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Narrative and obesity: Managing weight stigma associated with bariatric surgery

Álvaro Sicilia
University of Almería, Spain

María-Luisa Socías-Serrano
University of Almería, Spain

Mark D Griffiths
Nottingham Trent University, UK

Elena Martínez-Rosales
University of Almería, Spain

Enrique G Artero
University of Almería, Spain

Abstract

The present study examined how individuals who have been clinically diagnosed as obese explain their decision to undergo bariatric surgery and how they deal with the stigmatization that such a decision may entail. A total of 23 participants (15 women and 8 men) who were awaiting bariatric surgery within the Spanish healthcare system, were interviewed about their weight trajectory and their decision to undergo this surgery. In order to examine the participants' stories, a narrative analysis of the interviews was conducted, with attention to both content (*what* they told) and structure (*how* they told) and examining the stories in line with the socially and culturally available narratives that they had access to, and the context in which the stories were produced. The

participants explained their weight trajectory through the origin of their weight, the failure to control it, and their decision to have surgery to solve the weight problem. The narrative of a sick body that needs to be restored appeared to function as a schema or script through which participants attempted to defend themselves from anti-fat narratives that assume personal failure while at the same time presenting themselves as deserving to be operated on. Through their narratives, they positioned themselves as undeserving of stigma but did not challenge the stigma itself.

Keywords
body mass index, fatness, identity, narrative analysis, obesity

Introduction

'Obesity' is the dominant medical understanding of higher weight[1]. In contemporary society, the treatment of higher weight as 'obesity' is shaped by a complex and changing system of discourses, practice, emotions, material goals, and interpersonal relationships (Boero, 2012; Gilman, 2008; Lupton, 2018). Concerns regarding 'obesity' not only lie in tackling the risk of individuals classified as 'obese' for associated diseases and earlier mortality (Caixàs et al., 2020), but also avoiding the escalation of health budgets, due to associated chronic diseases (Organization for Economic Cooperation and Development, 2019). Although a combination of personal, sociocultural, and biological factors is indicated as causing the health crisis, analyses of public messages and news covering 'obesity' highlight that there is a preference for treating the issue as a fundamentally personal problem (Lupton, 2018; Saguy, 2013).

Some argue the negative discourses regarding higher weight and its *medicalization* through 'obesity' promote stigmatization of individuals with higher body mass index (BMI) (Murray, 2005; Phelan et al., 2015; Puhl, 2023). Although there may be some similarities to stigmatization due to other conditions or characteristics of

[1] We have chosen to present the terms with which different discourses (as well as the participants in the present study) refer to body weight in inverted commas to acknowledge the political and contested status of such labels (e.g., 'fat', fatness' but also 'obese', 'obesity', etc.).

individuals (e.g., LGBTQIA+, disability, AIDS), the obvious visibility, but especially the perceived social controllability of body weight, places individuals with higher weight in a group highly vulnerable to stigmatization (Puhl and Brownell, 2003). In line with the neoliberal culture (Harjunen, 2021), there is the idea that having higher BMI is a personal choice that should be guided by having willpower to resist the temptation of food and the will to lead a more active life (Guthman, 2011; LeBesco, 2011). In addition to being a health problem, 'obesity' is publicly represented as a moral problem, given that it is up to individuals to do their part to tackle the problem (Gard and Wright, 2005; Lupton, 2018).

Individuals who are considered suitable for bariatric surgery are a vulnerable group, because (i) they fall at one end of the scale used to classify body weight (i.e., BMI ≥ 35), and (ii) their size makes them a central target for moral censure. These individuals are often attributed with characteristics such as being lazy, undisciplined, unable to control themselves, and accused of a lack of individual responsibility for having reached their current weight (Phelan et al., 2014; Puhl, 2023). In addition, because bariatric surgery aims to limit the body's ability to consume and absorb food, it is often seen as cheating, an easy solution for those who do not show sufficient willpower to fight the weight themselves (Luck-Sikorski et al., 2019; Throsby, 2008). Therefore, individuals classified as 'obese' who decide to undergo bariatric surgery are often viewed beyond the strictly medical problem. Research has shown how primary care and healthcare professionals openly display negative views of individuals who have been defined as 'obese' (Phelan et al., 2015), at the same time that patients who attempt to medically treat 'obesity' report perceiving worse care from professionals versus patients with other ailments (Gudzune et al., 2013; Puhl, 2023).

Attempts to counter the dominant discourse that maintains the existence of an

obesity epidemic and a need to fight it can be found in critical studies and studies conducted through the lens of fat activism (Gard et al., 2022; Gard and Wright, 2005; Lupton, 2018; Murray, 2005; Saguy, 2013). Fat activists re-value the 'fat' body and have questioned bariatric surgery as a means to tackle the problem of obesity (Bacon and Aphramor, 2014; Cooper, 2016; Murray, 2005). Some activists argue that individuals undergoing bariatric surgery are either active and conscious collaborators of the medical discourse or innocent victims (Throsby, 2012). However, both the dominant anti-obesity view and critical perspectives and fat activism overlook the everyday experiences and active role of those who have decided to undergo bariatric surgery.

The present study examined how individuals who are defined as 'obese' explained their decision to undergo bariatric surgery, and how they handled the possible stigmatization of such decision using narrative analysis (Throsby, 2007, 2012). Through their stories, individuals must provide coherent explanations and, in doing so, manage the double moral failure that implies the: (i) impossibility of having been able to keep their weight under control so far, and (ii) need to have surgery as a last resort to achieve this control instead of continuing to struggle to lose weight on their own. In explaining the causes that have led them to put on weight to the point of deciding to undergo surgery, individuals engage in a process of claiming the way they want to be presented and seen by others (Atkinson, 2009; Frank, 2010). Therefore, individuals' accounts of failed attempts to control their weight and their decision to have surgery can be understood as attempts to construct coherent and respectable personal identities.

Method

Design

In order to address the purpose of the study, a qualitative empirical study using a

narrative approach was developed (Frank, 2010, 2013). By adopting this approach, we align with a non-foundational standpoint, assuming a position of epistemological constructivism (Crotty, 1998; Smith, 2011). The proposition is taken that there is no real world independent of our knowledge about it. Individuals make sense of their lives through the stories they tell (Atkinson, 2012; Frank, 2000; Gubrium and Holstein, 2012). Individuals are actors who do things with the stories they tell, rather than understanding these stories "as a portal into the mind of the storyteller" (Frank, 2010: 13).

A narrative perspective allows researchers to connect the social elements with the action of the individual as an agent within the group (Somers, 1994). Although in telling stories individuals prioritize their personal experiences, these stories also reveal the specific context in which they are produced and the broader narratives that circulate socially and culturally in which these stories can be situated (Atkinson, 2009; Frank, 2012; Riessman, 2008). The more personal explanations and stories allow participants to make sense of their lives, define themselves, and justify what they do, acting, in Somers' (1994) terms, as ontological narratives. However, participants should not be seen as totally free to fabricate stories as they please (Riessman, 1993). They can only make sense of their stories to the extent that they are situated concerning the public and collective narratives that they have access to within their culture (Somers, 1994; Taylor, 2006). The commonly available narratives that individuals have access to serve as the narrative resources they draw from when sharing stories about their lives (Frank, 2010, 2013). Individuals are largely immersed in culture and culture speaks through the stories that individuals tell (Riessman, 1993). The connection of the personal and social in the present study is more precisely established through the narratives that the participants provide concerning their weight trajectory that led them to bariatric surgery.

Participants

The present study is based on a wider research project focused on the experiences of individuals before and after undergoing bariatric surgery in Spain. Through the medical team in charge of the operation, 23 participants (15 women and 8 men) awaiting bariatric surgery were invited to participate in the present study. Within the key inclusion criterion being a patient awaiting bariatric surgery, the selection of participants was made seeking the maximum possible variety taking into account sex, age, type of health system through which they received the operation (public vs. private), level of education, and socio-labor situation. The pre-surgery participants' BMI ranged from 37.5 to 67, all of them being clinically classified as having some degree of obesity. Except for an 18 years-old man, all the participants were between 30 and 55 years.

Procedure

All participants were contacted through the medical team involved in weight reduction surgery, with whom two of the researchers (fourth and fifth authors) had previously worked. Within the medical context in which they were recruited, and as part of this participation process, participants showed interest in discussing their experiences with weight and giving explanations about their decision to undergo weight reduction surgery.

All individuals who were approached to participate in the study agreed to be interviewed and signed an informed consent. The present study was approved by the Research Ethics Committee of [institution omitted to preserve anonymity in the review process] (Ref 76/2016). Prior to the start of the interviews, participants were informed of their rights and ethical issues (e.g., not to answer the questions if they did not want to, withdraw from the study at any time, preserve their anonymity, be informed of the results of the study). The second author conducted unstructured interviews based on open-ended questions that allowed participants a starting point from which to tell their stories. Except

for one person who only agreed to a single interview, all participants were interviewed between two or three times, the first being conducted prior to bariatric surgery. Each interview ranged from one to two and a half hours. Interviews began in early 2018 and were extended with some participants until mid-2021. Depending on the interviewee's preferences and the health situation (COVID-19 confinement), some interviews were conducted face-to-face at the location of preference indicated by the interviewee, while others were conducted by telephone. All interviews were recorded and were subsequently transcribed for analysis.

In line with a narrative approach (Atkinson, 2012; Frank, 2010; Gubrium and Holstein, 2012), participants were interviewed seeking the biographical, historical and cultural context of each participant. Each interview was conducted adopting an open and accepting stance to allow each participant to share the stories of their experience in an atmosphere of support, solidarity, and empathy (Atkinson, 2012). To do this, we used an open-ended interview script with a conversational approach that began by asking each participant to recount their previous experiences and describe how they had gone from the time they had the memory to where they were now. From this starting point we asked how throughout their life they had arrived at the situation they were in now, that is, having decided to undergo bariatric surgery. Each participant was invited to provide a personal story of their life, allowing them total freedom to highlight issues, events, and use whatever story plot they considered. Interviews at different times allowed participants to retell moments of their life more effectively, while revisiting and clarifying some of the episodes previously recounted. Although participants were recruited in a clinical and medical context, there was an effort not to impose clinical categories so that participants could dictate the terms they used to recount their experiences.

Analysis

During data collection the authors assumed different but complementary roles. All collaborated in the discussion, interpretation and revision of the different drafts of the results, incorporating different approaches to the study's objective. The second author conducted all the in-depth interviews, transcribed them, and carried out the first analyses in continuous communication and discussion with the first and third authors, who participated in the process of the analysis and interpretation of the interviews. The fourth and fifth authors played a contrasting role, noting key issues that arose and engaged in conversation with the rest of the team to clarify, contrast, and push for a more understandable wording for all types of readers.

After multiple readings of the transcripts, the analysis was guided by a cyclical process between the *what*[2] and the *how* of the stories narrated (Gubrium and Holstein, 2012). The analysis of the *what* of the stories was guided by a thematic analysis (Riessman, 2008) to identify themes, typologies, or instances of paradigmatic categories. To dissect the original story into sections or categories, the first three authors repeatedly read the interview transcripts and made tentative annotations that were then reviewed and discussed between all three authors. The analysis of themes was initially carried out focusing on each participant, and then an inter-participant analysis was performed to compare and contrast themes and issues evident in the accounts of the different participants. The thematic analysis focused on what each participant told and what similarities or differences in themes there were across interviewees. However, as repeated reading and analysis delineated the themes of the stories, frequent analytical observations along with relevant segments of the text were introduced, which allowed us to orient the analysis to the form and processes through which participants told the stories (Gubrium and Holstein, 2009; Holstein and Gubrium, 2000).

[2] Italics used by authors to emphasize a word or phrase in the text.

By following a cyclical process focused on *what* participants told and *how* they told, we not only focused on the environmental circumstances of storytelling but also on the processes participants creatively used for their narratives and the effects they are trying to create with their narratives (Frank, 2010, 2013; Holstein and Gubrium, 2000). The analysis of *how* the narrative is produced (e.g., the metaphors used, the narrative linkages among culture, lived experience, and storytelling) was conducted in mutual interconnection with the *what* of the stories, through a process, denoted by Gubrium and Holstein (2009) as *analytic bracketing*. The stories told by participants were examined in line with theory and the social and cultural narratives in circulation that participants mobilized to give coherent meaning to their stories (Atkinson, 2009; Frank, 2012; Riessman, 2008).

Results and Preliminary Discussion

In what follows, we recount moments from participants' stories about their weight trajectory and their explanations that have led them to the current situation of undergoing bariatric surgery. These stories are interwoven with analysis and interpretation in line with relevant theory under three sections: (i) stories about the origin of my obesity: I come from a fat family, (ii) stories about diet and exercise narratives: They haven't worked for me, and (iii) stories about the reasons for operation: It's for health. This division should be understood as an interpretative structure that was imposed on the data, serving the narrative analysis as a practice for interpretation and not as a canonical sequence of steps to be followed (Frank, 2010, 2012; Smith and Monforte, 2020). Throughout the subsections that follow are stories told by participants that, although varied in content, show socially and culturally available resources that participants use to make sense of their weight history and their decision to undergo bariatric surgery. In this sense, the

explanations given by participants make sense within a narrative structure that allows them to present themselves as sick people deserving of a medical solution.

Stories About the Origin of my Obesity: I Come From a Fat Family

Without exception, the participants said that their higher body weight started at birth or during childhood. In all cases, the participants made the interviewer aware of an ongoing struggle with a situation that was already partly determined by their genetic predisposition or by the family environment in which they were raised.

Maria, a 45-year-old industrial engineer who is currently unemployed, acknowledged that she had been "chubby" for as long as she can remember (i.e., since she was a little girl). Moreover, she attributed her chubbiness to genetics. What was clear to her was that she had always weighed more than she *should have*, and this foretold an uncertain future for her health. Maria assumed she was "not on the right track" and established a clear association between weight and health. Her genetic history presented her as a person already predisposed to be 'obese'.

> *I think it runs in my family … in my family we are all like that. I guess genetics helps and then the person … I don't eat so much and I'm not depressive or anything to say that... My grandmother died at 48 years of obesity … My father has already had many health problems due to obesity. Because my brother (laughs) is obese, because my niece is, I don't know, because of what the environment tells you. All your life they tell you that you have to be the same, I don't know. I guess that's why* (Maria).

Body weight discourses in Western culture are based on a *normalization* of a slim and healthy body ideal, which reinforces the ideology that every individual must remain within a weight that falls within the limits of this *normality* (Gard and Wright, 2005;

Lupton, 2018; Saguy, 2013). Maria's predisposition to gain weight functioned as a plea against possible accusations of guilt for her weight, distancing any internal attribution that could place her at the center of the *moral failure* (Gard and Wright, 2005; Throsby, 2007) of having a body that is now classified as 'obese'. Manuel, a 47-year-old farmer, referred to his genetic predisposition to be 'fat' as being "broad-boned". According to the stories he heard from his mother, his weight was not striking at birth. However, after one or two years he gradually gained weight. He stated "I started fat, and I stayed fat" that highlighted his genetic predisposition to 'fatness', and ended by saying "I am broad-boned, what can I tell you?" Manuel, like many of the participants, used the genetic explanation of his 'fatness' as a way to emphasize that it was a characteristic of the body, rather than a behavior or habit that he had acquired. Alberto, a 43-year-old chef, also offered an account of his genetic predisposition to gain weight stating that he was "born big". He weighed six and a half kilos at birth and at the age of 12 years he weighed more than 100 kilos.

Participants' use of the *fat gene* has the discursive potential to explain that their 'fat' body should be attributed to the bad luck of their genetic predisposition, rather than to the lack of personal responsibility as an indicator of *moral failure* (Throsby, 2007). Nevertheless, all participants complemented their genetic explanations with other types of stories that serve to exonerate them from being ultimately responsible for their weight. Although participants never used the term 'epigenetics', an interaction between genetic and environmental factors seemed to become evident when they introduced other events through which this *fat gene* may be regulated and expressed differently (Rohde et al., 2019). However, it is noteworthy that, far from explanations centered on the obesogenic environment and the responsibility of social agents, the explanations were centered on

individual factors or personal events that exonerated them of any responsibility for their body weight.

Some participants focused on individual factors that pointed directly to those who had cared for them. Here, being born into a family with higher weight not only predisposed them to having higher weight, but also learning to live with it. Genetic explanations were complemented by accounts that pointed to a lack of nutritional education and healthy lifestyle habits in the family. Some participants mentioned overeating as children as a circumstance that enhanced their genetic predisposition to have greater weight. Fernando, a 58-year-old catering business owner, said that mothers insisted: "Eat, eat – believing that the more stuffed you were, the better health you had". As he recalled, there used to be no control over food and it was not known, as it is now, which foods were healthier. Simply put, "at mealtime you had to eat whatever was available, whether you liked it or not". Alberto also stated that, in addition to genetics, an individual has to have good habits, because the eating style an individual learns at home remains a habit in their future daily diet. For this reason, Alberto recognized that he now tries to instill in his children a better diet, such as not eating sweets. The same strategy of blaming her mother for her weight gain is what Noemí, a 43-year-old journalist, seemed to resort to when she stated the following:

> *Look, when I was little, I was thin, I was very small. I was very small, but what happened before with the mommies, "is that my little girl doesn't eat". My mother would give me a snack at five o'clock in the afternoon and it would come together with dinner. And my mother would come and say, "the child doesn't eat, the child doesn't eat". One day she took me to the doctor and the doctor told my mother "give your daughter these medicines". Some vitamins*

or what do I know. And I started to put on weight. I went to communion and I looked like a bride (Noemi).

Interviewer: (Laughs).

It's true, I see myself at my mother's house and I look like a loaf of bread from Guadix [a town in the province of Granada]. Then you lose weight, because you grow up, you are a teenager and you go to high school, but you still don't lose weight, you are not thin, your metabolism changes (Noemi).

The lack of due care on the part of the family recalls the public narrative in the anti-obesity discourse of parental culpability in childhood obesity (Gard & Wright, 2005). Antonio, a 41-year-old ambulance driver, acknowledges that he was very "trangoncillo" [Spanish word for a little swallower or gobbler]. He mentioned that he was given to eating, perhaps, as he acknowledged, because he was "nervous". Although he defined himself as a "rebellious" boy who was difficult to keep an eye on, he also recognized that a child is not to blame for what he does. Since the situation was not corrected, when he was 10 or 11 years old, and weighing 90 kgs, the problem was noticed by his physician:

The doctor told my parents, "either this child loses weight or he will not grow because he is already limiting himself with the issue of [his weight]. He's twelve years and ninety kilos". It was a projection of weighing one hundred and fifty [kilos] (Antonio).

The narratives of blaming parents, and particularly mothers, represent an available resource in the obesity discourse (Boero, 2013; Gard and Wright, 2005) that some participants echoed to manage potential accusations about their weight. With this resource, participants achieved the effect of presenting themselves as victims, rather than the cause, of their own weight. However, while children cannot be expected to take

responsibility for their lifestyle and weight, this changes as they grow into adults and assume full accountability for their actions. As stated in one of the press articles analyzed by Saguy (2013) "You can't choose your parents, but you can choose what you eat and how often you exercise" (p. 100). Therefore, genetic predisposition and family lifestyle may mitigate the responsibility of a child with higher weight, but, in the face of dominant narratives assuming the controllability of weight via lifestyle changes, the participants added stories addressing eating and exercise.

Diet and Exercise Stories: They Haven't Worked for me

The narrative of the body *tending to be* 'fat' was a central explanation in the participants' accounts, because it served to justify their starting position in the weight surveillance and to resist the attribution of responsibility as an adult person to control this weight. Thus, consistent with the *genetics* of being 'fat', all participants related that their *metabolism* was also a determining factor in explaining their higher weight. The biological functioning of their body was a resource used by the participants to describe their body functions differently in the face of food intake. In Antonio's case, metabolism explained that there are different bodies in the same family, despite repeated attempts to control weight.

> *Well, being chubbier, I think it was also a genetic issue because in the end my brother is. I was born chubby and he wasn't … In the end they are metabolisms, people, and so on. What is clear to me is that I have done a lot, a lot, a lot to control my weight* (Antonio).

Like Antonio, Ainhoa, a 37-year-old professional soldier, compared herself to her brother, whom she referred to as *"*super thin*",* and did not quite understand why diets and exercise did not work for her. Because of her profession as a soldier, Ainhoa was used to

exercising and recognized that this had helped her at times. However, the treatment with diets, as in all participants, had not worked for her. The fact of not being able to lose weight despite her discipline with diet and exercise began to "sound strange" and to shock her, to the point that as she said "I don't know, I must have something in my stomach".

Similar to Antonio and Ainhoa, Alba did not understand why the diets she had done all her life had not worked. She compared herself to her brother, whom she described as a "figurine", and was surprised why he did not put on weight like she did despite "eating like a horse". This comparison was highlighted by those who lived with her, who went as far as to tell her "You don't eat so much to be like this".

Juan, aged 18, had no concrete cause that could explain his weight gain. After a careful diet, he reported no other explanation for his weight gain than family genetics and the fact that this had led him to have a different metabolism for the rest of his life. Therefore, within the metabolic explanation, overeating must be understood within the relativity of each body, so that eating any amount of food is always overeating for that particular body.

> *In my case it is not that it is a bad diet either. I am not eating buns all day long or anything like that. It is a problem that I explained to the doctor. He says that many times you don't eat fats, you don't eat fried food, but for whatever reason your body is not able to eliminate it. It is also true that sport is something key and [weighing] 140 kilos it is very difficult to do sports like walking or running* (Juan).

However, having a genetically affected metabolism does not imply the inevitability of having higher weight (Rohde et al., 2019). Given the importance that more personal and individual factors take on in the anti-obesity discourse (Saguy, 2013),

individuals must show that their actions have been well directed toward preventing weight gain (Gard and Wright, 2005; Lupton, 2018). As Gibson (2022) suggests, if an individual with a disposition to gain weight shows appropriate behavior and lifestyle to keep weight in check, they may continue to be seen as innocent, given that they have shown to perform appropriate tasks. In this vein, the *good fatty* versus *bad fatty* discourse have been described as familiar archetypes of anti-obesity narratives (Chalklin, 2016; Harrison, 2021). Harrison (2021) suggests that the archetype of the *good fatty* who works responsibly to aspire to health is pitted against the *bad fatty* who does not work to control themselves. This dichotomy serves to justify the inclusion and exclusion of social privileges of some versus others in terms of access, opportunity, dignity, and respect. In this line, the participants' discourse of a *body prone to gain weight* does not seem sufficient to justify the representation of a *good fatty*. After all, having a predisposition in childhood to gain weight does not presuppose future higher weight in adulthood and, consequently, it is not enough to resist the attribution of a *moral failure* (Gard and Wright, 2005; Lupton, 2018; Throsby, 2007) for not having done enough under the circumstances to avoid gaining even more weight.

In line with showing kindness in their actions and moving away from the archetype of a *bad fatty* (Chalklin, 2016; Gibson, 2022), the participants shared other accounts that exonerated them from their inability to control their weight through lifestyle and instead seek bariatric surgery. Prominent among these accounts were injuries, accidents and other life events that made many participants lose control of their weight. All these events were presented as explanations for the failure in their attempts to control their weight and, in part, complement the metabolic explanation by highlighting factors that accentuate a metabolism already predisposed to a 'fat' body. The recounting of all these events might well be seen as discursive strategies to justify why as adults the

participants had not been able to curb their propensity to put on weight. When these events appeared in the participants' accounts, they were situated as key moments, as breaking points where they lost control of their weight or their personal battle against weight.

In the case of Elena, divorced and unemployed (aged 46 years), she reported that her weight was "normal" until she was diagnosed with epilepsy when she was 10-11 years old. She has had this health problem since early adolescence and it had led to a change in her lifestyle, although with varying intensity throughout her life. After describing her background, she recognized that there was something strange in her that made her put on weight and that it was not the food intake, because she said "I eat once a day and my digestion is so slow that I wake up the next day and I feel the food, I have no feeling of hunger, my stomach is full".

If, in Elena's case, the metabolism was altered by the epilepsy and the medication, in Luisa's case the metabolic alteration was attributed to endogenous causes. Luisa, a 41-year-old housewife reported that she had to stop working because of a rare disease (Guillain-Barré Syndrome), which she was diagnosed with at the age of 36 years. This syndrome is a rare disorder characterized by the body's immune system attacking the nerves in such a way that, after the first symptoms of weakness and tingling in the limbs, it can spread to the whole body and cause partial or total paralysis of the body. In Luisa's case, she suffered paralysis from the neck down, which led to hospitalization and, subsequently, to a wheelchair for three months. Like many of the participants, Luisa did not deny that she was "chubby" but that the disease ruined any chance of controlling her weight.

Along with illness, injuries were other events in some participants' lives that were presented as key points or moments in their lives that limited their weight control. Fátima, a 41 year-old sales clerk, acknowledged that she had generally managed to keep her

weight, until a recent injury. This appeared to be a key moment which she storied as the beginning of a complete loss of control over her body weight.

> *Yes, it's true that I've gone back three years, but it's because of an injury, which, well, it's not an injury. I started because I fractured my coccyx in a fall and it's true that I spent a year quite touched because it was complicated by herniated discs. And after that, I started doing less sport. I have become more comfortable in the car, I have become more comfortable with the fact that as I am in pain I can't, okay? Now in April it will be a year since I've been on sick leave, which is when I've really gained [weight]. Because I fell with bad herniated discs, and I'm still waiting for medical appointments. And I spent four months in bed, and then that's when I haven't been able to do it anymore. But normally I've never been a fat girl, I've been within my weight* (Fátima).

Noemi recognized that, although she was not thin, she managed to control her weight during her adolescence. Then, when she was 20 years old and in the prime of her life, she had a motorcycle accident. A SUV ran a stop sign and broke her leg, two ribs, her jaw, and paralyzed the right side of her body. It took her almost six years of recovery which resulted in her putting on a lot of weight. The key point of this event in her weight history was confirmed when she said: "You never finish recovering from the accident. Although I have gradually managed to get back into sports, my metabolism is not the same".

Along with illness and injuries that had derailed any attempt to control body weight, all the participants reported other types of life events in their lives. The responsibility and lifestyle that came with school, work, and marriage, their own or their parents' divorce, quitting smoking, pregnancies, childcare, or simply the effect of age were just some of the other events reported by the participants to try to explain why they

had not been able to control their weight. The rapidity of weight gain that came with other life circumstances, such as illness, accident or injury, contrasts with the slower, but equally progressive process of coping with all the responsibilities and obligations that come with life.

Although circumstances varied for each participant, all participants found events that disrupted their life prevented them from adopting a healthier lifestyle, which would have minimized weight gain. This highlights that explanations about the propensity to gain weight were not enough for participants to exonerate themselves from the responsibility for their current weight. Instead, individuals classified as obese used other discursive strategies to cope with the stigma associated with their weight (Puhl and Brownell, 2003; Throsby, 2007). All these discursive strategies should not be seen as simply excuses, but as full-fledged attempts to make sense of their weight history and provide coherence to their own accounts through the social and cultural resources available to them (Atkinson, 2009).

Stories About the Reasons for Operation: It's for Health

As seen above, participants reported multiple stories to explain their inability to control their body weight, which served to resist the moral responsibility required of them. However, these explanations also provided a coherent explanation for why they had decided to turn to such a drastic solution as surgery, instead of persisting through more culturally accepted means such as diet and exercise. Having surgery was presented by all participants as a last resort, acknowledging that their bodies had failed to maintain weight control. Participants used the narrative of positioning themselves as sick to present themselves as deserving of surgery, while defending themselves from any attribution of having higher weight because they had been too lazy or gluttonous.

> *I believe that people have the concept that fat people are this way because we want to be. Not because we have a problem, but because we are this way because we eat too much and because we don't move. That's what I told you before. When talking to people you find very few who understand that you have a problem, and that if you didn't have a problem, you wouldn't have gone through a series of specialists who have determined that you are a candidate for surgery. If it were that you are fat because you eat too much and because you feel like it, they are not going to operate on you. That's why they operate. You go through psychologists. You go through things. So, the concept that you are fat because you want to be, I think that is what people think. There are people who don't, but in general there are people who think, 'Couldn't you do sports and eat a little bit?' Yes, yes, but there are other things that are also preventing me, for whatever reason* (Alba).

The diagnosis of 'obesity' as a disease represents a crucial component in the language of medicine (Caixàs et al., 2020). Through diagnosis, medicine attempts to locate the parameters of normality and abnormality and, with this, to mark the professional and institutional limits for the social treatment of a disease. Being classified as ill allows an individual to be worthy of treatment and serves as an argument for receiving specific health services (Brown, 1995).

Many of the participants reported health problems that they blamed on their excessive body weight. However, health was not only understood as something present, but surgery was also interpreted as a means of preventing greater ills. Javier reported that he turned to bariatric surgery after repeated failures to control his weight with dieting and exercise, and as a measure to prevent more serious health problems. Like all the other participants, he admitted to trying various exercise regimens and diets that ultimately

failed. The surgery was seen as a way to cut the vicious circle he was falling into, which was threatening to worsen his health.

> *I have tried a thousand diets. I don't usually have problems complying with them. What happens is that they are slower, and you have to be patient with the results. I was already at a very high weight and I had no problem to go on a diet. I was going to do sports, go for a walk for an hour and a half, two hours a day. The first three days I could do them without problems, but the fourth day my eyelids hurt. Then you stop doing sports, because your knees hurt, your legs hurt, or because you are very tired. You get discouraged and then you stop eating the food they put you on and that's it. You go back to what you were doing before. It's not that I was unhappy with my body, but there came a point where my health was not good. I didn't feel strong enough to do sports because I knew that everything would hurt and I wouldn't be able to continue* (Javier).

For Fátima, the surgery was a preventive measure to avoid major problems as a result of the injury she had sustained three years previously and that affected her spine. Fátima stated that her doctor suggested either losing weight or undergoing surgery to fix several vertebrae. After talking it over with her husband, and aged 41 years, they decided that she would go ahead, because they did not want her to be in a wheelchair with the three girls they have. To Fátima, the obvious way to avoid back surgery was to lose weight, and she saw bariatric surgery as the quickest and most effective solution.

Avoiding major ills ensures not only an individual's own health, but also the health to be able to continue caring for and enjoying loved ones. This sentiment is echoed by Alberto, who resignedly shared that his progressive weight gain had prevented him from fully enjoying time with his children. In his words, "playing a soccer game with my children, spending an hour playing, I can't. I can't, I just can't. I can't, I just can't."

Weighing the advantages and disadvantages of having surgery, Carmen came to see it as an act of courage and a responsibility for those closest to her. After her daughter overcame thyroid cancer, this circumstance encouraged her to undergo surgery and to ensure a healthier future that would guarantee that she would be able to continue caring for her daughter.

Although surgery enabled the participants to change their bodies and to come closer to meeting Western ideals of a socially and culturally sanctioned body, bariatric surgery was in all cases presented as a matter of physical functionality, rather than a matter of physical appearance or aesthetics. Even in those few cases where the participants were younger and physical health was not so pressing at the moment, the participants stressed that it was not a question of aesthetics, but of mental health. Among the younger participants, where physical limitations had not become as drastic as in other cases, health was also defined in terms of its more psychological aspects. Such was the case of Juan, the youngest of the participants, who was aged only 18 years and had undergone private surgery. He wanted to make it clear that, in the face of some resistance on the part of some family members, he had undergone surgery because he was not well with himself, in addition to the limitations that having a "fat body" brought him. Like many of the participants, he acknowledged having suffered bullying during his school years and, as a consequence of such experiences, told of having internalized a strongly stigmatized identity throughout his life. He felt that the shame associated with his "fat body" hindered his ability to connect to others and negatively impacted his self-esteem. Therefore, as with all the other participants, he viewed bariatric surgery as a necessary step for improving his health.

General Discussion

The present study explored the explanations given by individuals awaiting bariatric surgery regarding their weight trajectory and their decision to undergo this surgery. Specifically, the participants explained their trajectory through three key moments comprising the origin of their weight, the failure to control it, and the irremediable decision to have surgery as a last resort to solve their weight problem. The stories provided an important means of accessing the personal experience of the participants and the way in which they constructed their identity. While each story was unique in its details, a common structure emerged with participants' framing bariatric surgery as a necessary medical solution they felt they deserved.

Participants highlighted their genetic predisposed to higher weight and the limitations affecting their metabolism's ability to balance of energy intake and expenditure. These genetic and metabolic factors were recurring themes in their accounts, combined with key events in their lives, to explain why their attempts to keep weight off, through dieting and exercise, had not worked. In doing so, participants seemed to align with the narratives offered by some fat activists by highlighting that their weight was due to metabolic diversity and variations in body shapes (Bacon and Aphramor, 2014; Cooper, 2016).

However, their accounts also reflected a move away from fat body acceptance movements, insofar as they did not challenge the assumption that 'fatness' is a problem per se. Therefore, the fact that participants supplemented their explanation, predominantly based on genetic and biological factors, with other narratives recounting contributing circumstances throughout their lives, does not negate the undesirability of a 'fat' body. As Boero (2013) has pointed out, the fact that individuals look for causes and tries to justify their 'fatness' reflects that for those individuals the fact of being 'fat' is in itself socially undesirable.

The explanations provided by the participants show some parallels with the change in discursive strategies of medical organizations and the pharmaceutical industry, which according to Bombak (2023), are trying to influence the way society perceives weight stigma. Medical organizations recognized 'obesity' as a chronic disease in part to mitigate weight stigma (American Medical Association, 2013; Bray et al., 2017). In doing so, this dominant medical narrative shares with fat activism a recognition of the multifactorial nature of 'obesity' and the serious shortcomings of the cultural trope that has linked 'fatness' to individual acts (Goldberg, 2014; Puhl, 2023). However, although this medical narrative embraces the anti-stigma discourse, it offers a quite different solution to fat activism by pathologizing the 'fat' body. Rather than removing stigma it reconstructs it by accentuating the difference, deficiency, and deviance of a body that is diseased and needs to be *treated* (Bombak, 2023). In this line, the participants' explanations, by pathologizing their 'fat' bodies, might inadvertently amplify stigma by, for example, making this type of body be seen as a defective, sick, or at least physically different body, potentially leading to their perception as a different being or species (Phelan et al., 2015).

This ambiguity in the participants' accounts must be interpreted within the attempt to construct a socially acceptable identity (Taylor, 2006), which must do so in interaction with other individuals and within a society that has declared war on 'obesity' (Boero, 2012; Gard and Wright, 2005). Therefore, because of the undesirable qualities and the abominable and *abject* character (Kristeva, 1982) that their 'fatness' represents to themselves and others, they avoid placing the blame for their 'fatness' on themselves. However, the participants managed their identity within socially and culturally acquired narrative resources, which are limited in that they frame the 'fat' body as a problem. Moreover, when explaining the origin of their 'obesity' primarily based on genetic,

biological and personal factors, their accounts hardly question the structural and social aspects of the obesity epidemic. In other words, the resources used to explain the origin of their higher weight and the reasons for their decision to undergo surgery seem to place them far from broader political, social and ethical interpretations that are far removed from the dominant public discourse.

In order to integrate their decision to undergo surgery into a coherent self, and given the limited resources at their disposal, participants resorted to presenting themselves as sick, and therefore deserving of surgery. As Frank (2013) has shown, the idea of body restoration is a dominant narrative that shapes the narratives of the sick in Western societies. This narrative of restitution enacts a mechanistic interpretation of the body, where excessive weight is produced within a body that is deemed diseased or not functioning properly. Under this interpretative scheme, the metaphor of the body as a machine is recurrent. Therefore, in order to correct the defect of origin that brings the *'*obese body*'*, it must be repaired through bariatric surgery. Consequently, the narrative resources available to the participants seemed to come from a medical narrative of body restoration. The narrative of restitution of a body that is diseased is a cultural framework through which participants interpret and make sense of their weight trajectory and their ultimate decision to have surgery. This restitution narrative is preferred by those with higher weight who have decided to have surgery, because having surgery is seen in some way as a (or the only) way to correct a body that is undesirable. Furthermore, the progressive understanding of epigenetics, improvements in bariatric surgery techniques, and recent advances in pharmacology, might well reinforce the medicalization of the 'fat' body and favor a public narrative of a diseased body that needs to be restored (Bays and Scinta, 2015; Bombak, 2023; Bombak et al., 2021). For a segment of the population, correcting body weight will be increasingly within reach, so without changing the

perception of the ‘fat’ body correcting it will likely continue to be seen as a citizen’s responsibility that is now easier to fulfill (Bombak, 2023).

The somewhat contradictory strategy of justifying increased weight as a disease while simultaneously seeking to counter stigma by correcting body weight reinforces the prevailing medical narrative. In this way, participants attempted to fit their ontological narratives within the popular narratives to which they have access (Somers, 1994), and this allowed them to make coherent sense of the self. This highlights that individuals construct their biographical narrative within the discursive contexts in which they acquire meaning.

The participants’ strategy of presenting their body as a diseased body may serve as an excuse to justify their failure to control their weight. However, it reflects the dominant conceptions of ‘obesity’ and could generate some problems for those who take on this view of higher weight bodies. In line with these conceptions, participants exhibited feelings of inadequacy of their body to the ‘*normal*’ state, such that bariatric surgery is likely to be a way of moving closer to that state. Therefore, a lack of access to other narratives on which to build their identity may limit the possibility of accepting other body models that deviate from socially accepted ideals.

Although participants’ accounts may have varied in content, they appeared to fall within a narrative structure that appears socially shared (Puhl and Brownell, 2003; Throsby, 2007). However, the findings of the present study should be understood as part of a *relational setting* (Somers, 1994) and, in this vein, it should be understood in the context of participants who have been classified as ‘obese’, have decided to undergo bariatric surgery, and are on the verge of receiving this surgery. Consequently, this might reflect the way in which participants share culturally acquired narrative resources, which may have been deployed in the face of the need to justify their decision to undergo

upcoming bariatric surgery. The clinical context surrounding the interviewees' participation may help to explain the narrative resources used by the participants. The recourse to a sick body in need of restoration was commonly used within a dominant medical narrative. Other narrative resources could have led to different situations, such as the recognition of the 'fat' body. From a narrative perspective, this is evidence of how participants successfully negotiate their narratives by aligning them within particular social and cultural settings (Frank, 2012). Future studies should examine whether this narrative structure is prevalent among other individuals facing bariatric surgery, but also individuals under other circumstances (e.g., individuals with similar BMI who have decided not to undergo bariatric surgery or those for whom long time has elapsed since they underwent surgery).

In sum, the medical narrative of a sick body to be restored seems to function as a schema or script, through which the participants in the present study understood the world (Frank, 2013). This can have both positive and negative consequences for them. On the one hand, it may boost participants' self-esteem, justify their decision to undergo surgery, and help mitigate feelings of stigma through body modification. On the other hand, constructing an identity around the concept of a diseased body could pose risks, particularly if the expected post-surgery outcomes are not achieved. A strong identity based on having a '*normal*' body might run the risk of serious emotional distress after the operation, especially for those participants who do not meet their expected results.

References

American Medical Association (2013) Recognition of 'obesity' as a disease (Resolution 420-A-13).

Atkinson P (2009) Illness narratives revisited: The failure of narrative reductionism. *Sociological Research Online* 14(5): 196–205.

Atkinson R (2012) The life story interview as a mutually equitable relationship. In: Gubrium JF, Holstein JA, Marvasti AB, et al. (eds) *The SAGE Handbook of Interview Research: The Complexity of the Craft*. Thousand Oaks, California: SAGE Publications, Inc., pp. 115–128.

Bacon L and Aphramor L (2014) *Body Respect*. Dallas, TX: Benbella Books, Inc.

Bays H and Scinta W (2015) Adiposopathy and epigenetics: an introduction to obesity as a transgenerational disease. *Current Medical Research and Opinion* 31(11): 2059–2069.

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

Boero N (2013) Obesity in the media: Social science weighs in. *Critical Public Health* 23(3): 371–380.

Bombak AE (2023) How pharmaceutical companies misappropriate fat acceptance. *Critical Public Health* 33(5): 856–863.

Bombak AE, Eckhart N, Bensley JH, et al. (2021) Bariatric surgery as prophylaxis: an emerging protection discourse. *Social Theory & Health* 19(3): 282–297.

Bray GA, Kim KK and Wilding JPH (2017) Obesity: A chronic relapsing progressive disease process. A position statement of the World Obesity Federation. *Obesity*

Reviews 18(7): 715–723.

Brown P (1995) Naming and framing: the social construction of diagnosis and illness. *Journal of Health and Social Behavior* 35: 34–52.

Caixàs A, Villaró M, Arraiza C, et al. (2020) Documento de consenso de la Sociedad Española de Obesidad (SEEDO) y de la Sociedad Española de Médicos de Atención Primaria (SEMERGEN) sobre la continuidad asistencial en obesidad entre Atención Primaria y Unidades Especializadas Hospitalarias 2019. *Medicina Clínica* 155(6): 267.e1-267.e11.

Chalklin V (2016) Obstinate fatties: Fat activism, queer negativity, and the celebration of 'obesity'. *Subjectivity* 9(2): 107–125.

Cooper C (2016) *Fat Activism. A Radical Social Movement*. Bristol, UK: HamerOn Press.

Crotty M (1998) *The Foundations of Social Research: Meaning and Perspective in the Research Process*. London: Sage.

Frank AW (2000) The standpoint of storyteller. *Qualitative Health Research* 10(3): 354–365.

Frank AW (2010) *Letting Stories Breathe*. London: The University of Chicago Press.

Frank AW (2012) Practicing dialogical narrative analysis. In: Holstein J and J. Gubrium (eds) *Varieties of Narrative Analysis*. London: Sage Publications, pp. 33–52.

Frank AW (2013) *The Wounded Storyteller: Body, Illness, and Ethics*. 2nd ed. Chicago, IL: The University of Chicago Press.

Gard M and Wright J (2005) *The Obesity Epidemic. Science, Morality and Ideology*. London and New York: Routledge.

Gard M, Powell D and Tenorio J (2022) *Routledge Handbook of Critical Obesity Studies*.

London and New York: Routledge.

Gibson G (2022) Health(ism) at every size: The duties of the “good fatty”. *Fat Studies* 11(1): 22–35.

Gilman SL (2008) *Fat. A Cultural History of Obesity*. Cambridge, UK: Polity Press.

Goldberg DS (2014) Fatness, medicalization, and stigma: On the need to do better. *Narrative Inquiry in Bioethics* 4(2): 117–123.

Gubrium JF and Holstein J (2009) *Analyzing Narrative Reality*. Thousand Oaks, California: SAGE Publications.

Gubrium JF and Holstein JA (2012) Narrative practice and the transformation of interview subjectivity. In: Gubrium JF, Holstein JA, Marvasti AB, et al. (eds) *The SAGE Handbook of Interview Research: The Complexity of the Craft*. Thousand Oaks, California: SAGE Publications, Inc., pp. 27–44.

Gudzune KA, Beach MC, Roter DL, et al. (2013) Physicians build less rapport with obese patients. *Obesity* 21(10): 2146–2152.

Guthman J (2011) *Weighing in. Obesity, Food Justice, and the Limits of Capitalism*. Berkeley, Los Angeles: University of California Press.

Harjunen H (2021) Fatness and consequences of neoliberalism. In: Pausé C and Taylor SR (eds) *The Routledge International Handbook of Fat Studies*. New York, NY: Routledge, pp. 68–77.

Harrison DL (2021) *Belly of the Beast: The Politics of Anti-Fatness as Anti-Blackness*. Berkeley, Los Angeles: North Atlantic Books.

Holstein JA and Gubrium JF (2000) *The Self We Live By*. New York, NY: Oxford University Press.

Kristeva J (1982) *Powers of Horror: An Essay on Abjection*. New York, NY: Columbia University Press.

LeBesco K (2011) Neoliberalism, public health, and the moral perils of fatness. *Critical Public Health* 21(2): 153–164.

Luck-Sikorski C, Jung F, Dietrich A, et al. (2019) Perceived barriers in the decision for bariatric and metabolic surgery: Results from a representative study in Germany. *Obesity Surgery* 29(12): 3928–3936.

Lupton D (2018) *Fat*. 2nd ed. London and New York: Routledge.

Murray S (2005) Doing politics or selling out? Living the fat body. *Women's Studies* 34(3–4): 265–277.

Organization for Economic Cooperation and Development (2019) *The Heavy Burden of Obesity: The Economics of Prevention*. OECD Publishing. Available at: https://doi.org/10.1787/3c6ec454-en.

Phelan SM, Dovidio JF, Puhl RM, et al. (2014) Implicit and explicit weight bias in a national sample of 4,732 medical students: The medical student CHANGES study. *Obesity* 22(4): 1201–1208.

Phelan SM, Burgess DJ, Yeazel MW, et al. (2015) Impact of weight bias and stigma on quality of care and outcomes for patients with obesity. *Obesity Reviews* 16(4): 319–326.

Puhl R and Brownell KD (2003) Ways of coping with obesity stigma: review and conceptual analysis. *Eating Behaviors* 4(1): 53–78.

Puhl RM (2023) Weight stigma and barriers to effective obesity care. *Gastroenterology clinics of North America* 52(2): 417–428.

Riessman CK (1993) *Narrative Analysis*. London: Sage Publications.

Riessman CK (2008) *Narrative Methods for the Human Sciences*. Sage Publications.

Rohde K, Keller M, la Cour Poulsen L, et al. (2019) Genetics and epigenetics in obesity. *Metabolism* 92: 37–50.

Saguy AC (2013) *What's Wrong with Fat?* New York, NY: Oxford University Press.

Smith B and Monforte J (2020) Stories, new materialism and pluralism: Understanding, practising and pushing the boundaries of narrative analysis. *Methods in Psychology* 2: 100016.

Smith C (2011) *What Is a Person? Rethinking Humanity, Social Life, and the Moral Good from the Person Up*. University of Chicago Press.

Somers MR (1994) The narrative constitution of identity: A relational and network approach. *Theory and Society*. 23: 606-649.

Taylor S (2006) Narrative as construction and discursive resource. *Narrative Inquiry* 16(1): 94–102.

Throsby K (2007) "How could you let yourself get like that?": Stories of the origins of obesity in accounts of weight loss surgery. *Social Science & Medicine* 65(8): 1561–1571.

Throsby K (2008) Happy re-birthday: Weight loss surgery and the `new me'. *Body & Society* 14(1): 117–133.

Throsby K (2012) Obesity surgery and the management of excess: exploring the body multiple. *Sociology of Health & Illness* 34(1): 1–15.