
Untold stories of living with a bariatric body: long-term experiences of weight-loss surgery

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Abstract This article explores patients' long-term experiences after undergoing bariatric surgery (BS) by individual interviews and the interplay between biographical disruption and biographical flow when the body's normal physiology and anatomy are intentionally altered. Based on interpretative phenomenological analysis the findings show that the bariatric body is still prominent in daily life, positively by displacing the overweight body and negatively due to the development of unexpected health problems after surgery. Due to individual informed consent to the treatment, the negative consequences are perceived as self-inflicted. The feelings of responsibility and shame make it difficult to seek help and to be open about undesirable long-term effects and other health problems after surgery. The study argues that undergoing BS is a disruptive event with uncertain long-term outcomes and living with a bariatric body as a vulnerable life continuously at the intersection of biographical disruption, flow and reinforcement. This study reinforces the importance of doing critical sociological studies of standardised medical interventions which aim to improve patients health problems. Included in these types of studies should be the patients' long-term experiences and the awareness not to uncritically present their experiences as universal and the treatment result solely as the patients' own responsibility.

Keywords: bariatric surgery, biographical disruption, patients' long-term experience, obesity, shame, responsibility for health

Introduction

This article explores patients' long-term experiences with bariatric surgery (BS). In contemporary society, there is a tendency to think of the body as an entity of becoming a project that should be worked at and accomplished as part of an individual's self-identity (Shilling 2003: 4). Obesity does not fit well in this picture (Greener *et al.* 2010) and is perceived as undesirable both by those who are obese and by society.

Our daily experiences of living are inextricably bound to the experience of managing our bodies (Shilling 2003: 20). The body as an object, in this case, the bariatric body, and the individual experience of the subject body, living with a bariatric body, are inextricably integrated into stories about living with a bariatric body. Framing BS as a medical intervention in the body social, I will take as a point of departure Turner's (2008: 245) notion of embodiment as multidimensional and the idea that we are simultaneously having, being and doing our bodies.

BS is currently the most effective treatment for achieving permanent weight loss and improving comorbidities for severely obese patients (Adams *et al.* 2017, Tewksbury *et al.* 2017). The treatment rests on two main principles: restriction of the stomach's volume, causing the patient to eat less, and a bypass intervention, reducing the nutritional absorption from the food consumed. These restrictive and malabsorptive effects cause instant weight loss, but the effects weaken after the first year (Martins *et al.* 2011). Norwegian health authorities provide BS free of charge, defining the procedure as part of a lifestyle-changing treatment and emphasising the need for lifelong follow-up and effort from the patients (The Norwegian Directorate of Health 2011).

Although the treatment is standardised, BS does not have the same effect in all patients (van Hout *et al.* 2005). Thus, a growing number of studies have shown that the long-term effects of the surgery remain unclear (Colquitt *et al.* 2014). Prior studies reported improved health-related quality of life after surgery (Andersen *et al.* 2014) but also a high prevalence of self-reported medical, nutritional and surgical symptoms (Gribsholt *et al.* 2016) and deficient long-term follow-up from health professionals (Meleo-Erwin 2018, Torgersen *et al.* 2017).

The research on the long-term experiences of those who have undergone BS and how the surgery affects their lives and social interactions remains modest (Graham *et al.* 2017, Natvik *et al.* 2014). Coulman *et al.* (2017) recently published what they believed to be the first systematic review of qualitative studies investigating the patient's perspective of living with the outcomes of BS, synthesising results from 33 qualitative studies from the period 2001–2014. Both positive and negative experiences were reported. Aspects of control, normality and ambivalence are prominent and interconnected in patients' experiences of living with the outcomes of BS. Only nine of the studies addressed long-term experiences ≤ 5 years.

Personal responsibility has been central to social, legal and political approaches to obesity (Brownell *et al.* 2010), and a fat body is considered to be the mark of an out-of-control subject (Vogel 2018). Bariatric surgery may be understood as a mode of symptom relief, through the modification of health organs, of a condition considered to result from lack of self-control (Hoffmann 2010) and as an option preferred over "high effort" weight-loss methods (Throsby 2009). This contributes to the surgery's stigmatised status (Trainer and Benjamin 2016). Moral views of personal responsibility are also reinforced in weight-loss surgery advertising presenting personal success stories and speaking of side-effects as self-inflicted (Groven and Braithwaite 2016).

Biographical disruption and flow

BS may be perceived as an intentional attempt to disrupt the experience of obesity and renegotiate the future prospect of everyday life to recover from severe obesity. Bury (1982) introduced the concept of biographical disruption, describing illness as an unintended disruption interfering with biography and demanding adaptations in everyday life. Since then, the concept has been the point of departure for several studies of illness, health and recovery. Later empirical studies highlighted the importance of context (e.g. Faircloth *et al.* 2004, Monaghan and Gabe 2015), suggesting that illness is not a universal experience but rather one event in a biographical flow in an ongoing life of events and is contingent on life context. For some individuals, the onset of illness can be just another facet of a "hard life"; for others, it may be an experience of continuity and normality rather than a disruptive event (Hubbard *et al.* 2010). Other studies suggest that the onset of illness functions as a biographical reinforcement (Carriaburu and Pierret 1995) or what Williams (2000) refers to as biographical conformation.

Following Leader's (1990) notions of the dis- and dys-appearance of the body, this study seeks to contribute to the body of knowledge that examines in-depth the long-term experiences of living with a body altered by BS in everyday life. Filling this knowledge gap is crucial to having an informed debate about the long-term effects both for those receiving and those performing BS. This study may also contribute to the understanding of the sociological terrain between biographical disruption and flow when bodies are intentionally altered to ameliorate obesity.

Method

This study derives from a phenomenological influence and the work of Merleau-Ponty (1962) emphasising the body as the centre of experience, our being in the world as embodied and our bodies always in becoming by our dialectic relation to the world. The study builds on seven individual in-depth follow-up interviews conducted 8 years after surgery with persons treated with BS in two different Norwegian hospitals in 2008. The participants were recruited due to their written consent to be contacted again after taking part in a qualitative follow-up study in their first year after BS. All participants agreed to a new follow-up interview in 2016.

The participants, four men and three women, were 35–61 years old at the time of the interview. Their weight before surgery was self-reported to be between 242 and 480 pounds, and their sustained weight loss was between 44 and 198 pounds. Before surgery, they all had severe weight-related comorbidities, and most of them had experienced long-term sick leaves due to these complications. Regarding civil status, all the women were married; two of the men were single without children, one was married and one was divorced. Those in relationships or divorced had two or three children. Before BS, all the participants had paid positions or cared for minor children full-time. After 8 years, all the men had taken several long sick leaves, and two of them received disability pensions. One woman also received a disability pension, while the other two had full-time positions. With respect to education level, all of them, except the oldest, had completed secondary school. After BS, two participants had completed bachelor's degrees.

As prior participants in three earlier in-depth follow-up interviews, the interviewees had extensive experience with interviews on the topic and with the researcher, and they received written and oral information before making their decision to participate. The Regional Committee for Medical and Health Research Ethics in Norway (REK-Midt 2015/1755) approved the study.

Stories from those living with bariatric bodies may, within the frame of medical sociology, be described as illness narratives. Frank (2013) insists that these stories not only describe experiences of illness, but also function as repair work. As “wounded storytellers” who cannot be completely open in public, participants may see telling their stories as beneficial to express their non-vocalised experiences and to contribute to generating the knowledge they themselves did not have as patients. On the other hand, it is important as a researcher to not merely function as an “uncritical microphone stand”, approving testimonials without questioning them. To prevent this, extensive attention was devoted to “contradictions” in the participants' stories, and follow-up questions were actively used to investigate the diversity of their experiences.

As an interviewer, I strove for an active, naive and exploratory role. Due to an established and trusting relationship, it was possible to confront the participants quite directly. Related to the stigma of obesity, the interview was seen as a rare opportunity to speak freely. The ethical approval process required an interview guide, and a semi-structured interview guide was developed for conducting phenomenological-inspired life-world interviews (Kvaale and Brinkmann

2009). In practice, the interviews were driven by follow-up questions to interviewees' narratives, statements and reflections.

All the interviews were transcribed verbatim by the author. A data-driven "bottom-up" analysis was conducted, inspired by interpretative phenomenological analysis (IPA), with the aim of providing detailed examinations of personal lived experience. IPA is described as a useful method for examining topics that are complex, ambiguous and emotionally laden and is especially suitable for examining major life transitions in homogenous groups (Smith *et al.* 2009).

The aim of IPA is to produce an account of lived experience in its own terms based on the recognition that humans are sense-making organisms attempting to make sense of what is happening to them (Smith and Osborn 2015). Recognition of the double hermeneutics in the interpretations of the phenomenon by the participants and the researcher investigating the phenomenon is distinct for IPA (Smith 2018). IPA analysis also distinguishes from more descriptive phenomenological approaches by embracing contradictions, rather than solely seeking commonalities (Pringle *et al.* 2011). In this study of long-term experiences of people with bariatric bodies IPA was considered an appropriate analytical framework.

The analysis began with micro-level readings of the participants' accounts, noting potential themes and rereading and identifying emergent themes before conducting analysis across cases. The next step focused on the themes themselves to define them in more detail and determine the interrelationships between them by reviewing all the transcripts several times, refining and renaming the themes. Finally, the themes were organised to create consistent and meaningful accounts while retaining the contradictions and tensions of living with a bariatric body. In accordance with IPA, the themes in the results are presented in narrative form with thick data descriptions. All the participants are represented by pseudonyms and anonymous verbatim extracts are used to underpin the analytical claims grounded in the participants' own words. Some of the participants are more extensively quoted due to their ability to articulate representative experiences, as well as to demonstrate development in experiences over time.

Results

The experiences of living with a bariatric body fell into three main themes: (i) the bariatric body in daily life, (ii) being a dignified patient and (iii) shame and unknown problems.

The bariatric body in daily life

The first cluster of narratives was about the presence of the bariatric body in everyday life. This presence was positive in that it enabled the experience of a normal weight and the elimination of obesity-related problems. It was negative, however, in that it demanded constant attention, ultimately making the body vulnerable as a biological unit.

Eliminating obesity-related problems Living with a smaller body instantly improved life after surgery by enabling a non-obese life – not necessarily in terms of pounds but mentally and in daily activities. As Ann initially highlighted:

Daily life is easier [How?] It's much easier to move. For example, before surgery, I dreaded taking the stairs. I found 10,000 excuses for not going to the basement. Such things are no problem anymore. Going for a walk is not a giant effort. If I do not have a car one day, I comfortably walk the four kilometres home from the train station after work. . .(. . .). . . The thoughts about, can I do that? Do I manage? They are gone. So, it's easier to be me

Prior problems and limitations disappeared, and participants felt that they came out as subjects, leaving their obese bodies behind. They experienced improved physical capacity and fewer worries. An increased energy level gave them opportunities to do what they wanted. As Barry explained, 'Now you can hold out and join in. . . you can last as long as the younger ones'. They could cope with their own and social expectations regarding their daily work, family and leisure activities. Their obesity in daily life was gone, even if some of them were still classified as obese.

The participants related their non-obese life to the presence of the bariatric body and specifically to dumping syndrome (DS). Thus, 8 years after their surgery, all the participants still had problems identifying what they could tolerate. Lynn, who succeeded very well in her sustained weight loss, pinpointed this continuous challenge in daily life: 'One day I can eat eggs, and the next day I react on eggs. . . [Are you still trying to figure it out?]. . . Yes, I have to. Every day, I have to figure it out'. (Lynn 4-7). The effort of sorting out what to eat is experienced as energy consuming and an uncertain science.

DS is an intended effect of surgery and kicks in as an instant bodily reaction when the wrong kind of food or/and too much food or in the wrong combination is eaten and is valued positively as a barrier to overconsumption. This bodily reflex causes rapid gastric emptying by vomiting and sometimes diarrhoea, and is often accompanied by sweating, dizziness and irregular heartbeats. The consequences of eating the "wrong" food in the wrong quantity and timing is causing an urgent need for a timeout in the bathroom and puts them out of action for several hours.

DS was a well-known and expected effect that was essentially viewed positively. Problems occurred when participants were unconscious or when other circumstances, such as activity, stress and illness, interfered with DS, issues not understood prior to surgery. Roger explains his three safe cards to avoid DS: coffee at work, sushi at restaurants and beer instead of dinner:

It is challenging to find the middle way. No days are the same and then it becomes difficult. I often refrain from whole meal. . .(. . .) . . I have cut the nine o' clock meal at work so I won't be sick, but then it becomes wrong because they say you should eat every third hour. I take comfort in drinking, or comfort is not the right word. I replace food with alcohol because then I am in control . . .(. . .) . . So after I became single I gave up dinner and took a beer instead. . .(. . .) . . I know how much I can drink before getting ill, but I can be sick from one meatball and a spoon of gravy. I was tired of gambling with eating. A couple of beers worked well and stopped the hunger, and then the ball just started to roll. . . [Cries silently]. I needed alcohol more than food. Food was too complicated . . .(. . .) . . [So summarized, food is still a big issue in your life after BS?] Yes, because food plays a major role in everyday life. Coming home after work, trying to participate in social settings, it is difficult. I have withdrawn socially. . .yeah. . . It goes in coffee at work and in the weekends with no plans, it is easy to resort to the beer box (R4-5).

As explained by Roger, the bariatric body must function in everyday life – not in a standard life, but in a post-BS life with its accompanying ups and downs. For Roger, who got divorced and moved to another city, problems with food reinforced problems with alcohol which again reinforced his nutritional problems in a negative circle. The participants were not able to control, or fully understand, their bodies. Their bariatric bodies interfered with, and were interfered with by, everyday life. I will now examine further details on how bodily problems, for some of the participants, accumulated as the years passed.

Crumbling bodies Three of the participants stated a clear split between the short- and long-term experiences of living with a bariatric body. Thus, several of them admitted to having

problems after BS. John summarised his experience at the beginning of his interview, reflecting on the pros and cons of living with a bariatric body:

Initially, it gets much better. You get rid of many of the problems you had before surgery, but after a while. . . , I realized that you receive too little information in advance. Bariatric surgery was quite new in Norway then. . . (. . .) . . . I see it now afterwards. I would not have done the operation again. I'd rather be locked up in a prison cell with locked jaws. . . because you're very plagued afterwards. . . [What problems have led you to such a conclusion?]

One of the things easy to pinpoint is the lacking absorption of vitamins and minerals, and the hormones freaking out all the ways.. You eat nutrition supplements for hundreds of pounds each month. . . but you cannot compensate. Nine days ago, I was at my GP and I think it really sum up how the doctor sees it: [reading to me from a letter he received the previous day:] "Blood samples taken 4/4 show very low levels of vitamin D. Maybe you should increase the dose of Etalpa?" So, when the doctor does not know what to do. . . [Yes, because he asks you if you can double the dose?] Yes because I am on the highest dose he can prescribe. . . (. . .) . . . and bone density measurements. . . (. . .) . . . They said that in 3-5 years I have osteoporosis if it does not turn. . . No.. (sighs) and vitamin D is important for taking up calcium. . . I've never had any dental problems, but now my teeth are breaking like crackers. . . (. . .) . . . So when it eventually gets empty [in the calcium reservoirs] I do not know what to do.

BS may, as explained by John, deteriorate the body, making it vulnerable both physically and psychologically but also creating irreversible and non-curable health problems. John explains that this type of problem has replaced the challenges of living as morbidly obese:

You know, I was about 342 pounds before surgery, in 12-18 months I went down to 209 pounds, and I am still pretty stable there. . . (. . .) . . . I am satisfied with my weight. That's no problem . . . (. . .) . . . [So, in that way you reached your goal to lose weight then?] Yes, I reached that goal, and in the beginning also my primary goal of better health, but then it just messed up.., I still have problems with diarrhoea and constipation alternating each other. . . (. . .) . . . I have also noticed a personality disorder, but that does not necessarily relate to surgery directly. It may be because the body is so run down . . . (. . .) . . . [But, do you think about your surgery often?] . . . I try not to think about it in daily life, but you notice them [the health problems] all the time. You cannot avoid them . . . (. . .) . . . You have to plan everything. It is not easy to do something spontaneous. If it is a diarrhoea day I cannot go into town, and if it is an constipation day I cannot go either because of the pain, and I need to bring emergency food to avoid blood pressure fall. [Because, that can just happen?] Yeah, I have tried to figure it out so I can be ahead. . . (. . .) . . . Dropping blood pressure and bone density is not a good combination [laughing] It can become interesting. [Do you think a lot about it? How the future looks?] Of course, I am concerned. Before I was at risk of heart attack, diabetes and all those things. . . and statistically my family haven't raised the average age. Now, after surgery, I wonder. . . am I really better? I am 35 years old, having high risk of osteoporosis, blood pressure problems and all kind of things. Disorders I am used to in my job at the nursing home, at 70+, so what is happening?"

Experiencing crumbling bodies and a rapid drop in capacity to cope with everyday life made participants draw parallels to aged bodies. As Roger summarised his similar experience:

'My body is breaking down faster than I am aging, the decomposition of the body begins before you die'. In sum, BS led to smaller and more capable bodies but also disrupted bodies undesirably, interfering with daily life. Participants had to comply with their bodies but were not able to control them, putting them at risk of unforeseen health problems. These issues spread to the whole body as a system and into their everyday lives, making them vulnerable when life went downhill. Regardless of their problems, all the participants felt a responsibility for their own situation, as they had undergone elective surgery provided by the Norwegian state. In the following, I will examine how this responsibility forms a second cluster of experiences.

Being a dignified patient

The feeling of responsibility is prominent in participants' stories about undergoing surgery, intertwined with their stories of compliance and making their "new" bodies function as intended in daily life.

First, BS was considered a last resort to preserve health and eliminate the obstacles created in daily life by having a large body and was seen by participants as a last attempt to take responsibility for their morbid obesity by putting their fate in the hands of the medical experts. Bariatric surgery is provided free of charge in Norway for those meeting the treatment criteria, but only as a last resort.

If participants experience "success" by having no serious complications or problems living with their bariatric body, they describe themselves as "being lucky compared to others" they know of. This "luck" is not necessarily easy to understand or measure in terms of a "successful" surgery. Lynn claims she was "lucky" with her operation, though she has experienced health problems:

I've been lucky because I haven't had any physical side effects. Because there are many who are plagued with many late injuries. I have not got them, nothing that inhibits me. I live a normal life... (. . .) . . . There is one thing, though, I wonder if is related to the operation, . . . but I do not know. It is my teeth. I'm really bothered with my teeth now, and I've noticed that there are several others as well. . . eh.. I've never been bothered with my teeth before. . . (. . .) . . . Now I have had three root canal fillings and have three more that are also most likely to be rooted, and I have a lot of pain in the teeth. Beyond that, there's nothing.. (. . .) . . . and, a mental down trip. Everybody operated on gets it, . . . I've also had it

Initially, Lynn states she is lucky and that problems must be expected. Nevertheless, as she thinks about it, she does experience some problems, though she cannot claim they are related to the BS. She wonders whether problems experienced by several patients are surgery-related. Nevertheless, these are problems they have to cope with themselves due to undergoing an elective and irreversible surgery. Problems are viewed as part of the "the price to pay" for undergoing BS and, as examined below, perceived self-inflicted by their responsibility to comply with treatment.

In Norway in the mid-2000s, there were long waiting lists for BS. Individuals felt, as Steve stated, "It was a gift from the Norwegian state" – a gift they had to appreciate, receive with gratitude and safeguard in a responsible manner as those chosen to receive BS. Hannah, educated as a nurse, explained the importance of taking care of oneself after surgery and stressed several times in the interview that surgery is not an easy solution and requires personal effort to attain the desired weight loss effect:

As for the slimming operation, in total I lost about 40 kg. But I have gone up again... almost 20 kg... (...). I'm very stable there without doing anything for it... I could have put in more effort and surely lost more, but... I cannot do that now... (...). I've been sick in other ways afterwards... (...). I got acute fatigue syndrome in 2011... (...). I might have thought differently about it if I had not become ill... (...). For the days it is quite demanding, it's more important that I'm alive and that I'm actually getting myself out of bed.. that the body is too big it's like... far behind there, in the back of my head.

Returning to her health problems at the end of the interview, she highlighted her general uncertainty in life:

[Do you think your disease can be related to the operation?]".. It could be that many small streams together, and maybe BS was one of them, right? But, I do not think it is related... (...). We did it. It was a very conscious and well thought out choice. I am very glad that the choice exists, but I think it should be taken seriously. Because it is not just a convenient solution... (...). But many who have problems say... I regret, but at the same time I could have had other problems if I had not been operated on. So it's impossible to say.

As Hannah explains, it is impossible to know what life will bring in general, and choosing BS is a lifelong, irreversible decision. Whether or not they are successful in the eyes of themselves and others, they must accept the consequences and do their best because the healthcare system has provided them with gold standard treatment. As Hannah summarises:

It's a big operation and absolutely incredible that it is possible. An awful lot happens with the body. One would not believe it had such an impact on the physiology... (...). So therefore I think that you have to know what you are getting yourself into. Of course, you are not guaranteed that it will be 100% fine. But, at least I think that I have to do my best to make it as good as possible. Because I hope and suppose they've done theirs. Then it is up to me... You cannot go back. So, you will accept quite a lot. You have to take it on your own self, and it is hard to say anything. It's a bit embarrassing to tell, because it actually means I haven't done my job or paid enough attention to the preoperative training.

As illustrated, the participants have an underlying feeling of responsibility, entangled with blaming themselves for their need for and choice to undergo the surgery as well as for problems experienced after BS. In the following, I will illustrate how this shame is confirmed by public opinion and in their encounters with the healthcare system, and how their unknown problems unfolding in two simultaneous and entwined experiences, *dismissed and personalised problems* and *falling between categories*. Experiences snowballing their self-blame.

Shame and unknown problems

Even 8 years after undergoing BS, all of the participants exercise caution in talking about their surgery if they are not 100% comfortable with their interlocutors, and they still have not told people they interact with daily about it, due to the feeling that surgery is a defeat and an abnormal way of losing weight:

Imagine losing a pound per day, it is not your achievement... (...). I'm not proud. It was no hard effort to get on the operating table either... (...). and I laid myself there voluntarily, and I know very well that I was too fond of chocolate. Therefore, it was self-inflicted to get there, because I failed. I was unable to do anything about my weight

problem myself..(..)..So, I'm not announcing: Hi, my name is Hannah and I had bariatric surgery [laughing] ..(..).. If I'm asked, I will tell..but I feel ashamed.. (..)..On the web for example, if anyone asks for some experiences, it is not certain I'm the first to help out. Because then, in a way, I am revealing myself [laughing].. (..)..I'm a bit embarrassed by the fact that I was so big that it was relevant.. I think it's more noble to lose weight by yourself.

Unlike Hannah, quoted above, Lynn, who had a successful weight loss and few comorbidities, describes these prejudices as unfair and provoking, as living with BS demands effort to maintain weight loss and keep the new body functioning:

The comments on the easy-way-out solution. I'm still experiencing it, and it provokes me because I think it's unfair. It's okay that it's a job to keep a diet and lose weight, but that is also what we are doing. It's just that the weight loss comes easier.

It may seem that, despite BS being a popular and more common treatment than ever, fear of prejudice still prevents participants from challenging negative attitudes towards BS.

Dismissed and personalised problems As described above, several of the interviewees experienced unknown problems and crumbling bodies, experiencing issues, in different degrees and combinations, such as poor short-term memory, emotional instability, cold intolerance, low energy and bad teeth. All of these issues were not experienced before surgery. For example, Barry, a former angler now living on a disability pension due to previous heart problems, still likes to go fishing, but he has problems with his fingers: they get stiff and he loses feeling in them in cold weather. These problems were restricting his activities as a leisure fisherman in Norway, so he went to his GP:

I froze so much so I thought the doctor might be able to investigate it a little... [Did the GP think it had to do with the operation then?] Nah... [Did she think you were just whining then?] Hell, I don't know... My blood pressure was low too... Once I was told it was because I was too calm and balanced, that's what she told me once.

Like Barry, other participants struggled to understand what was happening to them, and they could not even claim that these "non-existent" problems were related to the surgery. Nevertheless, they experienced problems that did not exist prior to their surgery, problems that were not acknowledged in encounters with the healthcare system. It became evident that the problems were theirs, independent of the BS or not.

In narrating these problems, participants often referred to the mandatory preoperative program and the fact that they were encouraged to get in touch if problems occurred. John described his only call to them:

At the hospital, we were told that side effects were hardly any to speak of, and we would receive good follow-up for 10 years and they had specialists. They followed us 9-10-11 months, something like that, then we got a pat on our shoulder when we left. The responsibility was given to the GPs because they had so much to do..[operating on new patients]. I tried to call them once to ask if they knew of others with dental problems. There was NO ONE who was bothered with teeth after these operations! Never heard of it, end of discussion.

Later in the interview, he returned to a similar experience. Due to several sick leaves, he had to report to the local labour and welfare services (NAV). He had difficulty making the office manager believe his problems:

The boss at the NAV office. She used to be my boss before, and she had bariatric surgery herself as well. She says you are not plagued afterwards, so she has been in contact with my doctor because she does not believe in his medical reports. Then it becomes difficult.

This excerpt illustrates the same problem, but this time from a professional nurse who had undergone surgery herself. When they spoke out about their problems they experienced them to be perceived by others as non-existent since they either were ignored, dismissed or not acknowledged. This perception was not only based on single events, but built on several experiences in a number of venues, including closed online forums for people who had undergone BS where they were blocked if they tried to discuss their problems.

Falling between categories Problems in life after BS, regardless of whether they are related to the surgery, are not acknowledged or approved. John summarised his reflections on the side effects of BS:

So the operation works well for what it should work for, but it was the side effects that were a bit worse. . . I had expected it to be side effects, but not so many. It is clear that all operations have side effects, but most frustrating is actually that none of them it is approved as side effects, so to say. You eat nutritional supplements for hundreds of pounds every year, but none of it can go on reimbursement. It comes straight out of my own pocket.

Taking matters into his own hands because he was short on money as a nursing student, John started to import his nutritional supplements from England to save money. The initial nutritional supplements recommended by the hospital were out of production, and he tried to find the best replacements himself.

Another notable example was given by Steve. As a bus driver sitting for hours on the driver's seat, he had problems with excess skin and moisture between the skinfolds in the groin causing soreness, bad odours and blood accumulation when the excess skin was squeezed. Applying for help with his real problem of surplus skin at his lower body, he was met with a nurse citing the treatment criteria for cosmetic surgery:

I felt like I wasted her time. Like.. I have other people who are more important to take care of than you. After all, you've got this operation for free. Do you think you should get here to a covered table? I felt the guilt again, (. . .). . . She says I need a BMI of 36. I had a BMI of 63 when I started. . . (. . .). . . You can disrobe your upper body. I will take a photo, so the doctor may consider if there is any need for them to look at you. After all, we have others who need more surgery than you. Ok, I say, but what BMI have they had? I really need this operation. . . It became a heated situation. Then she picked up her iPhone, and I had to say, this seems damn professional, where are those pictures of?

The guidelines failed him, thus it was evident that a lot of his weight was surplus skin. It did not matter; he was above the limit for surgery. His problems were real, not cosmetic, and in the lower, not in the upper, part of his body. Since his obesity was self-inflicted, he was not prioritised due to an individual discretionary assessment.

If other issues came up, as when Roger was referred for acute psychiatric treatment following a suicide attempt, participants were reminded of their unconventional treatment and their responsibility for their own destiny:

I was at the hospital a while ago... (. . .) . . . I have had several suicide attempts. They did not know what gastric bypass was. What is it? What is it? Once they had to use Google. Then I thought, what the hell have I done? . . . I've been so far down that I've wanted to kill myself.

The participants were given a treatment unknown in the other parts of the health system and, for Roger, even in another department of the same hospital that provided him the surgery. In reflecting upon the responsibility of undergoing BS discussed by all the participants, Roger is the only one to pinpoint the surgery's effect on the body as a system when reflecting on his experience:

Bariatric surgery is like playing with nature. The body is as it is for a reason. It is created in a certain way. . . it doesn't have to be by God, but. . . it is not meant to be redesigned. The body should be kept the way it is made. Don't mess with it. . . . You're gonna get in trouble, I know all about it. . . (. . .) . . . And in my situation now [alcoholic and with several suicide attempts behind him], I have nothing to hold back. I just want people to know what they're doing [choosing surgery]. Do not mess with your body. . . . They claim the body to be the world's finest machinery, and then the doctors cut out half of the cogwheels. It has to break down [laughing].

The only critique of the bariatric clinics, despite several of the participants' troublesome lives, came from the participant that considered himself as having nothing more to lose.

Discussion

Long-term experiences with BS from the perspective of former patients highlight the fact that BS as a standardised medical intervention in the physical body results in individual outcomes and consequences, opportunities and challenges for living with a bariatric body. Bariatric surgery expands beyond the boundaries of the body and into daily life. In a short time, surgery alters the physical body and functions as intended, enabling weight loss and normal weight.

In the long term, surgical alterations also affect the body beyond the digestive system by irreversible processes that weaken the inner body's structures and empty its reservoirs, establishing a vulnerability to unforeseen, unknown, unacknowledged and not yet curable health problems. The resulting vulnerability requires continuous attention to avoid problems and cope in everyday life. Living individual lives in different contexts, bariatric bodies may for some replace obesity-related problems due to regained health and avoiding obesity stigma, while for others it may not.

What BS offers is neither empowering nor disempowering per se but is rather a disruptive event in life with the potential to function as a biographical disruption by destabilising the contingencies and the daily practices associated with obesity.

Responsibility for health was a fundamental theme in the narratives, from choosing surgery, striving to comply with treatment and coping with problems after surgery. Still, 8 years later, the participants were cautious about discussing their former obesity, BS and post-BS problems, fearing stigma and a worsening of their situation. Talking about it would reveal their spoiled

identity (Goffman 1963) as morally weak and irresponsible confirming them as abnormal because they have undergone elective surgery for a condition understood as self-inflicted. Their internalised shame and self-stigmatisation results in efforts to non-disclosure and non-help-seeking.

In retrospect, by wanting and consenting to BS, the participants experienced unforeseen effects of treatment, some common and some individual, but all unexplainable and unaddressable. Whether the consent was informed is difficult to determine in hindsight with the knowledge available in 2008.

Undergoing irreversible elective surgery makes it difficult to speak out when informed consent was given, especially when doing so is disapproved by bariatric clinics. The participants are thus trying to solve the problems they experience on their own. The long-term follow-up program was cut due to costs and reprioritisations. Due to positive results in terms of weight loss and obesity-related comorbidities, Norwegian healthcare prioritised surgery over follow-up. First, in 2015, the Norwegian health authorities established a national obesity surgery registry (SOREg-Norge). These patients knew some of the risks and benefits of a new digestive system but not the potential effects on the body as a system and their extension into daily life.

Fear and internalisation of moral condemnation, in addition to negative feedback when attempting to seek help for their problems, made suffering in silence the preferred resolution among the participants. This is problematic, since experience with parameters other than those defined by the healthcare system are not part of the knowledge base for others considered for or considering BS. However, since the body is individual, life is lived in different contexts and patients have different medical knowledge, BS may be defined as experimental in regard to uncertain outcomes. Operating on bodies inseparable from life, BS provides opportunities to eliminate some problems and poses the risk of others.

As stated by Faircloth *et al.* (2004) in their longitudinal study of stroke survivors, treating patients' experiences as universal glosses over some important aspects, risking poorly designed interventions if master narratives remain unchallenged. The same may be said for bariatric patients, perhaps on a greater scale, as BS is part of an elective lifestyle intervention. Bariatric surgery does not fit into mechanistic truisms (Williams 2000) or linear expectations of healing trajectories for standardised medical interventions. Bariatric surgery may, instead, function as a reinforcement of specific aspects of biography (Carricaburu and Pierret 1995), most prominently the individual responsibility for health. This study supports the argument of biographical disruption as context specific (Faircloth *et al.* 2004, Monaghan and Gabe 2015, Williams 2000) as well as the findings of Hubbard *et al.* (2010) that people who had "a hard life" due to obesity may be less likely to experience biographical disruption, and thus disrupted bodies, in rewriting their identity. Bariatric surgery may be contextualised as biographical work (Corbin and Strauss 1988), an attempt to disrupt and rewrite biography incorporating contemporary society's values of self-control and responsibility for health.

This study suggests that BS cannot be isolated in personal biographies. Living with BS is something more than gaining normal weight bodies surgically; it also creates vulnerability to illness and contextual changes in life.

Conclusion

This study suggests that the experience of living with a bariatric body is highly individual and that BS offers a biographical disruption of obesity, providing a new digestion system. Outcomes and long-term experiences relate to the life context and can be valued both positively and negatively and can change over time. From this point of view, BS may be potentially

disruptive by destabilising the body as a physical unit and thereby engagement in daily life. Thus, BS can also reinforce biography due to the individual post-surgery experience and life context.

Thus, the variety of experiences of living with a bariatric body is underpinned by a common and strong feeling of responsibility for body and health. Undergoing BS voluntarily reinforces this responsibility. Success is defined as normal weight and no comorbidities and is achieved by personal effort and skilled surgeons. Failure is being unable to use BS as an opportunity for biographical disruption provided by the healthcare system.

Living with BS in the long run may be experienced as demanding, both due to the continual consciousness of the object body and the strong feeling of responsibility to comply with the new body to avoid problems after surgery. Bariatric bodies constitute a vulnerability both physiologically and psychologically and not least to prejudices towards obesity and BS. Speaking out about problems after surgery is difficult when experiencing unknown and unacknowledged problems.

This study highlights the need for in-depth studies on patients' experiences of living with bariatric bodies in everyday life to broaden the understanding of the effects of BS. Providing individual outcomes, BS may be perceived as an experimental treatment. Individual and contextual parameters of success guide whether BS functions as a positive biographical disruption or just another event in the biographical flow reinforcing an already difficult life. The patients success parameters is adjusted by time and life context, depending on daily experiences of living with a body interfering with life, reinforcing both the positive and negative effects of BS.

This study confirms the widespread illusion of the body as a controllable unit separable from life in contemporary society. In addition to documenting the experience of BS, this study reminds us of two potential pitfalls in medical sociology. First, the risk of presenting patients' experiences as universal, thus potentially legitimising medical intervention with insecure effects and the patients' responsibility for treatment outcomes. Second, the need for in-depth longitudinal qualitative studies in order to understand the long-term experiences of treatment. Finally, sociological knowledge should not forget to include the body as a social phenomenon in the analysis, and not merely study narratives of the body as a biomedical phenomenon.

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