. Biron. 1998. "Biliopancreatic Diversion with Duodenal Switch." *World Journal of Surgery* 22:947-954.
- Mark, Eugene J., Eva D. Patalas, Howard T. Chang, Richard J. Evans and Stanton C. Kessler. 1997. "Fatal Pulmonary Hypertension Associated with Short-Term Use of Fenfluramine and Phentermine." *New England Journal of Medicine* 337(9):602-606.
- Maroney, Diane and Sharon Golub. 1992. "Nurses' Attitudes Toward Obese Persons and Certain Ethnic Groups." *Perceptual and Motor Skills* 75:387-391.
- Marshall, John R. and John Neill. 1977. "The Removal of a Psychosomatic Symptom: Effects on the Marriage." *Family Process* 16:273-280.

- Mason, Edward E. 1982. "Vertical Banded Gastroplasty for Obesity." *Archives of Surgery* 117:701-706.
- Mason, Edward E., Cornelius Doherty, Joseph J. Cullen, David Scott, Evelyn M. Rodriguez and James W. Maher. 1998. "Vertical Gastroplasty: Evolution of Vertical Banded Gastroplasty." *World Journal of Surgery* 22:919-924.
- Mason, Edward E., Kathleen Renquist and Donald Jiang. 1992. "Perioperative Risks and Safety of Surgery for Severe Obesity." *American Journal of Clinical Nutrition* 55:573S-576S.
- Mason, Edward E., Shenghui Tang, Kathleen E. Renquist, Dwight T. Barnes, Joseph J. Cullen, Cornelius Doherty, James W. Maher and National Bariatric Surgery (NSBR) Data Contributors. 1997. "A Decade of Change in Obesity Surgery." *Obesity Surgery* 7:189-197.
- Matsura, Kencho, Miho Fujimura, Yuriko Nozawa, Yasuko Iida and Munehiro Hirayama. 1992. "The Body Shape Preferences of Japanese Female Students." *International Journal of Obesity* 16:87-93.
- Matthews, Victor and Charles Westie. 1966. "A Preferred Method for Obtaining Rankings: Reactions to Physical Handicaps." *American Sociological Review* 31:851-854.
- Mayer, Vivian. 1983. "The Fat Illusion." Pp. 3-14 in *Shadow on a Tightrope: Writings by Women on Fat Oppression*, edited by Lisa Schoenfelder and Barb Wieser. San Francisco, CA: Aunt Lute Books.
- Maynard, Mary. 1994. "Methods, Practice and Epistemology: The Debate about Feminism and Research." Pp. 10-26 in *Researching Women's Lives from a Feminist Perspective*, edited by Mary Maynard and June Purvis. London: Taylor and Francis.
- Maynard, Mary and June Purvis. 1994. "Doing Feminist Research." Pp. 1-9 in *Researching Women's Lives from a Feminist Perspective*, edited by Mary Maynard and June Purvis. London: Taylor and Francis.
- McArthur, Laura H. and Jane K. Ross. 1997. "Attitudes of Registered Dietitians Toward Personal Overweight and Overweight Clients." *Journal of the American Dietetic Association* 97(1): 63-66.
- McCann, Una, George Hatzidimitriou, Alison Ridenour, Carl Fischer, Jie Yuan, Jonathan Katz and George Ricaurte. 1994. "Dexfenfluramine and Serotonin Neurotoxicity: Further Preclinical Evidence That Clinical Caution is Indicated." *Journal of Pharmacology and Experimental Therapeutics* 269(2):792-798.
- McFarlane, Traci, Janet Polivy and Randi E. McCabe. "Help, Not Harm: Psychological Foundation for a NondiETING Approach Toward Health." *Journal of Social Issues* 35(2):261-276.
- McKinley, Nita Mary. 1999. "Ideal Weight/Ideal Women: Society Constructs the Female." Pp. 97-116 in *Weighty Issues: Fatness and Thinness as Social Problems*, edited by Jeffery Sobal and Donna Maurer. New York: Aldine de Gruyter.
- McLean, Robert A. and Marilyn Moon. 1980. "Health, Obesity, and Earnings." *American Journal of Public Health* 70(9):1006-1009.
- Miller, David K. and Gerald N. Goodman. 1989. "Gastric Bypass Procedures." Pp. 113-133 in *Surgery for the Morbidly Obese Patient*, edited by Mervyn Deitel. Philadelphia, PA: Lea and Febiger.

- Millman, Marcia. 1980. *Such a Pretty Face: Being Fat in America*. New York: Norton.
- Mitrovica, Andrew. 2001. "Top Court Lets Diet-Drug Suit Go Ahead." *The Globe and Mail*, September 7, A9.
- Mokdad, Ali H., Barbara A. Bowman, Earl S. Ford, Frank Vinicor, James S. Marks and Jeffrey P. Koplan. 2001. "The Continuing Epidemics of Obesity and Diabetes in the United States." *JAMA* 286(10):1195-1200.
- Mokdad, Ali H., Mary K. Serdula, William H. Dietz, Barbara A. Bowman, James S. Marks and Jeffrey P. Koplan. 1999. "The Spread of the Obesity Epidemic in the United States, 1991-1998." *JAMA* 282(16):1519-1522.
- Molliver, Derek C. and Mark E. Molliver. 1990. "Anatomic Evidence for a Neurotoxic Effect of ( $\pm$ )-Fenfluramine Effect Upon Serotonergic Projections in the Rat." *Brain Research* 511:165-168.
- Moore, Mary E., Albert Stunkard, and Leo Srole. 1962. "Obesity, Social Class and Mental Illness." *Journal of the American Medical Association* 181(11): 962-966.
- Morgan, Kathryn Pauly. 1991. "Women and the Knife: Cosmetic Surgery and the Colonization of Women's Bodies." *Hypatia* 6:25-31.
- Morris, Abigail, Troy Cooper and Peter J. Cooper. 1989. "The Changing Shape of Female Fashion Models." *International Journal of Eating Disorders* 8(5): 593-596.
- Moss, Arthur J. 1985. "Caution: Liquid Protein Diets can be Deadly." *Annals of Internal Medicine* 102(1):121-122.
- Mun, Edward C., George L. Blackburn and Jeffrey B. Matthews. 2001. "Current Status of Medical and Surgical Therapy for Obesity." *Gastroenterology* 120:669-681.
- Must, Aviva, Jennifer Spadano, Eugenie H. Coakley, Alison E. Field, Graham Colditz and William H. Dietz. 1999. "The Disease Burden Associated With Overweight and Obesity." *JAMA* 282(16):1523-1529.
- Myers, A. and J.C. Rosen. 1999. "Obesity Stigmatization and Coping: Relation to Mental Health Symptoms, Body Image, and Self-Esteem." *International Journal of Obesity* 23:221-230.
- NAAFA Newsletter. 1977. "University Rejects Fat Students." September/October, 1-2.
- NAAFA Newsletter. 1978. "Further Discrimination at Oral Roberts." May, 3.
- NAAFA Newsletter. 1989. "Nursing Student Wins Suit." April, 1,3.
- NAAFA Newsletter. 1996. "Pressing NAAFA Issues." February/March, 6.
- NAAFA Workbook: *A Complete Study Guide*. NAAFA Workbook Committee. 1995. Sacramento, CA: NAAFA.
- Näslund, Ingmar. 1986. "The Size of the Gastric Outlet and the Outcome of Surgery for Obesity." *Acta Chirurgica Scandinavica* 152:205-210.

- Näslund, Ingmar. 1999. "Effects and Side-Effects of Obesity Surgery in Patients with BMI Below or Above 40 kg/m<sup>2</sup> in the SOS-(Swedish Obese Subjects)-Study." Pp. 815-821 in *Progress in Obesity Research: 8*, edited by Bernard Guy-Grand and Gérard Ailhaud. London: John Libbey.
- National Heart, Lung, and Blood Institute Obesity Education Initiative. 1998. *Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report*. Bethesda, MD: National Institutes of Health Publication No. 98-4083.
- National Institutes of Health Consensus Development Conference on Surgical Treatment of Morbid Obesity. 1979. *Annals of Surgery* 189:455-457.
- National Institutes of Health Consensus Development Conference on Gastrointestinal Surgery for Severe Obesity. 1992. "Gastrointestinal Surgery for Severe Obesity: National Institutes of Health Consensus Development Conference Statement." *American Journal of Clinical Nutrition* 55:615S-619S.
- National Institutes of Health Technology Assessment Conference Panel. 1992. "Methods for Voluntary Weight Loss and Control." *Annals of Internal Medicine* 116(11):942-949.
- National Task Force on the Prevention and Treatment of Obesity. 1993. "Very Low- Calorie Diets." *JAMA* 270(8):967-974.
- National Task Force on the Prevention and Treatment of Obesity. 1996. "Long-Term Pharmacotherapy in the Management of Obesity." *JAMA* 276(23):1907-1915.
- Neff, Linda J., Roger C. Sargent, Robert E. McKeown, Kirby L. Jackson and Robert F. Valois. 1997. "Black-White Differences in Body Size Perceptions and Weight Management Practices Among Adolescent Females." *Journal of Adolescent Health* 20:459-465.
- Nehoda, Hermann, Helmut Weiss, Burkhard Labeck, Kathrine Hourmount, M. Lanthaler, Michael Oberwalder and Franz Aigner. 2001. "Results and Complications After Adjustable Gastric Banding in a Series of 250 Patients." *American Journal of Surgery* 181:12-15.
- Neill, John R., John R. Marshall and Charles E. Yale. 1978. "Marital Changes After Intestinal Bypass Surgery." *Journal of the American Medical Association* 240(5):447-450.
- Nemeth, Mary. 1994. "Body Obsession." *MacLeans*, May 2, 45-49.
- Neumark-Sztainer, Dianne, Mary Story and Loren Faibisch. 1998. "Perceived Stigmatization Among Overweight African-American and Caucasian Adolescent Girls." *Journal of Adolescent Health* 23:264-270.
- Nielsen, Joyce McCarl. 1990. "Introduction." Pp. 1-37 in *Feminist Research Methods: Exemplary Readings in the Social Sciences*, edited by Joyce McCarl Nielsen. Boulder, CO: Westview Press.
- Nightengale, Markham L., Michael G. Sarr, Keith A. Kelly, Michael D. Jensen, Alan R. Zinsmeister and P.J. Palumbo. 1991. "Prospective Evaluation of Vertical Banded Gastroplasty as the Primary Operation for Morbid Obesity." *Mayo Clinic Proceedings* 66:773-782.
- Nisbett, Richard E. 1972. "Hunger, Obesity, and the Ventromedial Hypothalamus." *Psychological Review* 79:433-453.

- Norgan, N.G. 1997. "The Beneficial Effects of Body Fat and Adipose Tissue in Humans." *International Journal of Obesity* 21:738-746.
- Oakley, Ann. 1981. "Interviewing Women: A Contradiction in Terms." Pp. 30-61 in *Doing Feminist Research*, edited by Helen Roberts. London: Routledge and Kegan Paul.
- Oberrieder, Heidi, Robert Walker, Denise Monroe and Matthew Adeyanju. 1995. "Attitude of Dietetics Students and Registered Dietitians Toward Obesity." *Journal of the American Dietetic Association* 95(8):914-916.
- O'Brien, P.E., W.A. Brown, A. Smith, P.J. Murrick and M. Stephens. 1999. "Prospective Study of a Laparoscopically Placed, Adjustable Gastric Band in the Treatment of Morbid Obesity." *British Journal of Surgery* 85:113-118.
- Ogden, Cynthia L., Katherine M. Flegal, Margaret D. Carroll and Clifford L. Johnson. 2001. "Prevalence and Trends in Overweight Among US Children and Adolescents, 1999-2000." *JAMA* 288(14):1728-1732.
- O'Leary, J. Patrick. 1980. "Review: Jejunioileal Bypass in the Treatment of Morbid Obesity." *American Journal of Clinical Nutrition* 33:389-394.
- O'Leary, J. Patrick. 1992. "Gastrointestinal Malabsorptive Procedures." *American Journal of Clinical Nutrition* 55:567S-570S.
- Ollenburger, Jane C. and Helen A. Moore. 1992. *A Sociology of Women: The Intersection of Patriarchy, Capitalism and Colonization*. Englewood Cliffs, NJ: Prentice Hall.
- O'Loughlin, J., G. Paradis, G. Meshefedjian and K. Gray-Donald. 2000. "A Five-Year Trend of Increasing Obesity among Elementary Schoolchildren in Multiethnic, Low-Income, Inner-City Neighborhoods in Montreal, Canada." *International Journal of Obesity* 24:1176-82.
- Olson, Cheri L., Howard D. Schumaker and Barbara P. Yawn. 1994. "Overweight Women Delay Medical Care." *Archives of Family Medicine* 3:888-892.
- Orbach, Susie. 1978. *Fat is a Feminist Issue: The Anti-Diet Guide to Permanent Weight Loss*. New York: Berkley Books.
- Orbach, Susie. 1983. *Fat is a Feminist Issue II: The Anti-Diet Guide to Permanent Weight Loss*. New York: Berkley Books.
- Orbach, Susie. 1986. *Hunger Strike: The Anorectic's Struggle as a Metaphor for Our Age*. London: W.W. Norton.
- Østbye, Truis, Joceline Pomerleau, Mark Speechley, Linda L. Pederson and Kathy Speechley. 1995. "Correlates of Body Mass Index in the 1990 Ontario Health Survey." *Canadian Medical Association Journal* 152(11):1811-1817.
- Pace, William G., Edward W. Martin, Ted Tetrick, Peter J. Fabri and Larry C. Carey. 1979. "Gastric Partitioning for Morbid Obesity." *Annals of Surgery* 190:392-400.
- Packer, Jaclyn. 1994. "Dr. Fat-Attack." *Psychology Today* 27(2):10.

- Papakonstantinou, A., P. Alfaras, V. Komessidou and E. Hadjiyannakis. 1998. "Gastrointestinal Complications After Vertical Banded Gastroplasty." *Obesity Surgery* 8:215-217.
- Pargman, David. 1969. "The Incidence of Obesity Among College Students." *Journal of School Health* 39:621-627.
- Patai, Daphne. 1991. "U.S. Academics and Third World Women: Is Ethical Research Possible?" Pp. 137-153 in *Women's Words: The Feminist Practice of Oral History*, edited by Sherna Berger Gluck and Daphne Patai. New York: Routledge.
- Pauley, L. Lynn. 1988. "Customer Weight as a Variable in Salespersons' Response Time." *Journal of Social Psychology* 129(5):713-714.
- "Pay of Fat Executives is Found Leaner Than Checks of Others." 1974. *The New York Times*, January 2, 2.
- Pettigrew, R. and D. Hamilton-Fairley. 1997. "Obesity and Female Reproductive Function." *British Medical Bulletin* 53(2):341-358.
- Pingitore, Regina, Bernard L. Dugoni, R. Scott Tindale and Bonnie Spring. 1994. "Bias Against Overweight Job Applicants in a Simulated Employment Interview." *Journal of Applied Psychology* 79(6):909-917.
- Pliner, Patricia, Shelly Chaiken and Gordon L. Flett. 1990. "Gender Differences in Concern With Body Weight and Physical Appearance Over the Life Span." *Personality and Social Psychology Bulletin* 16(2):263-273.
- Polivy, Janet and C. Peter Herman. 1976. "Clinical Depression and Weight Change: A Complex Relation." *Journal of Abnormal Psychology* 85:338-340.
- Polivy, Janet and C. Peter Herman. 1983. *Breaking the Diet Habit*. New York: Basic Books.
- Polivy, Janet and C. Peter Herman. 1995. "Dieting and its Relation to Eating Disorders." Pp. 83-86 in *Eating Disorders and Obesity: A Comprehensive Handbook*, edited by Kelly D. Brownell and Christopher G. Fairburn. New York: Guilford Press.
- Pories, Walter J., Melvin S. Swanson, Kenneth G. MacDonald, Stuart B. Long, Patricia G. Morris, Brenda M. Brown, Hisham A. Barakat, Richard A. deRamon, Gay Israel, Jeanette M. Dolezal and Lynis Dohm. 1995. "Who Would Have Thought It? An Operation Proves to be the Most Effective Therapy for Adult-Onset Diabetes Mellitus." *Annals of Surgery* 222(3):339-352.
- Poulton, Terry. 1996. *No Fat Chicks: How Women are Brainwashed to Hate Their Bodies and Spend Their Money*. Toronto: Key Porter Books.
- Poulton, Terry. 1999. "Guilt-Free Feasting in a Pill? Dream On." *The Globe and Mail*, December 29, A17.
- Powdermaker, Hortense. 1960. "An Anthropological Approach to the Problem of Obesity." *Bulletin of the New York Academy of Medicine* 36:286-295.
- Powers, Pauline S. 1989. "Conservative Treatments for Morbid Obesity." Pp. 27-37 in *Surgery for the Morbidly Obese Patient*, edited by Mervyn Deitel. Philadelphia, PA: Lea and Febiger.

- Powers, Pauline S. and Alexander S. Rosemurgy. 1989. "Psychological Sequelae of Surgical Procedures for Obesity." Pp. 351-358 in *Surgery for the Morbidly Obese Patient*, edited by Mervyn Deitel. Philadelphia, PA: Lea and Febiger.
- Price, James H., Sharon M. Desmond, Elizabeth S. Ruppert and Cathleen M. Stelzer. 1987. "School Nurses' Perceptions of Childhood Obesity." *Journal of School Health* 57(8): 332-336.
- Price, R. Arlen and Irving I. Gottesman. 1991. "Body Fat in Identical Twins Reared Apart: Roles for Genes and Environment." *Behavior Genetics* 21(1):1-7.
- Pugliese, Michael T., Fima Lifshitz, Gary Grad, Pavel Fort and Marjorie Marks-Katz. 1983. "Fear of Obesity: A Cause of Short Stature and Delayed Puberty." *New England Journal of Medicine* 309:513-518.
- Quinn, Diane M. and Jennifer Crocker. 1998. "Vulnerability to the Affective Consequences of the Stigma of Overweight." Pp. 125-143 in *Prejudice: The Target's Perspective*, edited by Janet K. Swim and Charles Stangor. San Diego, CA: Academic Press.
- Rabkin, Robert A. 1998. "Distal Gastric Bypass/Duodenal Switch Procedure, Roux-en-Y Gastric Bypass and Biliopancreatic Diversion in a Community Practice." *Obesity Surgery* 8:53-59.
- Rabkin, Simon W., Yue Chen, Lawrence Leiter, Liyan Liu, Bruce A. Reeder and the Canadian Heart Health Surveys Research Group. 1997. "Risk Factor Correlates of Body Mass Index." *Canadian Medical Association Journal* 157(Suppl 1):S26-S31.
- Ramsey-Stewart, George. 1995. "Vertical Banded Gastroplasty for Morbid Obesity: Weight Loss at Short and Long-Term Follow-Up." *Australia and New Zealand Journal of Surgery* 65:4-7.
- Rand, Colleen S.W., Karen Kowalske and John M. Kuldau. 1984. "Characteristics of Marital Improvement Following Obesity Surgery." *Psychosomatics* 25(3):221-223, 226.
- Rand, Colleen S.W. and John M. Kuldau. 1990. "The Epidemiology of Obesity and Self-Defined Weight Problem in the General Population: Gender, Race, Age, and Social Class." *International Journal of Eating Disorders* 9(3):329-343.
- Rand, Colleen S.W. and John M. Kuldau. 1993. "Morbid Obesity: A Comparison Between a General Population and Obesity Surgery Patients." *International Journal of Obesity* 17:657-661.
- Rand, Colleen S.W., John M. Kuldau and Lynn Robbins. 1982. "Surgery for Obesity and Marriage Quality." *Journal of the American Medical Association* 247: 1419-1422.
- Rand, Colleen S.W. and Alex M.C. MacGregor. 1990. "Morbidly Obese Patients' Perceptions of Social Discrimination Before and After Surgery for Obesity." *Southern Medical Journal* 83(12):1390-1393.
- Rand, Colleen S.W. and Alex M.C. MacGregor. 1991. "Successful Weight Loss Following Obesity Surgery and the Perceived Liability of Morbid Obesity." *International Journal of Obesity* 15:577-579.
- Rand, Colleen S.W., Lynn Robbins and John M. Kuldau. 1983. "Stressful Life Events and the Decision for Surgery for Obesity." *Psychosomatics* 24(4):377-384.

- Randolph, Jeanne. 1986. "Enhancing Psychosocial Adaptation to Gastric Partitioning for Morbid Obesity." *Canadian Medical Association Journal* 134:1359-1361.
- Ravussin, Eric, Stephen Lillioja, William C. Knowler, Laurent Christin, Daniel Freymond, William G.H. Abbott, Vicky Boyce, Barbara V. Howard and Clifton Bogardus. 1988. "Reduced Rate of Energy Expenditure as a Risk Factor for Body-Weight Gain." *New England Journal of Medicine* 318: 467-472.
- Reeder, Bruce A., Aubie Angel, Marielle Ledoux, Simon W. Rabkin, Kue Young, Lamont E. Sweet and Canadian Heart Health Survey Research Group. 1992. "Obesity and its Relation to Cardiovascular Disease Factors in Canadian Adults." *Canadian Medical Association Journal* 146(11):2009-2019.
- Regan, Pamela C. 1996. "Sexual Outcasts: The Perceived Impact of Body Weight and Gender on Sexuality." *Journal of Applied Social Psychology* 26(20):1803-1815.
- Register, Charles A. and Donald R. Williams. 1990. "Wage Effects of Obesity Among Young Workers." *Social Science Quarterly* 71:130-141.
- Reinharz, Shulamit. 1992. *Feminist Methods in Social Research*. New York: Oxford University Press.
- Reinhold, Randolph B. 1982. "Critical Analysis of Long-Term Weight Loss Following Gastric Bypass." *Surgery Gynecology and Obstetrics* 135:385-394.
- Renquist, Kathleen, Gary Jeng, Edward E. Mason and NBSR Data Contributors. 1992. "Calculating Follow-Up Rates." *Obesity Surgery* 2:361-367.
- Ricaurte, George A., Mark E. Molliver, Mary B. Martell, Jonathan L. Katz, Mary A. Wilson and Anne L. Martello. 1991. "Dexfenfluramine Neurotoxicity in Brains of Non-Human Primates." *Lancet* 338:1487-1488.
- Richardson, Sanford A., Norman Goodman, Albert H. Hastorf and Sanford M. Dornbusch. 1961. "Cultural Uniformity in Reaction to Physical Disabilities." *American Sociological Review* 26:241-247.
- Rimm, Ilonna J. and Alfred A. Rimm. 1974. "Association Between Socioeconomic Status and Obesity in 59,556 Women." *Preventive Medicine* 3:543-572.
- Ritenbaugh, Cheryl. 1982. "Obesity as a Culture-Bound Syndrome." *Culture, Medicine and Psychiatry* 6:347-361.
- Roberts, Susan B., Judith Savage, W.R.N. Coward, B. Chew and Alan Lucas. 1988. "Energy Expenditure and Intake in Infants Born to Lean and Overweight Mothers." *New England Journal of Medicine* 318(8):461-466.
- Roche, Nicolas, Sylvie Labrune, Jean-Marie Braun and Gérard J. Huchon. 1992. "Pulmonary Hypertension and Dexfenfluramine." *Lancet* 339:437-37.
- Rodin, Judith. 1992. *Body Traps*. New York: William Morrow.
- Rodin, Judith, Lisa Silberstein and Ruth Striegel-Moore. 1984. "Women and Weight: A Normative Discontent." *Nebraska Symposium on Motivation* 32:267-307.



- Roe, Daphne A. and Kathleen R. Eickwort. 1976. "Relationships Between Obesity and Associated Health Factors with Unemployment Among Low Income Women." *Journal of the American Medical Women's Association* 31(5):193-204.
- Ross, Jerry and Kenneth Ferris. 1981. "Interpersonal Attraction and Organizational Outcomes: A Field Examination." *Administrative Science Quarterly* 26:617-632.
- Rothblum, Esther D. 1990. "Women and Weight: Fact and Fiction." *Journal of Psychology* 124:5-24.
- Rothblum, Esther D. 1992. "The Stigma of Women's Weight: Social and Economic Realities." *Feminism and Psychology* 2:61-73.
- Rothblum, Esther D. 1994. "I'll Die for the Revolution but Don't Ask me not to Diet." Pp. 53-76 in *Feminist Perspectives on Eating Disorders*, edited by Patricia Fallon, Melanie A. Katzman and Susan C. Wooley. New York: Guilford Press.
- Rothblum, Esther D., Pamela Brand, Carol T. Miller and Helen A. Oetjen. 1989. "Results of the NAAFA Survey on Employment Discrimination: Part II." *NAAFA Newsletter* 17(2):4-6.
- Rothblum, Esther D., Pamela A. Brand, Carol T. Miller and Helen A. Oetjen. 1990. "The Relationship Between Obesity, Employment Discrimination, and Employment-Related Victimization." *Journal of Vocational Behavior* 37:251-266.
- Rothblum, Esther D., Carol T. Miller and Barbara Garbutt. 1988. "Stereotypes of Obese Female Job Applicants." *International Journal of Eating Disorders* 7(2): 277-283.
- Rubenstein, Richard B. 2002. "Laparoscopic Adjustable Gastric Banding at a U.S. Center with up to 3-Year Follow-Up." *Obesity Surgery* 12:380-384.
- Rubin, Herbert J. and Irene S. Rubin. 1995. *Qualitative Interviewing: The Art of Hearing Data*. Thousand Oaks, CA: Sage.
- Rubinstein, Sharon and Benjamin Caballero. 2000. "Is Miss America an Undernourished Role Model?" *JAMA* 283(12):1569.
- Salmon, Peter A. 1984. "Weight Loss Following Horizontal Gastroplasty With Rigid Stoma and Variable Pouch Size: Comparison with Intestinal Bypass." *Canadian Journal of Surgery* 27(3):234-235.
- Sánchez-Carracedo, C. Saldaña and J.M. Domènech. 1996. "Obesity, Diet and Restrained Eating in a Mediterranean Population." *International Journal of Obesity* 20:943-950.
- Sargent, James D. and David G. Blanchflower. 1994. "Obesity and Stature in Adolescence and Earnings in Young Adulthood: Analysis of a British Birth Cohort." *Archives of Pediatric and Adolescent Medicine* 148 (July): 681-687.
- Scanlon, Deralee. 1991. *Diets That Work For Weight Control or Medical Needs*. Los Angeles, CA: Lowell House.
- Schirmer, Bruce David. 2000. "Laparoscopic Bariatric Surgery." *Surgical Clinics of North America* 80(4):1253-1267.

- Schlosser, Eric. 2001. *Fast Food Nation: The Dark Side of the All-American Meal*. New York: Houghton Mifflin.
- Schoenfelder, Lisa and Barb Wieser, eds. 1983. *Shadow on a Tightrope: Writings by Women on Fat Oppression*. Iowa City: Aunt Lute Books.
- Schroeder, Charles Roy. 1992. *Fat is not a Four-Letter Word*. Minneapolis, MN: Chronimed Publishing.
- Schur, Ellen A., Mary Sanders and Hans Steiner. 2000. "Body Dissatisfaction and Dieting in Young Children." *International Journal of Eating Disorders* 27:74-82.
- Schwartz, Hillel. 1986. *Never Satisfied: A Cultural History of Diets, Fantasies and Fat*. New York: The Free Press.
- Schwartz, Hillel. 1990. "The Three-Body Problem and the End of the World." Pp. 406-465 in *Fragments for a History of the Human Body. Part Two*, edited by Michel Feher, with Ramona Naddaf and Nadia Tazi. New York: Zone.
- Scopinaro, Nicola, Gian Franco Adami, Giuseppe M. Marinari, Ezio Gianetta, Enrico Traverso, Daniele Friedman, Giovanni Camerini, Giorgio Baschieri and Alessandro Simonelli. 1998. "Biliopancreatic Diversion." *World Journal of Surgery* 22:936-946.
- Scopinaro, Nicola, Ezio Gianetta, Gian Franco Adami, Daniele Friedman, Enrico Traverso, Giuseppe M. Marinari, Sonia Cuneo, Bruno Vitale, Fabrizio Ballari, Maurizio Columbini, Giorgio Baschieri and Virgilio Bachi. 1996. "Biliopancreatic Diversion for Obesity at Eighteen Years." *Surgery* 119:261-268.
- Scott, Sophronia and Ulrica Wihlberg. 2002. "Finishing Touches." *People*, June 17, pp. 96-102.
- Seid, Roberta Pollack. 1989. *Never Too Thin: Why Women are at War With Bodies*. New York: Prentice Hall.
- Seid, Roberta Pollack. 1994. "Too 'Close to the Bone': The Historical Context for Women's Obsession with Slenderness." Pp. 3-16 in *Feminist Perspectives on Eating Disorders*, edited by Patricia Fallon, Melanie A. Katzman and Susan C. Wooley. New York: Guilford Press.
- Seidell, Jacob C. 1999. "The Worldwide Epidemic of Obesity." Pp. 661-668 in *Progress in Obesity Research* 8, edited by Bernard Guy-Grand and Gérard Ailhaud. London: John Libbey.
- Sheinin, Rachel. 1990. "Body Shame." *National Eating Disorder Information Centre Bulletin* 5/5, 1.
- Shilling, Chris. 1993. *The Body and Social Theory*. London: Sage.
- Sichieri, Rosely, Everhart, James E. and Harold Roth. 1991. "A Prospective Study of Hospitalization with Gallstone Disease Among Women: Role of Dietary Factors, Fasting Period, and Dieting." *American Journal of Public Health* 81:880-884.
- Sigall, Harold and David Landy. 1973. "Radiating Beauty: Effects of Having a Physically Attractive Partner on Person Perception." *Journal of Personality and Social Psychology* 28:218-224.

- Silverstein, Brett, Barbara Peterson and Lauren Purdue. 1986. "Some Correlates of the Thin Standard of Bodily Attractiveness for Women." *International Journal of Eating Disorders* 5(5):895-905.
- Silverstein, Brett, Lauren Purdue, Barbara Peterson and Eileen Kelly. 1986. "The Role of the Mass Media in Promoting a Thin Standard of Bodily Attractiveness for Women." *Sex Roles* 14(9/10):519-532.
- Singleton, R.A., B.C. Straits and M.M. Straits. 1993. *Approaches to Social Research*. 2<sup>nd</sup> ed. New York: Oxford University Press.
- Sitton, Sarah and Sharon Blanchard. 1995. "Men's Preferences in Romantic Partners: Obesity vs. Addiction." *Psychological Reports* 77:1185-1186.
- Sjöström, Lars V. 1992. "Mortality of Severely Obese Subjects." *American Journal of Clinical Nutrition* 55:516S-523S.
- Sjöström, Lars. 2000. "Surgical Intervention as a Strategy for Treatment of Obesity." *Endocrine* 13(2): 213-230.
- Sjöström, Lars, Aila Rissanen, Teis Andersen, Mark Boldrin, Alain Golay, Hans P.F. Koppeschaar, Michel Krempf and the European Multicentre Orlistat Study Group. 1998. "Randomised Placebo-Controlled Trial of Orlistat for Weight Loss and Prevention of Weight Regain in Obese Patients." *Lancet* 352:167-173.
- Smith, Dorothy E. 1979. "A Sociology for Women." Pp. 135-188 in *The Prism of Sex: Essays in the Sociology of Knowledge*, edited by Julia Sherman and Evelyn Torton Beck. Madison, WI: University of Wisconsin Press.
- Smith, Dorothy E. 1987. *The Everyday World as Problematic*. Toronto: University of Toronto Press.
- Smith, Jane E., V. Ann Waldorf, and David L. Trembath. 1990. "Single White Male Looking for Thin, Very Attractive..." *Sex Roles* 23(11/12):675-685.
- Sobal, Jeffery. 1984a. "Marriage, Obesity and Dieting." *Marriage and Family Review* 7(1/2): 115-139.
- Sobal, Jeffery. 1984b. "Group Dieting, the Stigma of Obesity, and Overweight Adolescents: Contributions of Natalie Allon to the Sociology of Obesity." *Marriage and Family Review* 7:115-140.
- Sobal, Jeffery. 1991. "Obesity and Socioeconomic Status: A Framework for Examining Relationships Between Physical and Social Variables." *Medical Anthropology* 13:231-247.
- Sobal, Jeffery. 1995a. "Social Influences on Body Weight." Pp. 73-77 in *Eating Disorders and Obesity: A Comprehensive Handbook*, edited by Kelly D. Brownell and Christopher G. Fairburn. New York: Guilford Press.
- Sobal, Jeffery. 1995b. "The Medicalization and Demedicalization of Obesity." Pp. 67-90 in *Eating Agendas: Food and Nutrition as Social Problems*, edited by Donna Maurer and Jeffery Sobal. New York: Aldine de Gruyter.
- Sobal, Jeffery. 1999. "The Size Acceptance Movement and the Social Construction of Body Weight." Pp. 231-249 in *Weighty Issues: Fatness and Thinness as Social Problems*, edited by Jeffery Sobal and Donna Maurer. New York: Aldine de Gruyter.

- Sobal, Jeffery and Mark Bursztyrn. 1998. "Dating People with Anorexia Nervosa and Bulimia Nervosa: Attitudes and Beliefs of University Students." *Women and Health* 27(3):73-88.
- Sobal, J., V. Nicolopoulos and J. Lee. 1995. "Attitudes About Overweight and Dating Among Secondary School Students." *International Journal of Obesity* 19:376-381.
- Sobal, Jeffery, Barbara S. Rauschenbach and Edward A. Frongillo, Jr. 1995. "Obesity and Marital Quality: Analysis of Weight, Marital Unhappiness, and Marital Problems in a U.S. National Sample." *Journal of Family Issues* 16(6):746-764.
- Sobal, Jeffery and Albert J. Stunkard. 1989. "Socioeconomic Status and Obesity: A Review of the Literature." *Psychological Bulletin* 105(2):260-275.
- Sobo, Elisa J. 1994. "The Sweetness of Fat: Health, Procreation and Sociability in Rural Jamaica." Pp.132-154 in *Many Mirrors: Body Image and Social Relations*, edited by Nicole Sault. New Brunswick, NJ: Rutgers University Press.
- Solow, Charles, Peter M. Silberfarb and Katharine Swift. 1974. "Psychosocial Effects of Intestinal Bypass Surgery for Severe Obesity." *New England Journal of Medicine* 290:300-304.
- Spelman Elizabeth V. 1982. "Woman as Body: Ancient and Contemporary Views." *Feminist Studies* 8(1):109-131.
- Spirt, B.A., L.W. Graves, R. Weinstock, S.J. Bartlett and T.A. Wadden. 1995. "Gallstone Formation in Obese Women Treated by a Low-Calorie Diet." *International Journal of Obesity* 19:593-595.
- Spitzack, Carole. 1990. *Confessing Excess: Women and the Politics of Body Reduction*. Albany, NY: State University of New York Press.
- Staffieri, J. Robert. 1967. "A Study of Social Stereotype of Body Image in Children." *Journal of Personality and Social Psychology* 7:101-104.
- Stake, Jayne and Monica L. Laur. 1987. "The Consequences of Being Overweight: A Controlled Study of Gender Differences." *Sex Roles* 17(1/2):31-47.
- Stanley, Liz and Sue Wise. 1993. *Breaking Out Again: Feminist Ontology and Epistemology*. Routledge: London.
- Stearns, Peter N. 1997. *Fat History: Bodies and Beauty in the Modern West*. New York: New York University Press.
- Sternhell, Carol. 1985. "We'll Always be Fat but Fat can be Fit." *Ms.*, April, p.66, p. 68, pp. 142-144, p.146, p. 154.
- Strauss, Anselm L. 1987. *Qualitative Analysis for Social Scientists*. Cambridge, MA: Cambridge University Press.
- Strauss, Anselm L. and Juliet Corbin. 1990. *Basics of Qualitative Research*. Newbury Park, CA: Sage.
- Stuart, Richard B. 1967. "Behavioral Control of Overeating." *Behavior Research Therapy* 5:357-365.

- Stuart, Richard B. and Barbara Jacobson. 1987. *Weight, Sex and Marriage: A Delicate Balance*. New York: W.W. Norton.
- "Student Kills Himself in Class in Cherokee." 1994. *The Atlanta Constitution*, March 26, C4.
- Stunkard, Albert J. 1958. "The Results of Treatment for Obesity." *New York State Journal of Medicine* 58:79-87.
- Stunkard, Albert J. 1992. "An Overview of Current Treatments for Obesity." Pp. 33-43 in *Treatment of the Seriously Obese Patient*, edited by Thomas A. Wadden and Theodore B. Van Itallie. New York: Guilford Press.
- Stunkard, Albert J., Jennifer R. Harris, Nancy L. Pedersen and Gerald E. McClearn. 1990. "The Body-Mass Index of Twins who have been Reared Apart." *New England Journal of Medicine* 322(21): 1483-1487.
- Stunkard, Albert J. and John Rush. 1974. "Dieting and Depression Reexamined." *Annals of Internal Medicine* 81:526-533.
- Stunkard, Albert J. and Thorkild I.A. Sørensen. 1993. "Obesity and Socioeconomic Status—A Complex Relation." *New England Journal of Medicine* 329(14):1036-1037.
- Stunkard, Albert J., Thorkild I.A. Sørensen, Craig Hanis, Thomas W. Teasdale, Ranajit Chakraborty, William J. Schull and Fini Schulzinger. 1986. "An Adoption Study of Human Obesity." *New England Journal of Medicine* 314(4):193-198.
- Stunkard, Albert J., James L. Stinnett and Jordan W. Smoller. 1986. "Psychological and Social Aspects of the Surgical Treatment of Obesity." *American Journal of Psychiatry* 143:417-429.
- Stunkard, Albert J. and Thomas A. Wadden. 1992. "Psychological Aspects of Severe Obesity." *American Journal of Clinical Nutrition* 55:524S-532S.
- Sugerman, Harvey J. 2000. "The Epidemic of Severe Obesity: The Value of Surgical Treatment." *Mayo Clinic Proceedings* 75(7):669-672.
- Sugerman, Harvey J., Janet V. Starkey and Regine Birkenhauer. 1987. "A Randomized Prospective Trial of Gastric Bypass Versus Vertical Banded Gastroplasty for Morbid Obesity and Their Effects on Sweets Versus Non-Sweets Eaters." *Annals of Surgery* 205:613-624.
- Sugerman, Harvey J., John M. Kellum, Kathryn M. Engle, Luke Wolfe, Janet V. Starkey, Regine Birkenhauer, Pauline Fletcher and Mary-Jo Sawyer. 1992. "Gastric Bypass for Treating Severe Obesity." *American Journal of Clinical Nutrition* 55:560S-566S.
- Synnott, Anthony. 1993. *The Body Social: Symbolism, Self and Society*. London: Routledge.
- Task Force of the American Society for Clinical Nutrition. 1985. "Guidelines for Surgery for Morbid Obesity." *American Journal of Clinical Nutrition* 42: 904-905.
- Taylor, Steven J. and Robert Bogdan. 1998. *Introduction to Qualitative Research Methods: A Guidebook and Resource*. 3<sup>d</sup> edition. New York: John Wiley and Sons.

- Teasdale, Thomas W. and Thorkild I.A. Sorensen. 1983. "Educational Attainment and Social Class of Adoptees: Genetic and Environmental Contributions." *Journal of Biosocial Science* 15:509-518.
- Thompson, J. Kevin and Leslie J. Heinberg. 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.
- Tiggemann, Marika and Esther D. Rothblum. 1988. "Gender Differences in Social Consequences of Perceived Overweight in the United States and Australia." *Sex Roles* 18:75-86.
- Tremblay, Mark S. and J. Douglas Willms. 2000. "Secular Trends in the Body Mass Index of Canadian Children." *Canadian Medical Association Journal* 163(11):1429-1433.
- Troiano, Richard P. and Katherine M. Flegal. 1998. "Overweight Children and Adolescents: Description, Epidemiology, and Demographics." *Pediatrics* 101(3):497-504.
- Troiano, Richard P., Katherine M. Flegal, Robert J. Kuczmarski, Stephen M. Campbell and Clifford L. Johnson. 1995. "Overweight Prevalence and Trends for Children and Adolescents." *Archives of Pediatric and Adolescent Medicine* 149:1085-1091.
- Trypuc, Joanne. 1994. "Women's Health." Pp. 260-275 in *Health, Illness, and Health Care in Canada*, edited by B. Singh Bolaria and Harley D. Dickinson. 2nd ed. Toronto: Harcourt Brace.
- Turner, Bryan S. 1984. *The Body and Society*. Oxford: Basil Blackwell.
- Turner, Bryan S. 1991. "Recent Developments in the Theory of the Body." Pp. 1-35 in *The Body: Social Process and Cultural Theory*, edited by Mike Featherstone, Mike Hepworth and Bryan S. Turner. London: Sage.
- Udry, J. Richard and Bruce K. Eckland. 1984. "Benefits of Being Attractive: Differential Payoffs for Men and Women." *Psychological Reports* 54: 47-56.
- Valley, Victoria. 1984. "Preoperative Psychologic Assessment in Determining Outcome from Gastric Stapling for Morbid Obesity." *Canadian Journal of Surgery* 27:129-130.
- Valley, Victoria and D. Michael Grace. 1987. "Psychosocial Risk Factors in Gastric Surgery for Obesity: Identifying Guidelines for Screening." *International Journal of Obesity* 11:105-113.
- Van Itallie, Theodore B. 1978. "Liquid Protein Mayhem." *Journal of the American Medical Association* 240(2):144-145.
- Van Itallie, Theodore B. 1980. "'Morbid' Obesity: A Hazardous Disorder That Resists Conservative Treatment." *American Journal of Clinical Nutrition* 33:358-363.
- Van Itallie, Theodore B. and Mei-Uih Yang. 1984. "Cardiac Dysfunction in Obese Dieters: A Potentially Fatal Complication of Rapid, Massive Weight Loss." *American Journal of Clinical Nutrition* 39: 695-702.
- Vanuystel, Johan L., Frank R. Nobels, Luc F. Van Gaal and Ivo H. De Leeuw. 1993. "A Case of Malnutrition After Biliopancreatic Diversion for Morbid Obesity." *International Journal of Obesity* 17:425-426.

- Vener, Arthur M., Lawrence R. Krupka, and Roy J. Gerard. 1982. "Overweight/ Obese Patients: An Overview." *The Practitioner* 226:1102-1109.
- Versélewele de Witt Hamer, Philip C., Michiel A.J.M. Hunfeld and Wim E. Tuinebreijer. 1999. "Obesity Surgery: Discouraging Long Term Results with Mason's Vertical Banded Gastroplasty." *European Journal of Surgery* 165:855-860.
- Wadden, Thomas A. 1999. "The Management of Obesity: From Past Failure to Future Attainment." Pp. 713-719 in *Progress in Obesity Research: 8*, edited by Bernard Guy-Grand and Gérard Ailhaud. London: John Libbey.
- Wadden, Thomas A. and Gary D. Foster. 2000. "Behavioral Treatment of Obesity." *Medical Clinics of North America* 84(2):441-461.
- Wadden, Thomas A. and Albert J. Stunkard. 1985. "Social and Psychological Consequences of Obesity." *Annals of Internal Medicine* 103:1062-1067.
- Wadden, Thomas A. and Albert J. Stunkard. 1987. "Psychopathology and Obesity." *Annals of the New York Academy of Sciences* 499:55-65.
- Wadden, Thomas A., Albert J. Stunkard, Kelly D. Brownell, and Theodore B. Van Itallie. 1983. "The Cambridge Diet: More Mayhem?" *Journal of the American Medical Association* 250(20):2833-2834.
- Wadden, Thomas A., Albert J. Stunkard and Jordan W. Smoller. 1986. "Dieting and Depression: A Methodological Study." *Journal of Counselling and Clinical Psychology* 54(6):869-871.
- Wadden, Thomas A., Theodore B. Van Itallie and George L. Blackburn. 1990. "Responsible and Irresponsible Use of Very Low-Calorie Diets in the Treatment of Obesity." *JAMA* 263(1): 83-85.
- Walby, Sylvia. 1990. *Theorizing Patriarchy*. Cambridge, MA: Basil Blackwell.
- Walden, Keith. 1985. "The Road to Fat City: An Interpretation of the Development of Weight Consciousness in Western Society." *Historical Reflections* 12(3): 331-373.
- Wallis, Mary. 2001. "Girls as Young as Five Worry About Their Weight, Study Says." *The National Post*, January 9, A1, A2.
- Wampler, Richard S., Joan B. Lauer, Joanne B. Lantz, Karen Smith Wampler, Muriel G. Evens and James A. Madura. 1980. "Psychological Effects of Intestinal Bypass Surgery." *Journal of Counselling Psychology* 27:492-499.
- Wardle, Jane, Renu Bindra, Beverley Fairclough and Alex Westcombe. 1993. "Culture and Body Image: Body Perception and Weight Concern in Young Asian and Caucasian British Women." *Journal of Community and Applied Social Psychology* 3:173-181.
- Wardle, Jane and Louise Marsland. 1990. "Adolescent Concerns About Weight and Eating: A Social-Developmental Perspective." *Journal of Psychosomatic Research* 34(4):377-391.
- Wardle, J., C. Volz and C. Golding. 1995. "Social Variation in Attitudes to Obesity in Children." *International Journal of Obesity* 19:562-569.

- Waters, Gregory S., Walter J. Pories, Melvin S.S. Swanson, Helen D. Meelheim, Edward G. Flickinger and Harold J. May. 1991. "Long-term Studies of Mental Health After the Greenville Gastric Bypass Operation for Morbid Obesity." *American Journal of Surgery* 161:154-158.
- "Weight Loss Surgery Patient Dies." 1998. *The Hamilton Spectator*, May 9, A5.
- Weintraub, Michael. 1992. "Long-Term Weight Control: The National Heart, Lung, and Blood Institute-Funded Multimodal Intervention Study." *Clinical Pharmacological Therapy* 51:581-646.
- Weissman, Neil J., John F. Tighe, John S. Gottdiener and John T. Gwynne. 1998. "Assessment of Heart-Valve Abnormalities in Obese Patients Taking Dexfenfluramine, Sustained-Release Dexfenfluramine, or Placebo." *New England Journal of Medicine* 339 (11): 725-732.
- Weitz, Rose, ed. *The Politics of Women's Bodies: Sexuality, Appearance and Behavior*. New York: Oxford University Press.
- Wilkinson, Jennifer Y., David I. Ben-Tovim and M. Kay Walker. 1994. "An Insight into the Personal and Cultural Significance of Weight and Shape in Large Samoan Women." *International Journal of Obesity* 18:602-606.
- Wilmore, Jack H. 1983. "Body Composition in Sport and Exercise: Directions for Future Research." *Medicine and Science in Sports and Exercise* 15(1):21-31.
- Wing, Rena R. 1992. "Behavioral Treatment of Severe Obesity." *American Journal of Clinical Nutrition* 55:545S-551S.
- Wiseman, Claire V., James J. Gray, James E. Mosimann and Anthony H. Ahrens. 1992. "Cultural Expectations of Thinness in Women: An Update." *International Journal of Eating Disorders* 11:85-89.
- Wiseman, Claire V., Robin M. Turco, Suzanne R. Sunday and Katherine A. Halmi. 1998. "Smoking and Body Image Concerns in Adolescent Girls." *International Journal of Eating Disorders* 24:429-433.
- Wittgrove, Alan C., Leslie Jester, Perri Wittgrove, and G. Wesley Clark. 1998. "Pregnancy Following Gastric Bypass for Morbid Obesity." *Obesity Surgery* 8:4461-4464.
- Wolf, Naomi. 1991. *The Beauty Myth: How Images of Beauty are Used Against Women*. New York: William Morrow.
- Wolfe, Honor. 1998. "High Prepregnancy Body-Mass Index—A Maternal-Risk Factor." *New England Journal of Medicine* 338(3):191-192.
- Wolfe, Louise. 1983. "Weight Loss Surgery: Miracle Cure or Mutilation?" Pp. 162-166 in *Shadow on a Tightrope: Writings by Women on Fat Oppression*, edited by Lisa Schoenfelder and Barb Wieser. San Francisco, CA: Aunt Lute Books.
- Wooley, O. Wayne. 1994. "...And Man Created 'Woman': Representations of Women's Bodies in Western Culture." Pp. 17-52 in *Feminist Perspectives on Eating Disorders*, edited by Patricia Fallon, Melanie A. Katzman and Susan C. Wooley. New York: Guilford Press.
- Wooley, Orland W., Susan C. Wooley and Sue R. Dyrenforth. 1979. "Obesity and Women—II. A Neglected Feminist Topic." *Women's Studies International Quarterly* 81-92.



- Wooley, Susan C. and Orland W. Wooley. 1979. "Obesity and Women--I. A Closer Look at the Facts." *Women's Studies International Quarterly* 2:69-79.
- Wooley, Susan C., O.W. Wooley and Sue Dyrenforth. 1980. "The Case Against Radical Interventions." *American Journal of Clinical Nutrition* 33:465-471.
- World Health Organization. 1998. *Obesity: Preventing and Managing the Global Epidemic. Report of a WHO Consultation on Obesity. Geneva 3-5 June 1997.* Geneva: World Health Organization.
- Young, Laura M. and Brian Powell. 1985. "The Effects of Obesity on the Clinical Judgments of Mental Health Professionals." *Journal of Health and Social Behavior* 26:233-246.
- Zacharias, Yvonne. 1997. "Controversial Anti-Flab Pill Goes on Sale." *The Montreal Gazette*, January 10, All.
- Zeldin, Theodore. 1977. *France 1848-1945, Volume 2: Intellect, Taste and Anxiety.* Oxford: Oxford University Press.