# THE FAT SUBJECT IN TRANSITION

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One of the things I have learned in the course of this project is that I see myself in others, and I find my edges through my interactions with them. I uncover myself and I become myself by what I find and perceive in others. Here I offer thanks to some of those who have shaped both this work and the person I have become since engaging in it. I cannot include here an exhaustive list. Instead, I endeavor to highlight those people who have most directly impacted my production of this text. I must stress that there are many names absent here who nevertheless mean a tremendous amount to me personally and whose influence has found its way into these pages.

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# ABSTRACT

Amidst histrionic media coverage of a purported “obesity epidemic,” weight loss surgery (WLS) has taken on greater saliency to institutions of biomedicine, individuals implicated by the labels “obese” or “overweight,” and those who challenge the hegemony of slimness that overshadows this whole arena. WLS demands tremendous lifestyle change of its recipients and frequently results in extensive personal upheaval, yet it is touted as a solution to the struggle involved in weight loss. WLS is a gendered procedure because its recipients are in large part women, but also because women are strongly implicated in weight-loss discourse and because household food management is gendered labor.

In this research project, I complicate simplistic biomedical constructions of WLS by relying on lived experiences of the procedure and demonstrate that WLS is both the result of and a contributor to larger sociocultural phenomena related to fatness. How do WLS recipients enact concepts relevant to their daily practices, such as will, appetite, and habit?

This project relies on ethnographic interviews and participant-observation with WLS recipients. My findings in this project are that the influence of post-surgical alcohol dependence is far more significant to recipients than is currently represented in existing ethnographic or biomedical literature about WLS; that family roles are intricately intertwined with feeding, eating, and the moralization of fat; and that recipients of WLS use a variety of innovative techniques to stake claims about their knowledge, will, and personhood.

This dissertation weaves together existing work in Science and Technology Studies that attempts to understand and critique how technoscientific procedures function socioculturally; scholarship in sociology of health that investigates patients’ lived experiences of WLS; and the

burgeoning field of Fat Studies which attempts to politicize fat and problematize efforts to “cure” it.

# 1. Introduction

Laura and I met in a noisy coffee shop one weekday morning to talk about her experiences with weight loss surgery (WLS). Right away and without hesitation, she delved into personal and poignant stories of a difficult childhood, a family history of substance abuse, her feelings of shame and lack of control when eating. She was efficient and down-to-earth in her manner, but not without emotion; she choked up once or twice when relating sensitive memories, but most of all she laughed. She delighted in the absurdities of her life, whether those came from disordered eating, interpersonal relationships, or bodily effects of WLS.

Eating was intensely fraught for Laura. She depicted her appetite as perpetually insatiable.

> *I always felt bad about what I was eating. And I was always thinking about when I could eat again. I have equated it to, basically, to addiction. Like, thinking about booze. "When can I drink again." Or drugs. I mean, it's a drug. I used it like that. It was a really great way to self-medicate all of my things. And so WLS made it so that, I could take the feelings away, and really just look at the facts.*

Of all of the individuals with whom I conducted interviews for this project, she drew the most evocative parallels between her experiences of eating and mainstream notions of addiction, and did so frequently. She went on to describe the kinds of problems she reaches out to fellow WLS recipients for by suggesting she might say, "I just came out of a bag of sugar," before adding in a cadence meant to mimic inebriation, "Oh, what am I doing?" In a later conversation, she more somberly talked about wanting people to understand her eating now as "sober," meaning that she abstains from certain foods because to consume any amount of them would result in her consuming copious quantities of them. She expressed frustration that others didn’t seem to see her in those terms, that they viewed food as innocuous when she viewed it as a threat to her “sobriety”.

## 1.1 Mapping the WLS Terrain

“Obesity” is the prime exemplar of what Boero calls a “post-modern epidemic” (2010); it is non-pathogenic and non-contagious, it shifts the burden for addressing a public health problem onto the individual, and it emphasizes risk over diagnosis or symptom. Indeed, part of what makes media coverage of the “obesity epidemic” so marketable is its implication of the whole population. As Boero tells us, “Those at risk of becoming obese are as central to the epidemic as those who actually are obese” (p. 308).

The field of bariatric surgery began in the mid-twentieth century. Surgeons observed that patients who had had portions of the stomach and small intestine removed for other reasons – most commonly cancer or ulcer – lost weight without any other changes. From this observation, procedures to restrict the size of the stomach and bypass portions of the digestive tract were pioneered. Early procedures had extensive side effects including nutrition deficiency so severe that the procedures sometimes had to be reversed. These procedures were improved and others created from the 1970s – 1990s resulting in the procedures commonly in use today (Faria, 2017; Moshiri et al., 2013; Saber, A. A., Elgamal, M. H., & McLeod, 2008).

With the term “weight loss surgery”, I refer to a set of procedures also described as bariatric or, more recently, metabolic surgery. These procedures include implantation of devices (such as saline-filled balloons that occupy most of the space inside the stomach, lap bands which wrap around the stomach compressing them to a smaller size, intestinal liners that prevent digestion by creating a barrier that isolates the absorptive intestinal wall from the food traveling through a portion of it, and pumps that directly evacuate stomach contents). Other procedures involve modifications to the digestive tract. Gastric sleeve entails removal of a portion of the stomach. Gastric bypass (also known as Roux-en-Y) and duodenal switch both entail detaching a part of the stomach (making it unused, although still present in the body) and moving the site where the stomach empties into the intestine further along the intestinal tract. These procedures are all expected (by providers and patients) to influence eating and weight by some combination of restricting the amount that can be consumed and altering how that food is digested.

WLS programs are accredited through the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP). The MBSAQIP has existed since 2012. Prior to this, two bodies, the American College of Surgeons' Bariatric Surgery Center Network and the American Society for Metabolic and Bariatric Surgery's Bariatric Surgery Center of Excellence, accredited WLS programs. The two merged to form the MBSAQIP. In part, this represents a growing emphasis on the "metabolic" nature of these surgeries in place of the older "bariatric" framing. For many, this shift is about de-stigmatizing the surgery and thus making it available to a broader range of individuals. This shift is not merely rhetorical; it is accompanied by changes to eligibility criteria for surgery that allows conditions like diabetes to be treated with the same surgeries originally designed merely to reduce body weight. For at least one of my informants, this shift is justice-oriented; it's about increasing opportunities for others to have the same embodied liberation she did. However, such a shift also serves the function of increasing the population of potential paying customers. Obtaining accreditation from the MBSAQIP entails meeting nine standards, including performing a minimum number of procedures annually, providing patient education, reporting outcomes of the surgery, and maintenance of equipment and procedures (American College of Surgeons & American Society for Metabolic and Bariatric Surgery, 2016).

Accreditation by MBSAQIP may be required by insurers before they will pay for surgery or may increase the amount of payment made per procedure.

Those who wish to get WLS are generally required to be referred by a primary care practitioner to a bariatric surgeon. They are required to undergo a series of trainings, counseling sessions, and screenings by their health insurance company (if the surgery will be covered by one) and by their providers for various clinical reasons. This is a laborious and lengthy process. After surgery, patients eat a highly restricted, easy to digest diet. Over a period of weeks, WLS recipients gradually increase the variety, complexity, and amount of food that they eat (though they are instructed never to eat beyond fullness in order to avoid stretching the newly-shrunk stomach). My informants frequently reference these sequences directly or obliquely throughout our conversations. While I explicate the relevance of this information when it is central to my analysis, I provide this as background information for the reader in the event that it shows up in passing in comments that I am focused on for other reasons.

Although WLS can be funded by Medicaid, all of my interlocutors had their surgery covered by private health insurance. In addition to financial expenses, insurers impose a burden of time and labor by virtue of the eligibility criteria imposed on potential WLS recipients. These criteria generally include completion of a series of tasks to prove fitness for surgery. These usually consist of: obtaining a psychological evaluation (including a substance abuse screening); following general health guidelines such as abstaining from smoking and undergoing cancer screenings; demonstrating sustained adherence to a non-surgical regimen intended to produce weight loss;[1]

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[1] Interestingly, these attempts may have to result in either exceeding *or* failing to attain a minimum amount of lost weight. Insurers expect that failing to lose weight will demonstrate the necessity of surgery, but limited success at weight loss demonstrates a potential patient's ability to adhere to a particular dietetic and physical activity regimen.

and eliciting a physician's endorsement of the procedure. My informants experienced the barrier of these bureaucratic requirements far more strongly than any financial ones. In many cases, interviewees broached the topic of this pre-surgical labor unprompted. At least two, expressly described the rigor of the bureaucratic and clinical pre-operative requirements as contributing to their ability to adhere to post-operative instructions; from their perspectives, failing at that stage would amount to having wasted all that earlier labor.

In the bariatric surgery programs with which I and my interlocutors interacted, post-surgical guidelines were structured according to multiple phases, three or four of them, each with an expected timeframe by which one should enter that phase. Each phase corresponds to a consistency of food which the patient should limit themselves to, ranging from only liquids to the full range of consistencies, i.e. "normal". (This last was generally unattainable for my informants; for most of them, certain food textures have never agreed with them again.) Once the ability to tolerate all consistencies is achieved, patients are instructed to only try one new food at a time until they know they can tolerate that food without nausea, vomiting, or difficulty digesting. There are daily feeding schedules available as a guideline, and there are hard limits offered to patients about how long to wait between meals, beverage consumption, and even bites of food.

One of the main fat studies critiques of biomedical responses to diagnoses of "obesity" has been that medical prescriptions for restricted diet and increased exercise have been clinically shown to be highly ineffective at the very outcome desired: sustained weight loss (Aphramor, 2005; Campos, Saguy, Ernsberger, Oliver, & Gaesser, 2006). The biomedical scholarship on WLS so far has shown very different results (Schauer, Mingrone, Ikramuddin & Wolfe, 2016; Buchwald et al., 2009). Not only is it more likely to produce long-term weight loss, it has dramatic effects on measures of health like blood pressure, and levels of blood sugar and fat. WLS is celebrated by providers and recipients alike for being a technoscientific tool for a previously intractable proposition, that of intentional weight loss. It is seen as an innovation in methods of imposing rationality on the misbehaving body. In this text, I aim to demonstrate, among other things, that despite the seemingly miraculous medical possibilities introduced by WLS, it is not functioning as a medical treatment so much as it is a particular set of practices and ordeals that are organized by the concept "WLS". This is in line with what we would expect from a treatment for a post-modern epidemic – a non-pathogenic and individual-level solution to a public health risk, one that simultaneously de-medicalizes and re-medicalizes various aspects of the embodied experience of fat.

## 1.2 The Undertaking

In this dissertation, I am interested in the formation of the fat subject. How does fatness influence personhood? How is the fat identity socially constructed? I investigate a small portion of the social world where these questions play out, specifically the arena of WLS. I hoped to find out why people are willingly enrolling themselves in the technoidentity "WLS recipient" and how it influences their other identities. I suspected it had to do with management of the appetite and of will in some way. There must be something satisfactory about a modified or malfunctioning digestive process.

"Fat" is a difficult and fraught identity. Fat bodies are often reviled, and this classification comes loaded with all manner of assumptions and preconditions. Maintaining one's status as a full, knowing, and complex being while fat is nearly untenable in the present moral landscape. This dissertation examines the ways the fat subject is constructed and how that construct subsumes other identities (including race, socioeconomic class, and sexual orientation); the political and social conditions that work to create notions of "fat"; and how people attempting radical physical transformation grapple with notions like will, appetite, and habit within currently prevailing moral economies.

As a researcher, I study obesity as a discursive formation. I am inquiring how the category "fat" is used to define not just bodies, but whole people. Who or what bodies are able to be acted upon? Who or what bodies are public? I propose that, as is the case with many marginalized identities, the naturalization of fat stigma – that is, the way it is constructed and understood as something inherent about fatness and entirely outside the social realm – helps to render fat bodies abject; works to restrict access to personhood; resists critical investigation; and prevents access to power, the kind of power required to undo these very phenomena.

I've declined to pursue questions about clinical outcomes at this time, because, although there are reasons to challenge scientific "knowledge" about weight (Aphramor, 2005), my aim is not to evaluate healthcare delivery nor to make prescriptions about how health can be improved.

This dissertation research addresses the specific questions:

- How do the processes of pursuing weight change and actually changing weight influence an individual's identity?
- How do family roles modify the association between body weight/shape and identity? How does weight change affect one's sense of one's ability to fulfill those roles?
- How do WLS recipients enact concepts relevant to their daily practices (dietary or otherwise), such as will, appetite, and habit?
- What are the embodied realities of the expert expectations of the weight loss surgery experience?

- How does embodied experience of eating and appetite management change with WLS and with weight change?

While the discursive formation of the fat subject has been well described in the fat studies literature (Boero, 2012; Farrell, 2011; Gailey, 2014; Gilman, 2008; Guthman, 2011; LeBesco, 2004; Murray, 2008), the ways that individuals incorporate and respond to expert advice around diet and weight renders those practices open to investigations in the field of science and technology studies. Specifically, this work enhances the STS inquiries into expertise (Epstein, 1996; E. Murphy, 2003); embodied health movements (Brown et al., 2004); and biomedicalization (Clarke, Shim, Mamo, Fosket, and Fishman, 2010). My findings about how this particular technoscientific procedure alters the formation of a fat identity and the lived experiences of those so identified will further illuminate all of these larger conversations.

This project entails the collection of ethnographic interview data via collaboration with people who have had WLS. I've used these interviews to build an interpretive repertoire with which to comment on the lived experiences, subjectivities, and positionalities of those obtaining WLS, including how those recipients understand the social meaning of the procedure and how they make moral choices or evaluations that have implications for their lives. The pressure on people classified as "obese" to "correct" their bodies in order to perform health and morality has been intensifying continually since the 1994 U.S. Surgeon General's declaration of the first concerted anti-obesity campaign, "Shape Up America," a program addressing "obesity" as a lifestyle problem and prescribing increased activity and decreased food consumption (Boero, 2007). The anxieties and contradictions generated by this "obesity epidemic" are made manifest in the bodies and lives of the people marked with this label, and this group is thus increasingly marginalized.

Just as mainstream discourse of the “obesity epidemic” is accelerating, so, too is the need for a radical reframing of the fat identity.

## 1.3 Methods

This is a post-modern and qualitative research project. This means that I understand it as necessary that I consider my role as a researcher critically, and that I do not aspire to neutrality. My presence in this research field influences my informants and vice-versa. Following in the footsteps of so many groundbreaking researchers of great integrity, I consider the relationship between myself and my informants to be an exchange… or at least, a potential exchange. Many of my informants expressed some form of relief or satisfaction at telling aspects of their story, and some even expressed this explicitly. Others, however, seemed to perceive the interview as a favor they did for me. (Which it was, but that perception alone suggests a non-reciprocal relationship for those informants.) For a few, this dissertation provided another avenue to express dissatisfaction with WLS to which representatives of the biomedical system (such as nurses or doctors) had been unreceptive.

In particular, a researcher’s own body weight will necessarily position the researcher in relation to all other actors in this particular arena. In my case, I am medically classified as “morbidly obese”, and I have never had WLS. At times in this research, I was terribly envious of the slimmer bodies of most of my informants. I was frequently horrified by the physical effects of WLS that they shared with me and often in awe of their strength and perseverance in enduring them. Many of my informants expressed concern that people who have not had WLS would consider them “cheaters” (and occasionally related actual experiences of just that). Informants sometimes spoke to me in conspiratorial terms – often, I inferred because of our shared experience of fatness, but sometimes such simple things as resentment at a romantic partner or exasperation with some exigency of modern life. In some of these cases, I forged connections or gained trust only because of my weight. It’s reasonable to believe I failed to elicit other confidences that a slimmer researcher would have. In so many ways (good, bad, and non-dichotomous), the experiences I had in the course of this research depended on my fatness.

My ethical commitments in conducting this research are to justly represent my informants’ points of view, to be accurate and thorough in explaining the purpose and venues for this research and their rights and risk by participating in it, to affirm their experiences and knowledge in the course of our interactions, to be mindful and reflexive about my position in relation to each of my informants and anyone else I interact with or write about, and, finally, to avoid reproducing the oppression and injustice at work in the world at large and work to undo them when possible. By “mindful and reflexive”, I mean that I am continually reflecting upon the power relations in a given situation, what privileges I bring to bear and what limitations on my understanding exist, how I and my informants are discursively constructed (and especially how we are discursively limited) and how much we are actively engaging in or endorsing those constructions and how we are resisting them. I endeavor to be aware when we are operating according to cultural scripts. I can then decide whether to break that script or utilize it to my best advantage. One common way I utilized cultural scripts was to strengthen connections with informants, when we commiserated about food, exercise, or lifestyle change. I paid particular attention to one arena as I reflected on my position in this research.

I try to keep an eye on my own deployment of “knowledge”. In the rest of my life, I am very touchy about the value and validity of my knowledge and very concerned with who the knower is in any given interaction. In short, I really, really want to be right, smart, and knowledgeable; my personhood is deeply tied up with all of those attributes. I recognize that this could hinder my data collection, impact the quality of my interactions with informants, or reify problematic power relations, in particular the construction of academics as more knowledgeable or in possession of more valuable knowledge than lay people. In spite of this (and much to my surprise), I did not find it particularly difficult to repeatedly position myself as not knowing during interviews. Although I did feel some resistance within myself to doing the counterpart — setting up my informants to play the role of knower — I was able to do so several times, and I felt no discomfort when I did so. I find this maneuver to be very effective at getting participants to increase how much they talk initially as well as getting them to provide me with a better picture of their internal representations of the concepts we discuss. I have been quite worried that my strong desire to be seen as knowing would interfere with my ability to do this research, and I don't think that has been the case. From this I conclude that I can deploy the concept of "knowledge" and to alter the power relations between myself and my informants.

There's a tremendous amount of folk knowledge about weight loss,[2] but there are also a tremendous number of people for whom that knowledge is not helping them to lose weight or change their health behaviors. Conversations about the daily practices of eating, held around the kitchen table or at the corner coffee shop – conversations like the ones I had with my informants – often seen as coffee klatchsy, dismissed as aimless clucking, and above all restricted to unoccupied housewives all circle around knowledge. The conversants collaborate to create a phenomenological understanding of their eating, their decision-making, their will and their management of the self to fill in those substantial gaps left by mainstream folk knowledge. I am left with a genuine belief that this is the only way for those in need of it to get this knowledge. It is this that most drives my conviction that my relationships with my informants – very generally

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[2] "Calories in, calories out!" comes to mind, and "Nothing tastes as good as skinny feels."

– were mutually supportive. The process of hashing and re-hashing knowledge and experiences of the body, food, the will, behavior, change is so important and so ongoing, that I believe I was truly in collaboration with most of my informants in producing and shaping some of this knowledge – even as a separate and external project to the production of the knowledge necessary to this dissertation.

This project would benefit by taking a deeper look at the WLS team, by "studying up". The surgeons, dietitians, psychiatrists, nurses, and primary care practitioners who serve as sources of expertise in the WLS recipient's biomedical experience are perceived to be neutral, knowledgeable, and authoritative. A thorough analysis of WLS should account for the fact that these roles are socially constructed and not unbiased. My original goal with this research was to do just that analysis, but the institutions of biomedicine proved too resistant to an "outsider" for that to be practical given the scope of a dissertation project. Often that resistance took the form of disinterest; few clinical staff saw any benefit to bringing me into their work lives, and those that did, were easily dissuaded by slight institutional pushback. However, the few clinical staff I *did* interview or receive feedback from were enthusiastic about my work and energetic in working around their institutional bureaucracies. I am deeply indebted to them and their generosity with their time.

The rigid and comprehensive procedures on which biomedicine depends were another substantial barrier. I remember one interview with a hospital nurse while she was scheduled to be on the floor. She arranged with me in advance where we would meet, where I would park, and exactly what I would say to the security staff at the front desk, yet her script *still* fell short when they said I couldn't be permitted entry (to the cafeteria our meeting was scheduled in) until I could tell them whether she was working that day on the North or the South side of the ward she had provided me.

### 1.3.1 Data Collection

For this dissertation project, I interviewed 14 people. I had only one methodological selection criteria: that informants must have previously undergone some form of WLS. Because English is the only language I am fluent in, I also required that they be able to conduct the interviews in English. I recruited by asking my friends and colleagues to connect me to any WLS recipients in their social networks and by asking my informants to connect me to other WLS recipients known to them.

Thirteen of my informants were cisgender women, and my remaining informant was a cisgender male. Two of my informants were Latinx, and the remaining twelve were white, non-Latinx. They resided in either Florida, Massachusetts, New York, or Illinois. Their ages at the time of our interview ranged from 34 to 73.

The majority of my informants had undergone gastric bypass surgery. Some had had a lap band, a gastric sleeve, or a duodenal switch, and two had had combinations of these procedures over time. The earliest surgery occurred approximately nineteen years prior to our interview and the most recent, three weeks. All of my informants were at a lower body weight at the time of our interview than their highest past weight. (Many people both within and outside this study describe this as, “Their surgery was successful.”) Most of them weighed more at the time of our interview than their lowest post-surgical weight. Official communications from WLS programs tend to describe this as the expected outcome.

In addition to interviews, I conducted participant-observation in formal and informal WLS support group meetings. I also conducted discourse analysis of a variety of textual materials. I asked everyone I interviewed to share any documents that they had received in the course of pursuing and undergoing WLS. Most of my informants stated that they no longer had any of that documentation, but two of them were able to provide me with copies of their dietary instructions and, of those, one also gave me copious insurance documentation. Several people spontaneously shared “before” pictures with me – that is, photographs of themselves prior to surgery and at a higher weight than at the time of our interview, intended to illustrate the dramatic effect WLS had on them bodily. One WLS team member provided me with a company newsletter that highlighted WLS and their patient education handbook, and another provided me with a mixture of resources that they use for both dietitian and patient education.

### 1.3.2 Data Analysis

To analyze the interviews, I used situational analysis, a specific implementation of discourse analysis (Clarke, 2005). I looked for thematic trends across the interviews, as well as recurring terminology, concepts, or logics. I began analysis of each interview as quickly as possible after it concluded, usually within thirty minutes. This initial analysis entailed writing a summary of the setting and interaction, focusing on data that wouldn’t be caught by the recorder and which I felt at risk of forgetting. Whenever possible, I then began transcribing and recording themes and impressions immediately. Transcription and review of transcripts continued for a minimum of one month after the interview, so I was able to collect my initial, fresh & chaotic interpretations as well as subsequent, increasingly organized & formalized ones as I visited and re-visited interviews. I used discourse and rhetorical analysis to study the textual materials I received from my informants and from clinicians. In analyzing these materials, I considered not just what was expressed by the sources[3] of the information present therein, I also inquired about the context in which these were provided and studied the artifacts of their use by WLS recipients and care providers.[4]

While this is not a phenomenological research project, I did gain an appreciation for the value of phenomenological methods to this research. So much of our everyday interactions around food depend on conveying phenomenological knowledge (the experience of eating, of pleasure, of grappling with conflicting drives), and my informants and I draw on this same skillset in our conversations. The bodily changes that occur immediately after surgery, the impact these changes have on one's relation with the outside world, the sensations of being a "successful" or "failed" patient or citizen or moral being – these are all phenomenological, and they are at the heart of the WLS experience. It's my position that biomedicine constructs the phenomenological as exactly that with which it need not contend, yet so much of what biomedicine tasks its patients with is wholly phenomenological. The professional boundaries that biomedical practices set up are designed to shift *everything* the patient experiences into a realm where the surgeon has no knowledge and no agency – thus rendering the patient at fault and the surgeon incapable of fault.

## 1.4 A Note On Language

While support for gender neutral usage of "they" and "their" in colloquial language is rapidly increasing, formal style guidelines still advise against the practice. In this dissertation, I use the terms "she" and "her" when a gender-neutral pronoun is required.

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[3] Most of these were authorless, "gray" literatures – those nebulous, often-government-produced literatures whose lack of an author allows them to allude to a kind of authority – and so I use the term "source" to highlight the ambiguity of the person or people who produced this information.

[4] You will see an example in chapter three where I identify a patient's notes as an indicator of the register in which she and her dietitian were speaking at the time of this nutrition counseling session.

Fat activists have worked to problematize the terms “obese” and “overweight” to describe body types, proposing the term “fat” as a desirable alternative. The term “obese” serves to medicalize fat bodies, and “overweight” to normalize certain bodies (on the basis of having a weight that is unmarked by “over”). Fat activism relies on the term “fat” on the basis that it is the most neutral and least value-laden term to describe the body type that organizes them and as a means of reclaiming an historically pejorative term (Cooper, 2016). While this dissertation is not intended specifically to forward the fat activist cause nor do I agree with fat activism on certain points that are relevant to this dissertation, I follow the lead of fat activists in this linguistic choice, because I agree with their reasoning and the political maneuver they are attempting. This usage of “fat” is colloquial, and one that many of us in the U.S. and other Western countries have been enculturated to avoid as distasteful or cruel. Discomfort is an inherent part of the process of change; any discomfort I experience writing this challenging term is more than justified by the political ambition of challenging thin privilege by challenging its unspoken “normalcy”, and I would encourage readers to contemplate a similar perspective on any discomfort this terminology may cause them.

# 2. Literature Review

The field of fat studies is in its infancy, and is distinct from my own discipline of science and technology studies (STS). Both have something to gain from the other, and putting STS literatures into conversation with those of fat studies has yet to be done. WLS, a technoscientific, biomedical procedure that produces major bodily transformation, the meanings of which are politically contested and divisive, provides a key site where fat studies and STS literatures can (and must) begin to speak to each other.

I begin my discussion of the literature by elucidating a subject that is key to this research, that is the concept of "identity". I rely largely on Goffman's conceptualization of identity, but I also proffer the notion of activities in lieu of identities as an additional useful conception. I next offer background on other ethnographic research into WLS, which has primarily been carried out by sociologists of health, with additional contributions from women's studies and anthropology. I then provide a general overview of the fat studies literature, its political aims, and the work to understand constructions of personhood and medicalization on which I rely. Next, I present a short discussion of the literature on motherhood, focusing specifically on how it may intersect with weight. I posit that one meaningful similarity is that motherhood and slimness are now both attainable with enough technological intervention. I then discuss the diverse ways that patients situate themselves in response to health expertise (in preparation for addressing this question specifically for weight and for WLS in a later section) and how health expertise is deployed. I have come to believe that "the will" is a key element of this research, and so the final section introduces theories of the will particularly those used in addiction studies — posing some suggestions as to how one ascertains the interiority of another that simultaneously suggest the problematic nature of that endeavor.

## 2.1 Identity

At the heart of this work is understanding how we see each other, how we are seen, and what we believe ourselves to be. To answer my queries, then, I need to establish a notion of identity that can be consistently relied upon.

For Goffman (1963), “identity” is that which can be spoiled. One with a spoiled identity is not whole, is marked, is other. One’s use of language and behavior are informed and sometimes limited by these identities, and an individual’s identities are not elective but are assigned by the social setting as a whole. We struggle to continue hiding those marks that are not yet invisible (which he calls discreditable stigma) and to compensate for the shortcomings made evident by our visible marks (or discredited stigma). So much of the research around stigma and particularly fat stigma focuses on the effects of being socially undesirable rather than on critique of the construction of the stigma or identification of how it functions more broadly than simple ostracization. Such research runs the risk of possessing a pitying quality in its treatment of fat individuals. It is largely Goffman’s conception of stigma and identity that allows me to challenge “the obesity epidemic” as a discursive formation. Goffman’s stigma is particularly relevant to WLS because it reflects a shift from a discrediting stigma (being visibly fat) to a discreditable one (the knowledge — often perceived as shameful — that one has previously had WLS or previously been fat).

For a number of authors, identities can be refigured as actions and not states. Becker describes “marihuana users” as those who engage in not just one activity together but in fact are the products of a common learning process (a three-stage process consisting of: successfully using the drug; perceiving the psychoactive or somatic effects of it; and enjoying those effects). Becker writes to undo the “other”-ness of the marijuana user (1953). In defining addiction, Sedgwick, paraphrasing Foucault, describes the fairly recent shift from addiction as an activity to addiction as an identity, then turns to her own, more complete definition of addiction as a deficiency of the will (which is a key tool in our decisions about actions) (1993). West, Zimmerman, and Fenstermaker propose a sociological re-conceptualization of three specific major identities — class, race, and gender — that would rely on action, interaction, and performance (West & Zimmerman, 1987; Fenstermaker & West, 2002). They describe this as a collaborative process, calling identity a "social achievement". Though they do garner criticism for their down-playing of identity categories besides gender (Collins et al., 2002), the idea of identity as a social collaboration remains useful. While I tend to favor the use of Goffman's discredited and discreditable individuals, the fact that I study not just a bodily state but bodies in transition means that at times, I am also addressing identities that are best described as *those who perform* x *activity*.

Crenshaw understands identity to be about categorization, but, in her influential 1991 piece, she discusses the problems such a definition of "identity" poses to political and intellectual work. Essentializing a category (for instance, *woman*) for political purposes also serves to elide the differences among that category. In short, anyone with a multiply-marginalized identity (such as women of color) can never be centered in the development of theory or in the design and operation of institutions, public services, and other structures. Crenshaw proposes that we rectify this by understanding identities as complex, particularly by viewing marginalized groups as a coalition of all the other groups composing it. (For instance, the feminist movement would best be viewed as a coalition of women of different races — and as a coalition of women of different ethnicities, classes, sexual orientations, et cetera.) Given fat as an additional avenue of oppression, intersectionality is a necessary conceptual element of this work in order to avoid replicating the same oppressions seen in the broader culture and to more fairly and accurately depict the identities and standpoints of my informants.

The “self” is a concept that appears repeatedly in literature dealing with WLS as a humanistic research question (Joanisse, 2005; Morgan, 2011). The idea that excess weight elides a “real self” is pervasive and deployed to various ends depending on who is using it. In this document, I use “self” to refer to the phenomenological interior sensation of independent existence and “identity” to refer to those ascribed categories which have the effect (among others) of discursively constructing limits on an individual and their other (often unrelated) attributes.

## 2.2 Lived Experiences of Weight Loss Surgery

Existing ethnographic research with recipients of WLS have largely been done in the context of the sociology of health, illness and/or medicine. Similar studies are also found in feminist theory. These studies have focused on questions of identity and of the self, on complicating simplistic understandings of those who undergo WLS and their reasons for doing so, and the meaning produced by the institutional policies associated with the procedure.

WLS is a particularly good example of the ways that patients’ motivations and identities are not simple but instead multiple and often conflicting. Because “obesity” discourse so severely limits the personhood of fat individuals, diverse discursive registers have developed and come into use for resisting those constructions. WLS complicates questions of responsibility and accountability and thus complicates the issue of morality with which high body weight is so fraught. If a medical technology can resolve the issue, then isn’t it medicine’s responsibility to do so? If the technology fails, whose fault is that? Ultimately, medical constructions of WLS tend to identify high body weight as a medical condition that is outside a patient’s control, while at the same time, blaming unsuccessful WLS recipients’ non-compliance for the failure of the medical procedure (Throsby, 2007, 2008, 2009). Throsby is, in essence, endeavoring to answer a question that weighs on the collective consciousness: is WLS cheating? Those who have undergone "successful" WLS (that is, surgery followed by significant, long-term weight loss), have lost the discredited stigma of being fat, but have taken on a new, discreditable stigma – that of being a WLS recipient. This poses unique information control difficulties because WLS can be accompanied by such physical and publicly visible "information" as frequent vomiting (Throsby, 2008).

Because medical constructions of need (for a particular treatment such as WLS) depend on stigmatizing concepts such as failure at other avenues of change (like being unsuccessful at "traditional" methods of weight loss) and severity of disease condition (that is, not just obese but *morbidly* obese — or "deathfat" as activists often archly put it), fat individuals are forced to reconcile their needs and desires for medically assisted weight loss or other medical services with their claims to a moral, unspoiled identity. They may rely on varying constructions of understandings of the causes of their body size: for instance, a "fat-prone body", a childhood background of being overweight, or disruptive life events (Throsby, 2007). WLS is rife with such double-binds as defining one as in need (of surgery) but still with agency. Glenn, Raine, & Spence (2014) specifically identify the double-bind stemming from pre-operative requirements of WLS hopefuls in order to qualify for surgery: both lack of success with conventional weight loss to demonstrate the medical necessity of the procedure and sufficient weight loss to prove one will be successful with the prescribed post-operative lifestyle changes.

The contradictions and double-binds extend to the process of doing sociological research of WLS. Throsby (2012), who positions herself as sympathetic to fat activism's WLS-critical stance (p. 4), asks how we might critique WLS while still taking seriously those who have had the procedure. She proposes relying on Haraway's "situated knowledge" as one answer; that is, we can value the specific viewpoint of a WLS recipient for what it alone offers and thus avoid the construction of a WLS recipient as some sort of unthinking dupe that might readily evolve from taking up a philosophical opposition to WLS. We might also look to the work done by WLS recipients themselves to claim or reclaim agency. While the mainstream of the fat activist movement is staunchly opposed to WLS, some fat activists have undergone WLS and so had to navigate the contradictions this produces. They do this through a confessional approach to their descriptions of their surgery — that is, by making a strong claim for *needing* surgery based on their past eating or other embodied experience — and by selectively taking up or rejecting biomedical labels for themselves (Meleo-Erwin, 2011). The powerful drive that culture-wide fat hate produces cannot be overlooked in this process. Simultaneously, increasing social approval for WLS and a neoliberal emphasis on the primacy of individual choice begin to illuminate why one would choose WLS (Morgan, 2011) over (or in addition to) political stances in favor of fat rights and fat liberation. Though media depictions of WLS often portray the choice to have surgery as risky, extravagant, and an easy escape, WLS recipients often position themselves as expert insiders, whether on the basis of their direct, embodied experience of the procedure or the research they've done to develop a technical understanding of that procedure (Drew, 2011). Alternatively, WLS recipients may position their weight as such an extreme burden that surgery was the only reasonable resolution available to them (Throsby, 2009; Meleo-Erwin, 2012; Jensen et al., 2014).

One might also challenge the restrictive conceptualizations of the physical body that are relied on in popular understandings of WLS; the analysis of WLS must account for the whole body as the site of excess weight and of weight transition as opposed to merely considering an altered digestive tract (Groven, Engelsrud, & Råheim, 2012). And what of the physical body of the researcher? While some authors entirely omit discussion of any body size, often as a political move to challenge the use of categories such as BMI, there are those who bring it to the forefront. In her phenomenological investigation into the embodied realities of post-WLS digestion, Groven et al. justify their methodological choice to deeply engage with topics of fairly extreme bodily indignities, citing Merleau-Ponty saying that bodies share a reciprocity and the only way of knowing the body is living in it. I interpret this to mean that the researchers believed they could understand these bodily indignities without directly experiencing them, because, through deep conversation and careful reflection, they are able to extend their lived experiences of their own bodies to others. Warin and her colleagues (Warin & Gunson, 2013) were very deliberate and thoughtful about the meaning in the field of both the enhanced social status their slimmer bodies gave them and the possibility of their bodily differences causing alienation from their participants. They found, however, that the notion of obesity and all its negative connotations were often invoked by their (the researchers') embodied presence or by broader social discourses, regardless of any efforts on their parts to prevent it.

An additional theme uncovered by existing social science research into WLS is that of the essential self. The popular perception of excess weight is that it obscures some "true" body (Throsby, 2008), and many recipients of WLS — both those who have lost weight and those who haven't — endorse that conception, describing the uncovering of their "real" bodies or, in the case of those who have not kept weight off, describing the true inner self as distinct from the physical body (implicitly affirming that their excess weight marks them as deficient) This can produce estrangement from the self through feelings of disgust and self-loathing, and even disembody the self; fat individuals describe their bodies as separate from their *selves* and understand their bodies as a contradiction of who and what they really are (moral and possessing worth), and the formerly fat describe their newly slim bodies as being for the first time a reflection of their true *selves* (Joanisse, 2005). Harjunen instead conceives of this notion of an inner, slimmer, "real self" as an indication that fat is always liminal, that people inhabiting large bodies do not experience fatness as permanent or essential to or defining of their subjective positions (Kyrölä & Harjunen, 2017). This true self, this idea that a fat body, a changeable body is always merely obfuscating something real (and thus, it can be inferred, that fat is artificial) is redolent of Sedgwick's epidemics of the will (1993). By alluding to a natural, un-fat self and disavowing the fat body through implications of its unnaturalness, one could be making a claim to one's inherent strength of will in spite of an outward appearance often interpreted as contradictory.

Another facet of the construction of the WLS patient is the discursive work of surgical qualification and preparation. Requirements such as minimum or maximum weight (sometimes, paradoxically, both), a demonstrated history of lifestyle change (as indicator of future likelihood of success at same), and compliance with mandatory education sessions or group and individual counseling all work to define the type of person who is both in need of and deserving of surgery (Drew, 2008). And at the other end of the medical pipeline, because of the associated post-operative lifestyle requirements, WLS allows for greater surveillance and regulation; recipients are then quick to take on the blame for any weight gain (Simpson, 2015).

Though these researchers ask important questions that work to trouble simplistic conceptions and complicate the personhood of individuals who pursue WLS — one of my main aims with this research — rarely do they even hint at the question of the management of the will. It appears to me that official WLS discourse deftly evades addressing the WLS hopeful's will despite how clearly this must be implicated in the surgical decision, both on the part of the WLS hopeful and the part of the surgeon or even clinic. Popular perception of high body weight is that it is purely a result of failed will. Some outstanding questions, then, for this body of literature: Why is biomedicine so ready to engage with the will as a component of disease in the case of, for instance, addiction, yet remains so unwilling to engage with it when it comes to "treatments" for obesity? What is the phenomenological experience of controlling or altering the will? What do peoples' conceptions of their own will (or lack thereof) do to their sense of self and how does WLS interact with that? Little of this research addresses the intersectional identities I consider particularly important in this arena, namely gender and motherhood status. Further, while some work has been done in this direction, this literature still doesn't adequately theorize WLS as a technology and as a process of biomedicalization. I now turn to some additional literatures that will help me to address these gaps.

## 2.3 Fat Studies

My broader interests in fat liberation mean that my work will be at least partially grounded in the burgeoning field of Fat Studies, which attempts to understand the intersecting issues of body image, appearance, and medicalization that surround a fat identity towards a goal of deconstructing naturalized ideas of fatness. Western culture's loathing of fat renders the fat subject abject (Murray, 2008), yet fat has also become a salacious spectacle in the West. Fatness as spectacle renders it highly visible while fat women — considered undesirable and unworthy in many social reams — are highly invisible, creating a unique status of "hyper(in)visibility" for fat women (Gailey, 2014). The contradictions of fatness are a recurring theme throughout this literature. It offers only limited consideration of WLS, and what analysis exists is purely critical (Throsby, 2012), failing to consider the productive aspects of WLS which are so central to this text. I build on the parts of the Fat Studies literature that address subjectivity and personhood and attempt to write it closer to sociological inquiries into WLS and to STS literatures on expertise, governance, and embodiment. Correspondingly, I expand those STS literatures with a consideration of what fat studies can contribute to broader studies of the role of technoscience as a constitutive feature of biomedicalization.

### 2.3.1 Gender and Fat

Theories of weight and embodiment in the fat studies literature are shaped by and contribute to theories of gender. Indeed, much of the fat studies literature focuses on the role gender plays in embodiment. Embodiment is gendered, that is, the salience of the body to women exceeds its importance to men both as subjects and in the definition of those subjects (Bordo, 1993). The social construction of the category "woman" necessitates a particular, idealized physical form, one that is both petite and appealing, and the quest for this form becomes internalized in individual women (Bartky, 1990). Weight is integrally linked to women's identities; one is not fully a woman unless one is a "normal" weight (Boero, 2012; Bordo, 1993; Murray, 2008).

The ways that women are persons, and the ways that women fulfill their social roles (or not) and the possibility of doing so depend on assumptions and requirements related to fatness and health, particularly because a significant component of mothers' labor is feeding children and teaching them nutrition and health habits (Cowan, 1983; DeVault, 1991; Mink, 1996). These considerations also hold when the person in question is not heterosexual or is transgender. Fat is construed as queer by way of being a performative bodily transgression that places into stark relief an "unremarked norm" (slimness and heterosexuality, respectively) (Murray, Wykes, & Pausé, 2014).

Fat women suffer substantially more weight-based stigma than men (Fikkan & Rothblum, 2012). Perhaps not unrelated, women are disproportionately represented among those who pursue WLS (Fuchs et al., 2015).

Is fat of special importance to women? Most scholars who've addressed the question agree that it is. Yet it is admittedly difficult to extricate these two marginalized identities — "woman" and "fat" — in order to parse out the basis for the phenomena we study. When it comes to intersecting notions of identity, which is the root of the phenomena we are investigating, which is epiphenomenal, and how do the two identities influence each other? Where does fat studies end and women's studies begin? These latter questions, unlike the previous one, are less well articulated in both fields.

### 2.3.2 Deconstructing Mainstream Conceptions of Fat

One of the primary aims of scholars of fat studies has been to reframe the topic of fatness as sociocultural and divorce it from "obesity", the dominant medical framework to which it is so tightly attached. The dominance of this framework allows for anti-fat discourses to become naturalized even as medicine's ability to intervene effectively in the "obesity epidemic" is, at best, limited (Aphramor, 2005). The moral panic surrounding this "epidemic" is unjustified by the clinical data (Campos, Saguy, Ernsberger, Oliver, & Gaesser, 2006). By rendering fat a political identity, it is possible to challenge and renegotiate the meanings of that label, "fat", in order to develop a richer and broader identity (LeBesco, 2004). Conceptualizations of weight and its effects diverge significantly between those central to the "obesity epidemic" framework and those that shape the lived experiences of people classified as obese and/or trying to lose weight (Boero, 2012).

Another important accomplishment of fat studies scholars is to challenge modern conceptions of fat throughout Western history. While it is widely believed that fat bodies were viewed favorably in the past, much of the recent historical scholarship challenges the veracity of that belief. Even the notion that it has always been conceived of as an identity in the same way is incorrect (Levy-Navarro, 2010). Fat bodies have often been associated with wealth, but only when used in conjunction with the most derogatory aspects of the label “wealthy”; those critiquing or lampooning the wealthy also critique or lampoon the wealthy for their weight and for their excessive appetites or habits of consumption. For the last 150 – 200 years, fat has been constructed in differing ways as a sign of moral failure (Gilman, 2008). In seeking to read fat as an enactment of identity, I move beyond reading it as a sign.

### 2.3.3 Moralization

A moral economics plays a role in defining and understanding constructions of will and moral responsibility, but is also important to understanding how fatness is constructed and responded to. Mainstream news coverage of the “obesity epidemic” depict high body weight as a moral failing (Saguy, 2012). Fat stigma stems from cultural anxieties about consumerism, race, otherness, and belonging; carrying the label “fat” poses a serious challenge to citizenship and to the exercise of the rights of personhood. Fat is associated with illness and laziness, thus a neoliberal landscape means fat individuals are failing their community (Tischner & Malson, 2012). Since at least as early as the beginning of the 20th century, attractive appearance and good citizenship have been linked in popular media (Farrell, 2011). I delve more deeply into expectations of mothers’ social reproduction of health, however the social role of mothers is also highly relevant to fat studies because they are uniquely implicated in moralizing surrounding the “obesity epidemic” (Boero, 2009).

The discourse of the “obesity epidemic” necessarily precludes alternative understandings of the causes or meaning of the data associated with it; this is in large part due to the complicated economic demands and limitations of U.S. industrial food production (Guthman, 2011). Yet the fat subject stands as an enigma for a capitalist system that encourages consumption. The fat are precluded by whole industries (such as fashion and air travel) while simultaneously being constructed as the ultimate and most voracious consumers (Kristjansson, 2014).

### 2.3.4 The Gap

What fat studies doesn't do is allow for a celebratory reading of WLS (Throsby, 2012). The journal Fat Studies has published only one in-depth article on WLS, an ethnographic study among fat gay men (Whitesel & Shuman, 2016) which identified "a divide between an insider's personal choice and an outsider's medical intervention" (p. 52), in the discourses of WLS on which this group relied.

The broader fat acceptance political movement is directly at odds with WLS (and in practice, often with those who have received it), (Meleo-Erwin, 2011). Fat studies scholars tend to respond to WLS with one of four general critiques: (a) allusions to snake oil claims that associate it with past failed endeavors (Farrell, 2011, p. 6); (b) associating surgery with barbarism as a means of resisting dominant and pervasive discursive registers that construct biomedicine as beneficent and necessary (Wann, 2009); (c) charges that a for-profit endeavor cannot be in the best interests of its customers; (d) beliefs that WLS is dangerous and ineffective (Murray, 2008). In contrast, the sociological scholarship (previously discussed) attempts to research the practice of WLS from a position that, while critical of the hegemony of slimness, is also receptive to the broad array of ways one might respond to that hegemony – an array that includes WLS.

## 2.4 Motherhood and Reproduction

In thinking about will, embodiment, and the responsibility for maintenance of health, I focus on mothers for several reasons. While not an explicit subset of Fat Studies, the current scholarly work on motherhood exists in a very loose and widespread constellation of disciplines, Fat Studies among these (as well as sociology, gender studies, and STS).

“Mother” is an embodied role; in the collective consciousness, the exemplar mother is capable of engaging in sexual activity, of conceiving, gestating and giving birth to a baby as a result of that activity, and then adjudged capable of performing physical and emotional labor to provide for that child’s needs once born. In addition, Western mothers are the primary party responsible for social reproduction; they teach children how to eat, how to maintain their bodies, and what responsibilities they have regarding health and bodies, as well as training them in the subtle and complex ways of Bourdieuian cultural capital. These requirements create a new avenue for potential failure and thus pose a burden. And like Bordo’s titular mother in the essay “Are Mothers Persons?” (1993) who is increasingly required to sacrifice and labor on behalf of a “whole person”, their fetus, personhood is whittled down a piece at a time for those who are fat.

The domestic responsibilities placed on mothers (and wives) work to construct and limit their identities and power relations (DeVault, 1991). Advances in household technology did not decrease the amount of labor performed by wives/mothers (as is commonly understood), but instead increased social expectations of cleanliness, thereby creating more tasks for the domestic laborer and thus having a net neutral effect on labor expended (Cowan, 1983). Women in families shoulder a disproportionate amount of responsibility for both the health of their children and partners. Expert nutrition advice on infant feeding has a moralizing effect on the mothers that that advice targets. Mothers both resist and incorporate that advice in their daily practices (E. Murphy, 2003). And the experts can likewise provide this advice either while resisting or incorporating expert discourses (DeVault, 1999). By virtue of inhabiting an embodied role, mother’s bodies are perceived as available for public comment or intervention. This effect is worsened if the mother in question receives some form of public assistance. The establishment of the U.S. welfare program functioned in part to open up poor mothers to intervention on the basis of this uniquely important role of mothers in producing future healthy, independent, responsible citizens (Mink, 1996). In short, the cost of a mother failing in any of these regards is perceived as so great that interventions into what would otherwise be her private life are justified.

Motherhood and weight often appear in the literature together, whether as an overt choice of the researcher (Kokkonen, 2009; Maher, Fraser, & Wright, 2010) or implicitly because they share one of the hallmarks of biomedicalization: the possibility for attainment of a desired identity via technological assistance (Clarke, Shim, Mamo, Fosket & Fishman, 2010). Just as the development of safe WLS techniques has brought with it a concomitant need to justify decisions about whether or not to get the surgery, the availability of genetic technologies produces social expectations for more genetically pure offspring (Roberts, 2009) and shifts risk and responsibility away from medicine and onto expectant mothers (Samerski, 2009). It would be a short logical leap, then, to posit that the existence of the possibility of WLS does similar work to shift the responsibility for the health and well-being of “obese” patients off of medical practitioners.

Mothers are framed as disproportionately responsible for their children’s health and nutrition and thus normal body weight, both in the sense that they are responsible for “fixing” children and that they are framed as a cause of any unwellness. This works to individualize the mother-child relationship, precluding any broader social contextualization and attributing social and economic disadvantage to maternal choice (Maher et al., 2010). Not only must mothers use food to nourish and produce health, they also ensure their children's moral upbringings by teaching them the performance of proper health and class behaviors. Mothers are likewise expected to maintain their own health disproportionately well – they must be physically capable of: bearing children; laboring to care for children; attracting a mate; and role-modeling health behaviors for their offspring. The role of mother is constructed by the culture's understanding of health, a shifting thing, and also one that severely delimits.

## 2.5 Medicine and Expertise

One of the aims of this project is to recognize how *fat* as a social identity and *obese* as a medical condition intersect with and diverge from other identities and conditions. I am looking at how one's health status gets incorporated into one's sense of self and how one responds to that incorporation. I look to existing literature on health expertise to provide something of a template for how existing marginalized identities have sought to stake political claims because of or in response to health discourses, as well as a range of tools for analyzing and framing medical knowledge, health claims and claims to expertise.

Medicine is broadly perceived as a universal good. As a revered and vital social institution, it has a unique ability to transform social issues into medical ones, a process known as *medicalization* (Conrad, 2008). At the same time, the prevalence of a medical frame for understanding problems means medicine also has a unique discursive ability to construct and define identities (Martin, 1987; Singh, 2016). Individual patients may choose to enroll themselves in or resist these identities, and often it is some complicated combination of these two that is chosen (Epstein, 1996).

The trend has been for an exponential increase in the claims made by medicine over the social sphere, a shift in the level at which medicine grounds its claims in our bodies towards the microscopic, and an increase in the amount of surveillance required of patients and the extraction of personal responsibility from them. This trend has been termed *biomedicalization* (Clarke, Shim, Mamo, Fosket, and Fishman, 2010). WLS is a key instance of biomedicalization: it as an example of the expansion of medicine's claim on the social sphere; it increases the expectation of personal responsibility and surveillance of individual lives and bodily habits, not only through medical requirements and instructions *during* and *after* surgery, but also *before* surgery by producing questions like "Do I need WLS?" within anyone who finds themselves implicated by the very existence of the procedure; and finally, it relies heavily on visual media representations of medical technology and its role in our lives (the *healthscapes* of biomedicalization theory) — namely, thin bodies are always healthy bodies and healthy bodies are always thin bodies.

Part of the way that identity and health status interact with one another is through moralization. The idea that a person's intrinsic worth can be judged on the basis of their visual appearance is a long-standing one in Western culture. In recent decades, we've seen increasing invocations of "health" as a way of speaking indirectly about someone's desirability or moral standing (Metzl and Kirkland, 2010).

How do patients stake claims for their agency, personhood, or knowledge in medical encounters and medical research? "Ill" and "in treatment" are each a tenuous and often distressing or disempowering state to be in, so the staking of such claims is necessarily fraught (Parsons, 1951). Although patients are traditionally understood as a distinct population from medical researchers or practitioners, under the right circumstances they can leverage their position to reframe themselves as active participants in the research process (Epstein, 1996). Activists play a role in the contentious process of developing a new discourse with which to address new health conditions. While still articulating the concept now known as "sick building syndrome," activists responding to a variety of complex medical conditions that resist mainstream biomedical classification or diagnosis (and thus were constructed by biomedicine as something outside of illness) needed to refocus the entire conversation so the modern office building became the unit of analysis (M. Murphy, 2006). Is activism in research always beneficial? Although increasing the use of diverse patient populations in clinical research trials produces better medical information for marginalized groups, it also supports biological essentialism and elides environmental health concerns (Epstein, 2008). At times, activism can take the format of an explicit political movement. Health social movements are important forces for change in the healthcare arena and pose a significant challenge to the status quo in a variety of arenas. *Embodied* health social movements are a particularly important type of this movement, with a focus on challenging or investigating a health identity on a biological basis (Brown et al., 2004).

Attempts by patients to reframe their knowledge, agency, or value are not the only context in which conflicting or rapidly shifting subject positionalities are at play in healthcare. Patients who make decisions about their course of treatment are responding to a plethora of forces. Rapp shows that the drives behind both the choice to get amniocentesis and to get an abortion if the results showed a likely birth defect are diverse and not always predictable, and – in another example of one of the processes of biomedicalization – that the opportunity to partake in these medical services simultaneously imposes a demand to do so (Rapp, 2004). Boundaries between mentally ill and mentally well are troubled and not always clear-cut; the relationship between expert discourse on, for instance, bipolar disorder and those diagnosed with it thus becomes a complicated one (Martin, 2007).

The prevalence of a medical frame for understanding problems means medicine exercises unique discursive power in constructing and defining identities and framing the knowledge available to subjects. Clarke and co-authors posit that we are living in a (relatively) new era in which the tendency to understand problems through a medical lens is heightened. This era is highly dependent on technology, enhancement, and genetic and other microscopic conceptualizations of disease. Even the healthy body has become a site for medical intervention, as the biomedical era has brought with it the possibility of enhancement and customization. The healthy subject is now responsible for knowing the correct information about health maintenance, “wellness,” and enhancement. The healthy body is one that is available for increased surveillance and is potentially a marketable commodity (for instance through blood, sperm, or egg donation). We understand our bodies through medicine and medicine through the limited portrait of it painted by the media, including advertising (Clarke, Shim, Mamo, Fosket & Fishman, 2010).

The shift from genetics to genomics in scientific and later popular understandings of the cause of autism has affected how individuals with autism and their families understand and experience the condition (Singh, 2016). That medical frame is far from neutral. Analysis of medical language is one tool that reveals the positions taken by medical science. The types of metaphors used and the situations those metaphors are applied to reveal the ways that medical knowledge relies on and reproduces existing cultural biases and elides a fully nuanced understanding of the functioning of the human body (Martin, 1987). The use of metaphor in discussing illnesses works to make (particular psychological) claims about the sufferer of said illness (Sontag, 2001).

Beyond just eliding identities, medicine reproduces inequities on the basis of identities. Heart disease and Americanness are intertwined (and thus so are concepts of race and the racialization of heart disease). Genetics is not and cannot be an explanation for racism in medicine, and medical treatment is “a site of social and political contestation” (Pollock, 2012). Racism in medicine matters to this project both because the intersectional identity “fat person of color” is doubly at risk in the medical setting, but also because it is true of both that “At the intersection of a disease category and a social identity, we have the opportunity to think through both the material and the semiotic aspects of our lived experiences” (Pollock, 2012, p. 12). The ways that conceptualizations of blood diseases were initially developed continue to define the identities of both patients and physicians, as in the example of sickle cell anemia and other anemias. Existing social classifications, particularly race, were reified by the way medicine provided scientific constructions of the observable phenomena associated with those classifications. Ambiguities about origins of disease allowed physicians to point to morality as one such source (Wailoo, 1999). By asking "The question of what makes a disease 'real' in any period" (Wailoo, 1999, p. 16), I can better strive to denaturalize present-day conceptions of "obesity".

While the provision of healthcare reproduces inequities, as evidenced by work in medical sociology on the doctor-patient relationship or systems-level issues, inequities are also apparent in the representation of health issues and the dissemination of information about particular conditions. In the news media, health issues are framed along dimensions of involuntary, universal, environmental, and knowingly-created risk; the position on these dimensions determines whether the issue is perceived as public or personal. Although news coverage increasingly frames the "obesity epidemic" as an environmental problem, there are still and always have been substantial instances of framing it as a personal problem (Lawrence, 2004).

## 2.6 Will

My research is concerned with the way that moral behavior is defined and made economically necessary; how will and the performance of health are understood as moral behavior; and how moralizing impacts subject formation. The current neoliberal landscape presents an expectation that individuals not just be healthy but actively demonstrate that they *are being* healthy: conducting an active lifestyle, participating in medical institutions, "eating healthy". These moral mandates suggest that it is possible to fail to *be* healthy by failing to be moral. (For instance, it is not enough to be free of cancer, one must have undergone the correct screenings for cancer to *be* healthy.) I believe that these rigid constraints differ for people of different identities, such as race and socioeconomic class. I am especially interested in how these expectations differ on the basis of family role; “mother” (including “potential mother”) is a uniquely relevant social site for my inquiry as the role comes with unique burdens of not just the mother's own health but the health of her offspring and the training of said offspring in replicating her own health behaviors. The literature on the will gives me tools to identify the neoliberal influences that have produced these moral landscapes. To do this, I draw on researchers looking at consumer behavior, maternal responsibility, ideology, medical compliance, addiction, and governance in the family.

The concept of “will” is important to any investigation of fatness. Fatness is popularly understood as the result of an inability or unwillingness to stop eating. Medical “interventions” revolve around the question of how to alter the will all while avoiding directly addressing it. But theoretically this is far larger than just a question of how does one resist eating or cut calories. Consumption, a historically situated concept, is integral to how we understand the economic system in which we live, and the metaphor of consumption does its work largely uncriticized and unseen (Graeber, 2011). In the last thirty years or so, U.S. responses to perceived threat have changed drastically towards an emphasis on individual, consumeristic solutions and an inverted quarantine, in which, rather than isolating disease from a population, the healthy are isolated from a potentially poisonous population (Szasz, 2007). Correct consumption comes to look first feasible, then like the only solution to a multitude of problems, and ultimately like a moral responsibility.

Sedgwick suggests that the will is tightly intertwined with cultural conceptions of the “natural” and the “artificial” (1993). The meaningful results of this are that the naturalness of a substance can be (and often is) contested as a means of staking claims about the extent of the substance’s hold over a person’s will, and groups of people are constructed and reified as inherently unworthy of survival due to their seemingly unnatural activities. She further positions addiction and homosexuality next to each other as two cultural constructions (that emerged at roughly the same time) which entail partaking in these sorts of “unnatural” activities. She probes different purported addictions to try to produce a well-formed definition for addiction, considering in turn the question of whether addiction is about activities or identities, whether addicts are best described as an active subject trying to manipulate his or her condition or passive, needy objects for the intervention of societal forces, which substance or absence of substance or “overarching abstraction that governs the narrative relations between them” (Sedgwick, 1993, p. 130) might define addiction. She ultimately describes addiction as “the *structure* of a will that is always somehow insufficiently free” (p. 131).

Raikhel, in discussing the use of traditional and placebo pharmaceutical treatment of alcoholism in Russia, introduces a concept I find useful, that of “prostheses of the will,” (Raikhel, 2013). In part, Raikhel grounds his claim in the fact that physicians who prescribe it, cannot provide a mechanical cause for the success of the treatment. Implicitly, he sets this up to indicate that the functioning must happen at the level of some less-anatomical structure such as the will. Raikhel identifies a necessary component of this procedure: the successful production within each patient of anticipated future (negative) consequences — and, as part of achieving that, the cultural and institutional structures that support this production (i.e. a necessary component for believing the treatment will work is believing that most of the people around you believe it will). It seems fair to describe WLS — whether involving implantation of a device or simply surgical alteration of the body — as performing a similar prosthetic function for those who have undergone the procedure, and to describe individual willingness to partake in it as dependent on a broader cultural understanding that (a) high body weight is harmful; and (b) WLS is an effective way to alter one’s body weight. Another research project into WLS describes a broader cultural understanding of this sort; in this case, it is the fairy tale framing of the results of WLS — women made objects capable and deserving of being saved and men made powerful and strong (Glenn, McGannon, & Spence, 2013). Raikhel’s investigation demonstrates the analytic weakness of attempting to reduce the efficacy of a medical intervention merely to the clinical protocol, saying it depends on an assumption that “clinical technologies are discrete, portable, and transposable between contexts” (2013, p. 210). The standardized application of WLS to various health and somatic conditions may be an example of medicine making the same mistake.

Medical language and interactions serve in part to reproduce different ideologies and enact social control (Waitzkin, 1989). Medical practitioners are likely to talk about will in the framework of “compliance”, that is, the patient’s successful acquiescence to the physician’s demands and to dosages determined by standards set for “ideal” bodies. The ideology of compliance (which stems from successful efforts historically to control infant feeding) has become a contentious tool for reinforcing the physician's authority (Trostle, 1988). However, the fact of a patient’s “compliance” is a result of their “desire to control symptoms within the constraints of their daily routines,” and their ability to successfully find a balancing point between these two needs (Hunt, Jordan, Irwin & Browner, 1989). There is a clear-cut power relationship implied by this framework: knowledge and instruction flows from physician into patient, resulting in changed patient behavior and thus changed health outcomes; when that process breaks down, it is a lack of compliance, in short, a failure of will on the part of the patient.

# 3. Motherhood, Family, and Relationships

Alexandra and her husband are raising a toddler, and she works full time running a booming, three-year-old business. I conducted my interview with her in her home sewing room, the orderly and extremely-well-stocked headquarters for her children's clothing line. She spent the duration of our interview tracing and cutting pieces of fabric in bulk in preparation for future assembly. We began talking about food and the complexities of eating almost immediately. It was clear that her thinking is greatly wrapped up in these issues. She shared that she traces these eating complications to her own upbringing by a very slim, very body obsessed mother who, nevertheless, left her with no knowledge "about how food is processed through our bodies," a gap filled only by pre-WLS educational requirements. It is important to her not to reproduce her own experiences of eating in her own child, so she avoids any notion of forbidden foods, instead framing eating expectations in terms of basic, holistic nutrition guidelines, like, eating enough growing foods (protein). But this endeavor comes at some cost to her. "I have a child who I don't restrict. He can have cereal and crackers and all of the things that I try not to eat. Because of that, they are in my home. And I see them. And I want them."

One of the identities that works in the most interesting ways when it intersects with "fat" is that of "mother". All parents engage in social reproduction, but motherhood is of particular salience to this topic for several reasons. Mothers are apportioned a far greater share of the burden for the development of sound children than fathers. As women, they are under significantly more pressure to attain physical beauty (Bordo, 1993) and a normative body (Boero, 2012; Murray, 2008). Finally, they are responsible for feeding the family and for the health of the family, thus strongly implicated in calls to address that favored source of panic for alarmists everywhere, "childhood obesity".

Since at least the eighteenth century, motherhood in the U.S. has been constructed as a civic responsibility (Apple & Golden, 1997; Mink, 1996). Producing future citizens that are capable of the labor a civilization needs, that comport themselves according to social norms and in ways that facilitate communal life, and who can in turn reproduce those same social values is a vital social function, and that function falls to mothers. Historically, these properly produced citizens have taken the form of soldiers for the nation's defense, but the expectations of a proper citizen also include moral behavior, maintenance of good health, and economic productivity (Mink, 1996). Scientization – the growing propensity to turn to science to solve all dilemmas, even the sociocultural – leads to notions about how science can and should inform mothering and citizenship (Apple & Golden, 1997). This means, among other things, that mothers must raise good *patients*: people who are compliant with expert advice, whose bodies function and appear "normal", who publicly perform health through their visible consumption and habits, and who, when transgressing any of these things, utilize the proper means of atoning: a variety of rhetorical maneuvers to justify alternate forms of expertise (such as proponents of organic food who've managed to associate the presence of "chemicals" with harm), shame when failing to perform health (like the young woman declaring, "I'm being so *bad* today!" while eating cheesecake), and active engagement in invasive biomedical procedures[5] intended to address bodily abnormality.

I primarily address mothers and motherhood in this section because child-rearing and feeding are gendered occupations. Household labor falls disproportionately to women, even in families where the couple endeavors to share that labor equally (Hochschild, 1989). By utilizing a feminist analysis of household labor, I don't aim to marginalize the nurturing and labor that men put into

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[5] And by that, I mean not just subservience or willingness in the face of biomedical intervention, but an active seeking out and embracing of biomedicine as solution to abnormality.

“mother’s” tasks, but it is vital to keep sight of the following: that these endeavors are primarily allocated to women, are collectively understood to be women’s work, are viewed as an aberration in men (while their absence is viewed as an aberration in women), and are a main way in which women collectively perform gender (DeVault, 1991). In 2018, gender is fraying. When we consider domestic work, we can no longer call it “gendered” on the basis that it is solely limited to one set of individuals. We must say that when we talk about women’s work, we are talking about work that is marked by the weakness or insignificance that a sexist culture associates with women. Even as the proportion of male caregivers and household laborers increases, we should continue to apply a feminist analysis to the work of the household.

Mothers’ own health behaviors are both impacted by motherhood and invoked by their position as role model and authority. More than any other piece of housework, the production of food defines a mother’s role. Family eating becomes more complex and more fraught as the family grows and as each person attempts to negotiate conflicting needs. An analysis of motherhood, therefore, gives us a unique insight into food and eating for those occupying any family role.

This chapter will also address the diversity of ways that mothers’ labor is constructed and perceived, how weight influences and is influenced by motherhood, and other relationships that have influenced my interlocutors’ weight and food experiences. Finally, I close the chapter with my findings about how metaphoric motherhood is imposed on (and denied to) those pursuing WLS and what we can see from this about how the biomedical system constructs WLS recipients.

## 3.1 The Necessity of Slimness for Child Production

Slimness is a pre-requisite for “proper” motherhood and for the ability to do the social reproduction required of mothers. Mothers must have the skill and knowledge to “be” healthy and maintain a proper weight in order to pass these on; a slim body is a necessary piece of evidence attesting to that skill and knowledge. By most mainstream definitions, mothers must be capable of gestating and giving birth to a child. Mothers must be capable of the physical labor of child-rearing. All of these characteristics work to render fat bodies incapable of motherhood by definition, even if not in practice. Mothers occupy a variety of contradictory spaces, and fat and formerly fat mothers even more so.

### 3.1.1 Labor

Housework, constructed primarily as a responsibility of wives and mothers, is obscured in the collective consciousness. It is generally unpaid, unsupervised labor, making it possible for some to question whether it is "work" at all. The labor mothers do is largely invisible, often even to those mothers themselves (DeVault, 1991; Hochschild, 1989). Yet there is tremendous labor being done by mothers for their families (Cowan, 1983). Slippery understandings of gender and social roles are what allow for these contradictions and elisions. One of the ways this appears in my empirical data is mothers and grandmothers who cite as one of their reasons for pursuing surgery the ability to play on the floor with their children or grandchildren. While "play" is usually understood as being in direct opposition to labor, here, both the physical duress and mandatory nature of playing for the purposes of bonding with, entertaining, and developing the skills of young children become visible, highlighting the laborious nature of this form of "play".

For Alexandra, the issues of labor and what kind of labor is or is not the purview of a mother were clearly at the forefront of her mind. I initially interviewed her at her home, then met with her again just a few days later in a small group consisting of myself and some of my interlocutors. In both conversations, two things came up clearly. The first is that she is overwhelmed by the amount of work she has to do *just* with the business, let alone the incredible time involved in raising a child, feeding a family, and maintaining a post-WLS diet and exercise routine. The second is that she is always on guard against the possibility of this work going unseen. The blurred lines between her paid and unpaid employment means it is easy for labor to become invisible in either category (Hochschild, 1989). She seemed very attuned to suggestions that stay-at-home motherhood is easy or that her business is a hobby or a pleasant diversion. Such constructions seem self-evidently problematic, not in the least because, as these two examples do, they can be deployed in either direction (that is, to minimize the work of motherhood or of entrepreneurship) to perpetually suggest that she is not laboring. As a result, Alexandra does a tremendous amount of work in her social interactions to defend what she does as labor. This takes the form of relying on corporate terminology to describe what she does ("draw an annual salary"), responding to comments that hint at maligning her work with serious, nearly stern attention, and often retelling to others the situations where she has already clearly defined which of her activities will be called work. Pam, another full-time work-from-home mother, also experienced some anxieties around work-life balance and frustrations with how outsiders perceive her life, though she was less diligent than Alexandra about responding explicitly to these.

What I aim to draw attention to here is not, as it may come across, some sort of oversensitivity but instead how fraught the subject of mothers' labor is. Just as Alexandra experiences in her life, the value and burden of mothers' labor is generally available to be deployed in more than one direction. I suspect that it has often been the case that, when it is useful for dominant discourses to construct mothers as laborers, they become laborers, and when it is useful to describe them as passive, they are passive. Thus, almost as soon as mothers are constructed as laborers, they are alienated from that labor. So-called "welfare mothers" are the best example of this, women under such a tremendous burden of labor with their child-rearing that they are unable to earn sufficient funds from paid labor and thus depend on government assistance, yet who are damned by the general public for not working enough.

Mothers have seen themselves alienated from pregnancy and childbirth, too, in the latter half of the twentieth century as technologies like ultrasound and amniocentesis give technicians and doctors specialized knowledge about a mother's internal condition, previously something about which only she was an expert (Rapp, 2004). Like fatness, pregnancy (and by extension motherhood) has been transformed from a private concern to a public one.

Identifying and clearly understanding this alienation and contradiction under which mothers exist is necessary to understanding some of the interesting and otherwise inexplicable phenomena that occur in the arena of WLS.

### 3.1.2 Maggie

One of my interlocutors provided a thorough picture of the ways that motherhood, the pursuit of bodily normality, and the journey towards self-actualization all interacted in her history. Maggie initially pursued WLS at the recommendation of the doctors and specialists she was consulting to treat her fertility problems. Her only goal at that point in her life was motherhood, and it seemed clear to her (by way of her medical providers) that her body weight was a barrier to that goal. "That's when the idea of the surgery came in. Because it was basically like, what we think is going on is that your weight is affecting your periods and your ability to conceive…. And it was like, okay, so this is what I have to do in order to get my health to a point where this is even possible." Maggie's descriptions of this thinking evoke a rhetorical move made by several of my informants, that of allusion to "realness". In the next chapter, I present Alexandra's reliance on the term "vessel" to describe her body's readiness for gestation, and Deirdre's emphasis on the "physical" nature of her limits as if her body might ever be something other than that. Here, Maggie stresses "possible". It's a nearly poetic meter with which they enunciate these words, endeavoring – I suspect – to attain legitimacy. The move suggests that their theory is unimpeachable, their argument a prima facie sound one. What could be more undeniable than the body? (I delve more deeply into this rhetorical move in the next chapter.)

Maggie, however, would never verify her doctors' belief that WLS would rectify her fertility problems. By the time her surgery and subsequent weight loss were complete several years later, her marriage had dissolved, and the family she had been envisioning had disappeared along with it. Telling me some fifteen years later about that experience, she stated unemotionally that she no longer wanted children. Maggie had come to realize with time and great work that the intensity with which she was driven to motherhood stemmed not from what she considered a genuine interest in parenting but from the need to fully inhabit the role of caretaker, one she had been taking on throughout her life, the only role she saw for herself. The only aspiration available to her younger self was motherhood. She also saw motherhood as potentially mediating her interactions with the outside world in a very desirable way, one that allowed her to connect more with a frightening and alien world while also protecting her from it. This narrow view of her own possibilities was not only the result of her own youthful perspective but of those held by the community around her. She described the members of her family and the broader community in which she was raised, saying they shared a communal belief in these gendered limitations and nurtured in her a view that there is no joy to be had in life, that there is only work — no thinking, no aspiration, and no growth. In this world view, men work as physical laborers and women raise children;[6] no one is queer, no one rests, and no one enjoys their lives. Higher education was mostly lower quality and limited in variety of degree programs (or so elite it was unavailable to locals);

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[6] Note how with this construction, again the labor of child-rearing is elided.

transportation was poor, including transportation to these lackluster colleges and universities; wages were low; most work was physical; and the availability of even that work was dwindling. “Mother” was the only identity available to women in Maggie's hometown, and for Maggie, that identity was only attainable through biomedical intervention.

When she sought that biomedical intervention, she experienced it as a depth of nurturing she had never known. The amount of one-on-one attention provided by healthcare workers was an exceptional experience for her. (Previously, the closest such interactions she had had were with a dietitian her doctor sent her to in her teenage years.) It wasn’t until Maggie began to push back against the mainstream valorization of slimness that she ever began to question her initial, uncritical impressions of biomedicine. By the time of our conversation, she had nearly entirely abandoned traditional medicine, turning to alternative medicine, her own knowledge of nutrition, and a deep attunement to her body.

Most of my interlocutors experienced a transition after WLS that was not directly related to the surgery or weight loss, namely other lifestyle changes such as break-ups with long-term partners or career changes. Maggie’s story has an exceptional amount of transition. In addition to her complete reversal on the value of allopathic medicine, she divorced her husband, came out as a lesbian, moved out of state, earned a college degree, decided against having children, and regained a significant amount of the weight she had lost – to her satisfaction. The number of these shifts makes identifying any cause and effect difficult. Her experiences of weight loss (which produced a body she found horrifyingly alien), coming out as a lesbian, coming to terms with conflicting feelings about biomedical expertise, and learning to trust her bodily knowledge all share the theme of uncovering of an authentic self. There is a kind of emergent effect for many of my interlocutors and most especially Maggie whereby each transition was dependent on the other, creating a narrative cycle it is difficult to penetrate with analysis.

Maggie has grown to see her disavowal of any sort of mothering self as an asset, pointing to relatives that now draw inspiration from her and saying that she thinks it is her rejection of that limiting identity that inspires them. She also describes the crisis she observes in mothers of newly-adult children, saying they "don't develop their core identity, their sense of self," and are subsequently lost when they – as she suggests - lose the identity of *mother*. For Maggie, authentic selfhood is at odds with motherhood, as it is with slimness.

### 3.1.3 Social Reproduction

Slimness is required for one to be seen as suitable for reproduction and capable of the physical labor of child-bearing and child-rearing. Further, by providing supposed evidence of both one's knowledge about proper health behavior and capacity for applying that knowledge in daily practice, slimness is also necessary for the social reproduction of health and appearance norms. Slimness thus becomes a requirement of citizens in order to fulfill their civic responsibilities.

One of the influences at work on social reproduction throughout the twentieth century is scientization – the scientization of the family, of motherhood, of the home, and of diet and exercise. In the 1920s and 1930s, as the New Deal and other social welfare programs were being crafted, one of the tools which both enabled reformers to make needs-based claims about these programs *and* constructed welfare recipients as less competent and their lives available for "expert" intervention was the scientization of the family by way of tools like family budgets and quantitative sociological research on family habits (Gordon, 1994). The ideal mother according to those who promoted both government welfare programs and scientized motherhood was a middle-class, Anglo-American white woman (Mink, 1996). Though welfare reformers earnestly sought to improve the conditions of the poor and of racial and ethnic minorities, this valorization of only one narrow definition of "mother" effectively defined proper motherhood as unavailable to them, at best merely approachable by imitating their "social betters".

Throughout the latter half of the nineteenth and early half of the twentieth centuries, the public readily embraced the scientization of nutrition. "The calorie," for instance, "was a means of translating the emerging science of nutrition into everyday and personal terms. In the context of a growing public fascination with modern science, by counting calories people could now not just think scientifically but also eat scientifically" (Scrinis, 2013, p. 52). Since the inception of the scientized domestic sphere, it has gone hand-in-hand with the centering of weight loss.

The scientization of motherhood ultimately is a paradoxical proposition as it renders mothers incompetent at mothering. In the twentieth century, the extent to which women were expected to permit expertise into their child-rearing decisions was so great that they were being "…told not just that they needed to learn from scientific and medical expertise but that they needed to follow the directions of experts" (Apple & Golden, 1997, p. 91). This is the difference between opting for vegetables over grains in the grocery store and following a prescribed diet, item by item. Without choice or the opportunity to exercise judgement, mothers become simply an extension of the expert, an automaton carrying out instructions from above, much the way the production line works (or at least is imagined to).

Apple goes on to articulate the implications of this extension: "This aspect of the ideology presented women with a tension-laden contradiction: it made them responsible for the health and welfare of their families, but it denied them control over child rearing. In other words, women were both responsible for their families and incapable of that responsibility" (Apple & Golden, 1997, p. 91). This contradiction is what makes the role of "mother" key to this research. Every mother is struggling to find a position that feels the *least* impossible in the space between these two incompatible limitations.

In the case of fat women, their own bodies betray their failure to feed themselves in line with expert guidance. WLS can now provide them a way to resolve the paradox. By virtue of actively expanding the space for expert intervention in their lives, WLS recipients have both demonstrated agency of their own and incorporated even more expert direction into their lives, thereby "atoning" for their unsuccessful and ineffectual motherhood – whether actual or figurative – and which, due to the paradox, was ultimately a foregone failing on their part.

### 3.1.4 Coming Together

Both mothers and fat people occupy complicated, shifting, often paradoxical ground, their personhood ever threatened, frequently diminished always under the guise of a noble, civic purpose. Together, these two identities can magnify these effects. Some of the tools by which this magnification happens are the scientization of motherhood, the invisibility of household labor, the valorization of mothers (such as Maggie longed for), and the moralization of bodies. The way these phenomena render problematic social conditions (poverty, fatphobia, sexism, a lack of financial or social support for mothers, heteronormativity) invisible or naturalized is at the heart of this research. In the next section, I offer more detailed ethnographic evidence of parenting and WLS coming together in order to illustrate how all of this plays out in daily practice.

## 3.2 Direct Experiences of Parenting

For the purposes of this section, I have grouped my interlocutors by a somewhat arbitrary "family age". Of the fourteen people I interviewed, four had children exclusively under the age of ten, two had children that included at least one teenager, six had exclusively adult children not living with them, and two were childless. These groupings provide enough similarities within the groups to be analytically interesting, and so I consider the first three groups of interlocutors here, namely those who are new to parenting, those who have finished the task of daily parenting, and those who are roughly in the middle of it.

I found it much more difficult to get detailed information about my interlocutors' child-rearing experiences than their weight loss. I speculate that, by virtue of both the affective, obtrusive experience of WLS and the way that experience sets them apart from most others in their social worlds, they are explicitly aware of the ways that WLS has informed them, while their experiences as parents are largely transparent to them. For instance, feeding themselves is something they have recently spent exhaustive amounts of time explicitly thinking about, learning about, and practicing, but preparing family meals is a chore that has become de rigueur for them. This is supported by the fact that the parents of young children (those for whom learning to parent is still an explicit process) I spoke with were far more attuned to their identities as parents than those who have been parents for one or two decades.

### 3.2.1 Novice Parents

The parents of toddlers that I spoke with had multitudinous observations of how they interact with their children, how they feed their children, how they make choices about their children's eating, how mothering impacts their own eating, what they role model for their children with their own eating. Two of the mothers of toddlers that I spoke to were quite enlivened discussing this last point, because a side effect of their WLS is frequent vomiting. This occurs when they eat quickly or chew only roughly. Eating cannot continue under these circumstances until they've expelled the indigestible bolus, so it happens sometimes that they have to excuse themselves from family meals to vomit. They are concerned how much this could look to an unsophisticated observer (such as a toddler) like the purging often associated with disordered eating, scared they might effectively normalize routine purging for their children. One of their toddlers describes this occurrence as, “Mommy has to go cough in the potty,” a fact his mother related to me with equal parts mirth and chagrin.

Another common thread for all of the mothers of young children was the near impossibility of planned or even just calm eating at this stage of their lives. The intensity of their schedules[7] and the perpetual distractions posed by toddlers present significant barriers to food preparation, sitting down long enough to eat a meal, or eating with the concerted attention (such as extensive, careful chewing) that WLS requires. For efficiency reasons, they get a fair amount of their food intake from snacking on whatever they prepare for their children, which then limits their food choices by their children’s palates and nutritional needs.

### 3.2.2 Experienced Parents

Star – one of the parents of teenagers – and I spent almost half of our conversation discussing her experiences of motherhood, yet in all of that time, she offered nothing about her ideals as a parent, her successes or shortcomings, her feelings about her children or her children’s feelings about anything. At times, this seemed like a consequence of that most bemoaned attribute of teenagers, disaffected ennui. Her children were not interested in her drastic diet changes, in her dramatic physical changes. Yet at times it seemed very clear that she was invested in reproducing her notions about health and slimness. She said she “has” her younger child, her son, in three sports (karate, gymnastics, and soccer), and when I asked about her daughter’s participation in athletics, her tone of voice clearly conveyed her disappointment that her daughter is, “no longer interested in it.” Her daughter *does* play volleyball, but Star downplayed this fact, explaining that it doesn’t have her daughter running a lot.

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[7] All are engaged in paid employment on top of the labor of parenting.

She does not cook for her children and does not like doing so (as I describe in greater detail in the next section), and between differences of palate and the exigencies of WLS has almost no food preferences or choices in common with her family. It struck me that her post-WLS eating had really alienated her from food. Whether this also produced alienation from food as a shared family activity or if that had existed previously was unclear to me. That alienation could contribute to what I saw as disinterest in how her children eat.

### 3.2.3 Post-Child-Rearing Parents

While I still got less information than I would have liked from the parents with grown children, this group was more reflective about their child-rearing than the parents of teens. As one might expect for this stage in a family's life, there was greater physical and psychic distance between these parents and their children.

One, Ellen, spoke at length about things like her son's food preferences when he was young. She was clearly concerned with social reproduction (though she might not have used that term). She spoke to me about her aspirations in feeding him as a youngster, as well as about her fears of replicating traumatic family patterns with him. (She told me with satisfaction that she had ultimately succeeded at *not* repeating her own parents' most egregious missteps.)

In the case of one family, I got to closely observe the interactions between parents, adult child, and grandchildren around food. Tammy is a retiree in her mid-sixties now several years out from a gastric bypass. She lives with her also retired husband in a house very near the one occupied by her son, daughter-in-law, and two grandchildren. There are two main mechanisms through which they maintain regular interaction. One of these is childcare, which Tammy frequently provides on an impromptu basis for her four- and two-year-old grandchildren. The other is dining out together. The family has a rotating stable of several chain restaurants that they meet at for meals together, all with a corresponding nickname the grandchildren have bestowed on it. (For instance, the Olive Garden has been dubbed “Purple Grapes” for its former logo.) We dined together at “Yellow Bread” (so named for the color of the bread Texas Roadhouse serves its patrons). Though we would eventually eat a total of four meals together, I was initially quite nervous and uncomfortable about eating a meal with someone who had WLS. So much of the knowledge I now have about WLS and appetite is theoretical: what, I anxiously wondered, would it look like in practice, in front of my own eyes? I was concerned about what my “normal” eating would look like to her and how alien her eating might feel to me. I was thus relieved first to learn that her family still ate at mainstream eateries and later to sit down in a restaurant next to each other and discuss our reactions to the menu in ways that felt familiar and not at all limited as I had imagined. She ate and expressed interest in the same kinds of foods I did, even ones that didn’t entirely adhere to expert prescriptions for a post-WLS diet, but she also ate in (what looked to me like) the small portions advised. Several of my informants perceive their restricted eating as producing social pressures and unwanted attention, so I noted with interest that Tammy’s portion restrictions didn’t feel strange or even noteworthy to me in practice.

In the approximately three days I spent with Tammy, her enthusiasm for keeping the people around her well-fed – myself included – was self-evident. This consisted of ensuring both that people had more than enough to eat and drink and that they enjoyed what they were eating. Food is key to making her social world go around, and she has found ways to accommodate that even within the complicated limitations of WLS.

Ruben, a retired NYC subway operator and my only male interlocutor, was in the very earliest stages of post-operative recovery when we were introduced. Perhaps because of this, he spoke the most evocatively and earnestly about food, something that made our conversation very vivid for me. Even months later, on listening to our recorded interview, I was left longing for the unattainable pizza he described lovingly to me. Ruben made it abundantly clear that his family members were very important to him, though I'm not sure his relationships to his children stood out among his other family relationships. His attendance to his health and his body were, for him, expressions of his devotion to his loved ones. He has been sober from alcohol for many years now, and he couched his telling of that fact in terms of familial devotion. Being here for his family, embodying an ideal they can aspire to, is central to how he organizes his life. He is an outgoing, gregarious man who is extremely enthusiastic about WLS, and I introduce him in greater detail in the next chapter.

### 3.2.4 Uneasy Compromise

While the mothers I spoke with were by and large reticent to overtly address their identities as mothers, we can see hints of how daily, mundane family interaction produces and assigns the many identities family members may be implicated by, including "fat", "healthy", "unhealthy", and "laborer". These are complicated tendrils to attempt to order as a coherent narrative.

I've shown that parenthood can interfere with one's ability to adhere to WLS guidelines, and also that it can likewise serve as motivation for the pursuit of WLS, as in the case of Ruben who wants to serve as inspiration to his children or of the many women who felt that the only way to perform the physical labor of motherhood was through the drastic weight loss produced by WLS. The roles of "weight loser" and of "mother" seem, if not entirely incompatible, certainly abrasive to one another.

These findings support the existing scholarship showing that the labor mothers do is largely invisible. The daily activities of motherhood often sideline a mother's own needs. Mothers sometimes respond to this by sublimating aspects of their own needs so that meeting them can be accomplished in the same stroke as meeting their children’s, an uneasy compromise to say the least. The broader scale activities of motherhood – namely, social reproduction – are often harder for mothers to explicitly attend to, though these mothers generally *do* show evidence of commitment to them, even if they are not noticing they are doing so.

## 3.3 Daughterhood

While most of my interlocutors' motherhood was not central to their depictions of themselves, for several of them, their daughterhood was.

Most remarkable of these was Erica, an accomplished businesswoman who sought surgery while at such a low weight that she had to deceive the doctors by hiding rolls of quarters in her pockets to even qualify for the procedure. Erica's mother was housebound due to high body weight by the time she developed severe kidney problems. Erica reported that no nursing homes would admit her mother due to their inability to provide nursing care to bodies over a certain size. Throughout her life, Erica garnered resentment, anger and even obstruction from her mother in her own weight loss efforts, dating back to her teenage involvement in Weight Watchers. Her mother thought Erica’s participation in Weight Watchers was foolish and a waste of time. Erica believed her mother saw Erica’s participation in Weight Watchers as being a comment on herself; Erica’s mother believed she herself was implicated by *Erica’s* own desire for weight loss. At times, Erica expressed sadness at her mother's passing and the indignities leading up to it; at others, shame resulting from association with a mother so obviously transgressing social norms; and at others still, fear that she would experience the same things her mother had. This fear particularly seemed to manifest not in her own body weight but her own (in)ability to lose weight. She never described her own fatness to me, only her experiences of lost weight or unchanged weight in the face of restrictive dieting. Again and again, she pointed to this struggle, this failure as the thing that needed to be rectified. The deception she described at the medical appointment to determine her candidacy for WLS provides the most obvious evidence of this; she knew her weight was not transgressing bodily norms far enough that mainstream medicine would label it in need of its intervention, yet she was convinced there *was* a problem to fix. That problem was her weight's intractability.

Erica has four stepdaughters she has participated in raising since their childhood. When I pressed her to talk about how all this fear and all the strife in her relationship with her mother affected her own mothering, she was untroubled, almost uninterested, eventually offering only that her stepdaughters had no weight problems, that although overweight, they could lose weight whenever they wanted. We see here again this idea of the mutability of weight as more important than the weight itself, this time extended to her daughters.

Other women discussed barriers posed by their mothers to their weight loss, but these barriers worked in very different ways. Amy, a nurse in her thirties who had lost a tremendous amount of weight following WLS, calls her mother her best friend and describes her as being generally very supportive of her weight loss, but prior to surgery, her mother’s intense fears about the danger the surgery posed to Amy prevented her from supporting Amy or her decision to get WLS. Amy experienced this as a heart-breaking disappointment. (She notes that after the surgery and her subsequent weight loss, her mother came around and now boasts of her daughter’s WLS-driven accomplishments.)

Star’s mother recently moved back in with her and her teenage children and does all of the household’s cooking, something that theoretically could provide support for Star’s post-operative eating, but her mother doesn’t plan meals around Star’s unique dietary needs. Further, Star experiences the requirement that she financially support her mother to be a significant burden.

Laura and Pam both had mothers who they indirectly said played a significant role in hindering their ability to eat mindfully or dietetically through the mother’s dysfunctional relationships to food during their childhood years. Both of them continue to feel this influence strongly in their lives today, Laura relating that she doesn’t perceive food as a part of parenting in any way, and Pam implying she had no choice but to take on the role of “parent” early, quipping dryly that, “I separated my parents from parenting. I was like, ‘Okay, that’s not a job you’re up for.’”

## 3.4 Other Relationships

At some point in my interviews, I observed that the most frequent way family roles appeared in our conversations was when mothers described having to cook two or more separate meals at a time to manage conflicts between their family's appetites and their own nutritional requirements. After making that observation, I brought it up in future interviews, and most informants confirmed energetically that this was a common occurrence in their household. One person described it as doing more “short order cooking” than meal production.

Star talked about this pattern in her household, saying her children would never eat the things she does. Star probably had the most extreme dietary restrictions I encountered, having an exceptionally limited capacity that results in meals consisting only of protein from meat (slightly less than the large amount prescribed for her) and a modicum of vegetables. Eating sufficient vegetables is necessary to alleviate some of her chronic and severe constipation, yet she only has enough room in her digestive tract to consume them if she omits some of that prescribed protein. Star unequivocally told me she does not cook. She dislikes cooking and, even prior to surgery, found that it puts her off wanting to eat at all. Speaking of how cooking impacts her appetite, she said with subdued disgust (and no further elaboration), “It’s like, you smell this, you smell that.” She had required her stay-at-home boyfriend to do the cooking until her mother moved in, and she subsequently broke up with him (explaining to me that she could only support so many people). Her mother now does all of the cooking even though she routinely makes foods that are either unpalatable to Star or impossible for her to eat.

The mothers of young children whose conversation I was invited to attend all shared that they experienced pre-operative eating as a form of suffering. This took different forms for them, whether that was fear of not having enough to eat, obsession with food, inability to feel in control of their food choices, disappointment at not being able to modify their eating enough to lose the amount of weight they wanted to, or dependence on food as a tool for emotional management. They also had in common that their partners were long-term “normal weight” individuals with no direct experience themselves of food suffering. None of them expressed frustration at that fact, but they did describe other food- and weight-related frustrations with their partners. They all expressed exasperation at their partners’ apparent ease at losing weight when they attempted to do so – and sometimes even when they didn’t, describing how they swore they could see a difference in their partners’ physiques after a mere forty minutes of yard work. This was exacerbated by the fact that all of their partners had been or were currently on testosterone injections, something to which they attributed much of the dramatic weight loss and muscle gain.

For others, the intractability of their relationships and their changing relationships to food proved insurmountable. While Ellen did include her divorce as a component of her weight loss story, she framed it more as an element of a personal growth narrative.

For several of my interlocutors, including Ellen, they struggled throughout our conversations to say whether the changes they identified in their lives were the result of the WLS or of the mental health counseling they began participating in at the same time. Maggie, as you may recall, also experienced the dissolution of a relationship in conjunction with her WLS. So, it is not necessarily the case that WLS produced these changes for them; it is equally likely that these changes led to WLS. Both possibilities warrant analytic consideration.

Deirdre and I met on a cold, gray day in February in her Cape Cod home. She lived alone in a pleasant, mostly sterile home, and we sat by a picture window under that dull sky as she described a social life so lively I envied her. Deirdre pursued WLS after many years of very gradual weight gain. She attributes this gain to her use of food as a tool to cope with the pain of her unintentional childlessness. She was widowed young, in her late twenties, and her second long-term partner was a man who did not want children or marriage, but with whom she spent many years under the assumption he would eventually change his mind. She spoke evocatively of the serious grief – "the pain of not (having) the joy of having children" – this caused her over about two decades; she only found relief from it after sustained counseling that she initially entered as part of the WLS pre-operative requirements. Once those requirements were met, she found counseling useful enough that she continued of her own volition. Did her eating become easier because of that relief or because of the surgery? She gives substantive credit to both, making it hard to draw clear lines of meaning about motherhood, food, and weight from her experiences.

## 3.5 "Failed Mothers"

While my interlocutors had varied relationships to the role and concept of motherhood, I propose that what is universal to them is they are all constructed as failed mothers *to themselves*. The primary duty of a mother is nourishment, so much so that the nursing mother is one of the most iconic representations of motherhood. Once children have grown beyond the nursing stage, the creation of palatable family meals remains a central function of motherhood. So, too, are mothers responsible for maintenance of the family's healthy, normative bodies and production of future disciplined citizens (Mink, 1996). By virtue of the "obese" diagnosis, each one of these patients has been marked as incompetent at feeding themselves and as failing to fulfill those disciplinary duties of self-governance requisite of modern citizens (Tischner & Malson, 2012).

WLS thus serves as a means of redemption for these failed mothers. It implicitly offers a biomedical explanation for their failure as opposed to a moral or political one. In the biomedical ideology subscribed to by my interlocutors and by the healthcare industry, WLS is understood to enable those who've undergone it to eat differently, thus redeeming those who previously failed at self-feeding and self-care by virtue of producing in them new, morally correct behaviors. Their newly slim bodies are perceived as visual evidence that they are now compliant, disciplined, and moral.

Once redeemed, WLS recipients are celebrated both as new mother and new child in the educational materials about post-operative life that are provided to them. One WLS patient guide closes with "A Final Word", a short paragraph meant to inspire a struggling dieter. It opens, "Congratulations on giving this wonderful gift to yourself," and goes on to assure patients that, "It is a wonderful world waiting for you" (Martin Memorial Center for Bariatrics and Metabolic Surgery, n.d.). In another patient guide, this one a set of dietary instructions, patients are advised among other helpful hints to "Chew! Chew! Chew!" in phrasing that is redolent of how one would speak to a recalcitrant toddler. (The WLS recipient whose copy of these instructions I viewed had scrawled a firmly underlined "NoNos" at the top of one food list, again relying on the register of a parent addressing a toddler.) Some of my interlocutors mirrored this discourse in their conversations with me, describing their post-operative habits in a tender near-baby-talk. Others play the role of stern disciplinarian mother to themselves now. Star adheres stringently to a daily diet of nearly ninety grams of protein and a modest amount of vegetables. When she reflected on other WLS recipients she has known, she asserted that she cannot understand why they struggle with the effects of the procedure, pointing to her own strict adherence as explanation for her confusion.

Additional support for the idea that WLS recipients are depicted as childlike can be found in an extensive promotional video for a WLS program. The featured post-WLS patient talks about herself in the register of a bashful child who did wrong when she knew she shouldn’t. (She speaks in the plural here because she is discussing how her whole family’s eating habits changed along with hers.) “Not only do we have different foods that are in the house, we look at it differently: How is it going to work in our body? Do we need to move in order to eat something different? ...um... Or is my portion too much?" (Maine Medical Center, 2012) As she delivers this line in a soft, tentative voice, she is shown ducking her head and peering up at the viewer in the classic pose that evokes innocence and shame.

What these constructions all share is a clear divide not just in the pre- and post-operative status, but in the depictions of the subjects as the feeder and the eater, the mother and the child.

There are other mechanisms by which WLS aspirants (pre-operative WLS patients) are constructed as children. One of these is the rendering of fat bodies as sexless, akin to a child’s. Mainstream discourses construct the fat body as lacking both a gender[8] and a sexuality (LeBesco, 2004). WLS thus “matures” the body by moving it from a sexless state into a sexed one, that is, now sexually desirable and appropriately performing gender. In this regard, female patients’ failed motherhood is rectified by rendering them merely *potential* mothers (that is, bodies that are socially constructed as acceptable for biological reproduction).

Another is the heavily evoked notion discussed earlier that a fat person is unknowledgeable. This appears in the messages communicated to WLS aspirants pre-operatively, in my informants’

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[8] Evidenced most evocatively by the frequently used anti-fat epithets “it” and “thing”.

self-descriptions, in general public health and anti-obesity messaging, and the cultural discourse around the “obesity epidemic”. A primary characteristic of children is a general lack of knowledge. One of the key markers of coming of age – particularly in the United States where the start of adulthood is strongly associated with the conclusion of secondary education – is successful attainment of sufficient knowledge.

The most overt example, however, lies in the explicit instructions patients receive about how they should eat during the post-op recovery period. As previously described in chapter one, the post-op period imposes phased eating guidelines that have patients gradually progressing from a clear liquid diet up to a relatively “normal” diet. Some of my informants took to this schedule religiously, utilizing apps that allowed them to click every time they took a bite so they could be alerted when the next bite should occur or pressing close family members into service to time their eating.[9] This prescribed pattern of eating closely mirrors new baby recommendations: the phased expansion of texture and diet variety and the regimented feeding schedule. The post-WLS patient is instructed in self-feeding very much the way a new parent is about their newborn’s diet. One could also read this recovery period of progressive de-infantilizing as the liminal space in which the surgery is still doing its work of transforming the child-patient into an adult-weight-loser.

In another testament to the perception of pre-operative childishness, my informants frequently express shame or bashfulness in describing their pre-operative selves, performing public confession to atone for their faults. At the same time, they mimic the wise and benevolent countenance of a good parent as they speak about their current decision-making and eating.

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[9] This timing served both to limit the frequency of eating and drinking and ensure it is happening often enough to provide sufficient quantities of needed nutrients.

Pam directly addressed the idea of taking on a parental role towards herself subsequent to WLS, describing her post-operative eating in parental terms. “Any time that I am placing some sort of boundaries around my behavior, I sort of feel like I'm acting as my own parent.” She clarifies, “In a very loving way, not as an authoritarian parent.” She describes her parent self as a “part of my consciousness” that has a narrative consisting of, “I have been through this, I have more information than you, and I know what the right decision is for you.” She struggles between a childish self who does not want restrictions on what she eats and a parental self who speaks from a place of wisdom and experience in crafting these restrictions. But she also experienced her new parental self quite literally in the early stages of post-operative eating. “The physical sensations very much felt like I was learning how to eat again. Or like a brand-new baby… I'm literally eating baby food.” When Pam discussed this with Laura, both of them pointed to their own parents’ insufficiency at feeding them. Pam portrayed her response to that as a kind of reclaiming of what parenting might mean with regards to food, whereas Laura has wholly divorced the ideas of parenting and food from one another. While she couldn’t see any resonance between that framing and her own experiences, she expressed heartfelt appreciation for Pam’s parental take on eating in post-surgical life, saying “I like the notion of, ‘I’m going to parent myself in a way that I was not parented. I’m going to make these decisions based on what I want to do and how I want to parent myself.’”

This “redeemed mother” construction functions to define adulthood and limit fat individuals’ access to it, and it is also one of several ways that a temporal framing is applied to WLS. In order to embrace biomedicine as a solution or option, one must accept that the course of a human life and the pursuit of health both work according to a linear progression. Illness is followed by intervention, which is followed by a slowly increasing state of bodily normality. An illness once arrested will not normally recur. “Before” pictures and “After” pictures will never become reversed. Without tenets like these three, biomedical intervention couldn’t be seen as solving a problem. Promotional material for WLS is rife with imagery, language, and stories that promote a deterministic view of medical treatment, and patient education materials create immutable timelines for preparation and recovery diet & activity schedules. I explore additional temporal framings more deeply in later chapters.

## 3.6 Conclusion

Mothers shoulder a disproportionate amount of household labor and much of that labor is made invisible. WLS brings with it unique labor requirements (such as specialty meal preparation and, particularly in the initial post-op stages, the labor of learning to consume food again). This means that the demands the roles of motherhood and WLS recipient place on a mother’s time can come into conflict, sometimes irreconcilably so.

Mothers are responsible for the reproduction of health ideologies. They must role model proper health, they must teach children to *do* health, they are held accountable for unhealthy children.

# 4. Knowing, Showing, & Not Showing

Maggie, the former hopeful mother in the last chapter, sees her WLS as one part of a massive sea change. As a very young woman, she describes herself as unthinking, passive, and hopeless, and believes her socioeconomic and geographic positions enforced those conditions on her. WLS and motherhood were her final attempts to work *within* that frame of herself and the world, and when they still failed to bring her any happiness or self-actualization, she experienced a dramatic disruption she described to me as, “I'm gonna be the fiercest, loudest, queerest, weirdest, Paganest, feminist, crazy fat woman you've ever met.” Maggie now holds a bachelor’s degree and lives two states away from where she was born, both circumstances she would have considered impossible at the time of her WLS. Her formal education along with her personal knowledge about weight, behavior, and politics were major contributors to her ability to make this transition.

Knowledge is a key tool for understanding how WLS accomplishes its work as a sociocultural object. Knowledge takes on four different forms in the WLS arena that are of particular interest for this study.

The first form of knowledge that we see in this arena is in biomedicine’s enactment of a knowledge-based hierarchy where change is effected and status is attained through deployment of knowledge. WLS recipients are thus strongly impacted by expert knowledge and the politics and problems that surround it. The logics of biomedical institutions depend on credentialed experts (physicians or surgeons) serving as the source of knowledge, attending to a set of subjects to whom that knowledge unidirectionally flows (Lupton, 2012) and who are thus constructed as non-knowing and non-expert. “Knowledge” is a means in the arena of biomedicine for subjects rendered powerless and irrelevant to re-stake claims to personhood and agency. A variety of maneuvers[10] that render those subjects knowledgeable enable them to make shifts in their power relations that may produce that agency and construct them more fully as persons.

The next form of knowledge is its use in altering the access that individuals have to power *outside* the biomedical arena. These are intentional maneuvers made by WLS recipients. The fat individual must appear to be knowledgeable in order to make claims of agency and subjectivity. This unjust logic is a key component of fat oppression. As such, it influences the decision to pursue WLS. Access to power is also an effect of weight; because of the social stigma associated with high body fat and the construction of such individuals as unknowing and out of control, fat individuals have less access to power. Often, status in one of these areas can be substituted for the other. One who is implicated by the label "obese" and wishes to re-gain some amount of moral worth can stake such a claim by virtue of being well-educated about "proper" eating.

Third, as illustrated in my interlocutors' statements throughout this chapter, knowledge is deployed as a tool for WLS recipients, one which they believe enables them to alter their behavior, appetite, will, or weight along with their conception of those things. My informants don't just change what they eat, they "learn" to eat differently; they don't for the most part have desires for food, but instead make decisions about it.

Finally, the experience of WLS produces unique kinds of knowledge among its recipients, some of which are key to how WLS does its sociocultural work, including knowledge about appetite and will. With this form, I refer to knowledges external to the biomedical arena, those which do not fit a biomedical frame for eating, health, and the body. I see this as a fruitful production of knowledge. Here, knowledge is not deployed but used to increase WLS recipients' agency. In the previous chapter, we saw instantiations of "will" in the ways that informants

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[10] These include online research and formal education.

experienced and grappled with their appetites. "Knowledge" is another tool by which appetite is conceptualized and managed.

This chapter will explore each of these four forms knowledge takes on in the WLS arena. Section one will consider the power relations and discursive construction of knowledge in healthcare spaces, particularly as regards fat patients. Section two looks at more general power relations as influenced by fatness and knowledge. In the remaining two sections, I then discuss ways "knowledge" works *for* WLS recipients and finally consider what kinds of knowledge WLS recipients are themselves producing.

## 4.1 Knowledge in Bariatric Healthcare Spaces

The structure of mainstream obesity discourse means those labeled "obese" cannot be knowledgeable. Public health efforts to address the "obesity epidemic" consistently rely on education components, suggesting that fat bodies are the result of ignorance. Neoliberal pleas for sympathy for the abject fat individual likewise depend on an ignorant subject deserving of understanding, since someone who willfully and knowingly transgresses makes for a poor target of sympathy.

The unknowing fat subject is reified by biomedical reliance on an expert medical-care-provider with care-recipient subjects. If ever the patient were constructed as knowing, both the hierarchy and the logic of institutionalized biomedicine would collapse. WLS is a unique arena for exploring how knowledge, social status, and power interact to produce and reify fat-based oppression because it is the only medical procedure where the patient population is – by definition – entirely fat. Providers are now tasked with caring for people who are doubly marked as ignorant and unworthy.

### 4.1.1 The BMI: Establishing the Fact of "Obesity"

A diagnosis of "obese" is delivered by determining a patient's BMI and evaluating what range it falls in. Body Mass Index, or BMI as it is almost always known, is calculated by dividing weight in kilograms by height in meters squared[11] (and is thus measured in units of $kg/m^2$). "Normal" BMI ranges from 18.5 – 25, and BMIs above this are categorized into one of several levels of "overweight" or "obese". This number allows for the construction of obesity as a measurable, scientific, and physical condition, shifting the act of diagnosis away from classification as an art, the art of formulating an opinion of someone's corporeal makeup based on his or her appearance. Its formula, simple to understand and calculate, makes that "science" available to a broad swath of non-experts. BMI is thus special among patient metrics in its ability to enhance the technoscientific expertise of biomedical practitioners while simultaneously expanding lay access to technoscientific claims.

#### 4.1.1.1 Shortcomings in Expert Use of BMI

Ruben aborted his first attempts at obtaining WLS after a deeply off-putting interaction with a bariatric surgeon. The two struck up a conversation while riding in the elevator after a seminar for those contemplating surgery. Ruben, a 486-pound, 6-foot-1 man at the time of this conversation, asked the surgeon what his BMI was. The surgeon pulled a calculating wheel out of his pocket, then glibly pronounced Ruben's BMI incalculable because the wheel didn't go that high, offering instead his own rough estimate of 65. As an editorial comment, he added that his liability insurance would preclude him from operating on Ruben. Ruben was furious, not just at the time, but even when relating the tale to me ten years later, the sorrow in his eyes and the shame

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[11] In the U.S. where the metric system is less common, the more well-known formula is 703 times the result of dividing the square of the height in inches by the mass in pounds.

and anger as he sputtered and struggled to even form the words he spoke to me were unmistakable. "I walked that day. I was so – I thought that was so, so- I said, 'Then why you think I'm going there for?!'"

Despite his substantial physical form, Ruben was rendered insignificant in this interaction, so worthless to the biomedical system as to not even be redeemable. This is akin to the phenomenon Gailey highlights among fat women, that of *hyper(in)visibility*. By this, she refers to the unique status of being simultaneously invisible (irrelevant in, for instance, design considerations, the dating world, and overall depictions of "woman") and overly-visible (that is, a bodily spectacle, as evidenced by the use of fatness as visual humor or television news obesity-scare-piece illustrations). For Ruben, too, he occupied enormous physical space and, through his emotional interaction with the surgeon, psychic space, yet he literally did not exist for the designers of the calculating wheel.

In addition to the deep personal harm done by the possibility of the BMI's use to reduce a human being, I see another phenomenon at work here that is worthy of discussion. There seems to be a professional fascination with the process of BMI calculation, one so substantial that it can preclude critical thought. The surgeon ultimately answered an implied, underlying question when Ruben asked for his BMI, namely that of, "What is the significance of my BMI to you?" But he only turned to the underlying question when his technology failed to enable him to engage in the BMI process.

Quite some time prior to this research, I was engaged in a project to produce an electronic medical record for use by psychiatric and social work staff. A very small and straightforward component of this project was to record the BMI of each patient. I probably had between a half dozen and a dozen conversations about the collection of BMI data in the course of this project.

Initially, the collective opinion was that clinicians should record a height, a weight, and a BMI in the electronic record (citing the fact that this was the paper-based process in use at the time). It took prolonged and intense discussions with two technical staff tasked with implementing this EMR to convey to clinical staff that manual calculation is unnecessary in a computerized system. In follow-up conversations on the subject, every attempt I made to elicit the formula for BMI from clinical staff was met with floundering and, ultimately, failure to produce it, frequently accompanied by references to saved web links to online calculators that they had back in their offices. For these clinicians, this process of calculating BMI occupied immense intellectual space and was of significant value. Although for them, it was the process of *manually* calculating BMI that was the crucial facet of their expert role, they – like the surgeon in the elevator – were nearly at a loss when faced with the proposition of technology that they perceived to be interfering with their expertise.

#### 4.1.1.2 Biomedical Critiques of BMI

The BMI is widely recognized as an unsatisfactory metric by clinical practitioners, fat activists, and research scientists (Burgard, 2009), yet the BMI retains its popularity due to its remarkable accessibility. The core critique of it is that the BMI was designed for use in assessing body mass on a *population-wide* scale. It is a measurement intended primarily for public health research. It fails to accurately classify many bodies and provides insufficient medical information on an individual basis (Bouchard, 2007; Hernandez et al., 2009; Ulijaszek, Henneberg, & Henry, 2013; Wheeler & Twist, 2010).

In addition to contesting BMI as a clinical measure on the basis that it does not ascertain the amount of body fat correctly, critics also disfavor it for not correlating closely enough to the health outcomes BMI purports to allow one to study. Biomedical research investigates both of these sides of the question of the utility of BMI as a measure. While BMI is an insufficient measure of body fat percentage, its continued use is justified by calling it an acceptable rough estimate (Barreira, Harrington, Staiano, Heymsfield, & Katzmarzyk, 2011; Johnson, Chumlea, Czerwinski, & Demerath, 2012; Romero-Corral et al., 2008). BMI also fails to correlate to the same body fat percentages for different ethnic groups and nationalities (Deurenberg, Yap, Van Staveren, et al., 1998).

Several alternatives to the BMI have been proposed, including the waist-to-height ratio (Ulijaszek et al., 2013), the “Body Adiposity Index” (Barreira et al., 2011; Bergman et al., 2011; Johnson et al., 2012; Schulze et al., 2012), “Burton’s Model” (Hruschka, Rush, & Brewis, 2013), inverse body mass index, (Duncan, Mota, Vale, Santos, & Ribeiro, 2012), waist circumference, hip circumference (Schulze et al., 2012), and the “Health Index”, which combines body composition data with personal medical history (Hernandez et al., 2009).

The reliance on a measure that cannot accurately identify body composition, cannot consistently identify body composition, and cannot predict health outcomes suggests an uneasy biomedical understanding of the nature of the “disease” of obesity. Yet those implicated by its diagnosis and those hoping to diagnose it all believe that “obesity” identifies some real corporeal state. This uneasiness allows for an ever-shifting relation between expert and knowledge which positions fat patients such that they are unable to escape the label “unknowing”.

### 4.1.2 Dietetic Expertise

Ellen described the ways her providers construct her as non-knowing. They use othering language around discussing patient behavior. They resist sharing her medical chart offering only “I’m just writing,” to defend that resistance. They treat her observations of alcoholism with head patting and — she remains convinced — absolutely nothing else. And in a story that struck one of the deepest chords with me in the course of this research, Ellen presented a record of her week's eating to a dietitian, who with intense energy and not a little bit of horror, responded, "You see this Reuben sandwich that you had… Do you *know* that corned beef is one of the highest-?![12]" Ellen replied not with disgust or disappointment that this professional would attempt to scold her into a proper level of shame for what she ate last week, but with anger that the dietitian would imply Ellen didn't know the contents of a Reuben sandwich. She related her response to me, "Do you really think I got to be this fat and this old and I don't know that? Do you really think that I don't understand the way food interacts and how much fat is in-?" The dietitian sent Ellen home to repeat the exercise, as if reporting "unacceptable" foods were akin to failing at the task of reporting altogether. Ellen told me she outright lied on it this time, and the dietitian was very satisfied with the resultant document.

The appetite, of course, has gone wholly unmentioned by the clinician, even though it is powerfully implicated throughout this vignette. Is the dietitian ignorant of the appetite? It would certainly seem so when she quickly concludes that the only reason Ellen could have eaten a Reuben sandwich is ignorance of its nutritional content. Yet her professional training could hardly have failed to bring appetitive concerns to her attention.

### 4.1.3 Lay Knowledge Interactions in Biomedical Environments

After we attended a WLS support group together, Tammy described recently post-operative patients to me as know-it-alls, telling me at least three times that what they needed to but failed to do was listen (and on one occasion she also added "read" to that prescription). Specifically, she said they didn't understand how unpleasant the digestive symptoms would be or what they would

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[12] In both this and the following quote, Ellen left the end of her sentence unspoken as she expressed intense exasperation, suggesting no further articulation of her point was necessary.

feel like (which the longer-term WLS recipients did know) and especially that their appetites would change, and they should stop depending on a consistent, predictable future appetite. (She depicted these appetite changes as resulting both from surgery and from an occurrence common to many specialized diets of overindulging in one food product when it is the only one you find palatable that also meets your nutritional needs. She harped on this point, that all the foods and products the newcomers were describing enthusiastically and purchasing in bulk would become repellent to them eventually.) Yet I was left with the impression that Tammy's desire was not to better inform newcomers but to maintain structures of social hierarchy. She rarely offered advice or posed questions to the group at large, participating only through side conversations and undirected comments tossed into the fray during periods of significant cross-talk. When she confided her concerns about newcomers' unwillingness to listen, there was an element of distaste, almost of impropriety. She observed the transgression of a social order.

I interviewed one of those newcomers, Ruben, later. He seemed entirely guileless about this newcomer / old-timer division of Tammy's, and responded to my questions about his support group by saying sincerely that he liked support group because it gave him good advice. I inferred from his tone that it would be almost silly not to embrace such an opportunity. Both Ruben and other support group attendees I met saw the group as centered on knowledge. Ruben sees it as a good source of knowledge, other newcomers described themselves as there to receive knowledge, and the experienced attendees like Tammy participated solely by delivering it. No other forms of power seem visible to them.

We can observe here a relative re-positioning of their lay knowledges. Tammy attempts to articulate and reify her knowingness as a means of access to power *relative to* the wholly unknowing newcomer. Ruben, just such a newcomer, in turn is blithely acquiescent to said expertise.

### 4.1.4 Conclusion

Knowledge can be wielded like a cudgel by unthinking biomedical practitioners, as in the case of Ruben's elevator encounter with a thoughtless surgeon and Ellen's condescending dietitian. For some, adopting those biomedical discourses of knowledge allows for a pre-emptive response to the threat of such an encounter, establishing a surer position in a knowledge hierarchy. The establishment and reification of power relations within biomedical discourses is the first of four forms of cultural work done by knowledge.

## 4.2 Epistemic Inequality

I return now to the issue of mainstream constructions of "obesity" which preclude a knowledgeable, "obese" subject. We see this construction occurring in the messages communicated to WLS aspirants pre-operatively. General public health and anti-obesity messaging, too, conveys the lack of knowledge perceived to cause "obesity". The cultural discourse around the "obesity epidemic" further contributes to such a construction.

My informants' stories show a pattern of shame strongly associated with lack of knowledge. The abject, fat patient – constructed in both lay and biomedical discursive registers as ignorant, abhorrent, and incapable – is a label most would struggle to escape. So, a plausible explanation of this pattern is that there is a logical correlation between shame and anything that might support such a label. A second facet of this shame is that of childishness: confessions and confidences of a lack of knowledge were almost universally conveyed with the verbal and expressive modes of a child. A primary characteristic of children is a general lack of knowledge, and coming of age requires gaining knowledge; adults are knowing and children are ignorant. Also like children, my informants frequently expressed shame or bashfulness in describing their pre-operative selves. The pre-WLS subject as child relies on and reifies constructions of a fat subject as unknowing. This theme is explored further in chapter three.

Knowledge is always a power relation (Foucault, 1980). When Ellen's dietitian asked her scathingly whether she *knew* what was in a Reuben sandwich, she wasn't educating Ellen (an already very well-educated woman), she was *positioning* her. Ellen's failure was not confusion about what she should or did eat, but rather having the audacity to flout dietary recommendations, and the dietitian had to respond to this in order to retain the access to power to which both of them implicitly understood her to be entitled. Ellen's complaint was not about the dietitian's power, it was about her deployment of ignorance as a tool for constructing Ellen as one who does not know. This is what makes knowledge so personal, so fraught, and so felt when healthcare practitioners and "obese" patients meet. It both disempowers and infantilizes.

Maggie was passionate and vociferous about the ever-shifting flows of knowledge throughout her life. Do doctors know through study, or do patients know through embodied expertise? She pushes back against the hegemony of institutionalized medical knowledge, saying:

> *The second you say something like ["You should lose twenty more pounds,"] to me, I have lost all respect for you. Because you're now not giving me your medical opinion. You're giving me your prescribed social construct of me. Like, what you have now interpreted as what my body needs. Which is completely inaccurate.*

Is academia a good source of knowledge? She both refutes and relies on that being the case in one conversation, relating how she argued with a professor in her graduate program when that professor complained about the modern Western diet.

> *I've had so many conversations, being in the [behavioral health] field, I've had so many conversations that: I understand what's going on, and I feel like the asshole in the room for being like, that is not the damn solution.*

Here, she positions herself as a knower through practical, direct, embodied experience. However, as she expands on that classroom discussion and on the broader arguments it ties into, she refutes the idea that weight alone is a predictor of health. Speaking of a hypothetical patient she said, "This person had a family history of high cholesterol, high blood pressure, stroke, heart disease. You're conflating that with their weight. If you just looked at the weight alone, guarantee you'd find different data. I'm like, I've done this research!" Here, she positions herself inside the institutional production of knowledge by relying on "data" and formal "research" to support her claim of knowledge.

Most of all, what stood out about Maggie's use of knowledge is that she defines knowledge in terms of a perpetually shifting perspective on truth: she only ever describes her knowledge in contexts where she is in disagreement with someone else: where someone else was convinced of something she understood to be false, and she offered her knowledge to contradict that claim or where she believed someone's understanding belied a lack of knowledge on their part (as evidenced by her description of it to me well after the fact). This included professors, doctors, classmates, and her own patients. Regardless of the power relations involved, what she valued was the movement of knowledge.

Erica was exceptionally committed to explaining, to knowing. She referenced her online research efforts repeatedly. In one such case, she referred to the work she did to understand the eligibility criteria for WLS. She was able to tell me exactly how much she would have to weigh and at exactly what point in the process of determining eligibility she would have to be at that weight. She told me that, while contemplating the possibility of surgery, she had read the entire post-op diet on a local bariatric surgeon's website; in fact, she was so familiar with the extent of the dietary changes that she found them much easier in practice than expected. She even gave me promotional materials for the nutritional supplements that she sells as a side job and later followed up after our conversation with information about an alternative health practice she has been using in lieu of traditional mental health counseling. She was interested in the process of knowledge production, frequently using the phrases, "what they've figured out" or "what they found out" when telling me about scientific or technical knowledge that she believes will be useful or interesting to me or is relevant to her own experiences. She offers a narrative perspective on the production and circulation of technoscientific knowledge; for Erica, knowledge doesn't merely exist, it has a history, it was produced through a process, the details of which don't necessarily matter to her, but the existence of which is clearly so important that she references it almost every time she shares information.

She also values knowledge as a means for making change and having power over one's body and life. Like Maggie, she often understands this knowledge in contrast to an implicit mainstream discourse. (Her cadence and prosody at the end of this portion are strikingly similar to Maggie's response to those who might believe she eats at McDonald's.) In her case, she is often responding to mainstream conceptions about health and proper eating. This is evident in the following excerpt (which also contains an instance of her use of the "figuring out" construction).

> *People think that, oh, why can't you just diet and exercise and then you'll lose the weight. And they don't realize that, and I think Doctor Jawad - the surgeon that did my surgery - he said it, he said at a certain point in time, the ghrelins in your body, just are - they're sending out so many hormones that are causing your body to store that, that you physically will not be able to lose weight. There's really a biological reason why, once you get to a certain weight, it is nearly impossible. Do people do it? Yes. But, you know, from his opinion, and now they're finding, they're researching that it might be due to different bacteria that you have in your gut… But it makes sense to me why, when people get a certain weight, they can't lose it. And the perception of everybody else is: they're lazy, they've gotta watch what they gotta eat, they have to exercise more. They don't realize that that isn't the case. I've always exercised. I've always been active.*

In her conclusion, she draws a connection between this technoscientific knowledge of hormones and gut microbiota and knowledge of a person's moral worth. We can infer from her general observation that, when she was "overweight", she believed she was perceived as lazy and unwilling to exercise or modify her eating, and that she suspected that her "overweight" body served as evidence of that to others. However, she asserts that such beliefs are untrue, suggesting a lack of technoscientific knowledge about the process of weight gain and loss produced the logical flaw that maligned her moral worth.

Throughout our conversation, Deirdre relied heavily on the notion of "recognition". She doesn't just describe behaviors, she describes the fact that she has recognized them. She suggests something about recognition as a form of self-empowerment. Ellen, by contrast, primarily uses the term to refer to conclusions she's come to with life experience, therapy, or sobriety. Deirdre, who uses the term much more extensively, seems to me to be doing so in order to say, "Here's what I get wrong, but I can see the wrongness." Recognition is also deeply grounded in her eating as she understands it. Describing her decision against other forms of surgery that were reversible or modified the appetite less dramatically, she said of gastric bypass, "I did know that there was a high possibility that I couldn't tolerate foods for the rest of my life, and I would have a physical reaction… I can't go back. So, that's why I chose that. I said, for whatever reason, my brain doesn't know how to recognize when to stop."

There's almost a finality to their use of the term: "I have evolved in x way and recognition is how I know I did that evolution." They offer this process of evolution as a remedy to a kind of static unknowing that is expected of them. Their evolved present selves atone for past failures with this maneuver. It works to put away the mistakes and the struggles and replaces them with enlightened recognition.

## 4.3 Deploying Knowledge

The last two sections have included instances of study participants who used knowledge to do sociocultural work, first to negotiate power relations in the biomedical setting and then to stake claims for an epistemic equality of personhood and moral worth in the broader discourse of the obesity epidemic. Now, I move on to consider more diverse scenarios in which knowledge is deployed within one's own life as a tool. My informants talked at length about their use of knowledge to modify, among other things, their behavior, appetite, will, and weight. In this section, I focus my analysis on those examples relating to appetite, legitimacy, and subjectivity.

### 4.3.1 Appetite

Rhonda and I conversed in her home which contains an indoor aviary with a dozen or so tropical birds. Birdcall provided the backdrop to our conversation as we sat on the couch with her dog and one of her cats. Rhonda, a poised and thoughtful retiree, had the largest weight re-gain of all my interlocutors. When we first met at a WLS support group, she was energetic and cheerful about her renewed interest in weight loss.

When we discussed the history of her appetite following WLS, she offered an eloquent and simple description of the ways our expectations may not be available to us. I asked whether she believed that most WLS recipients think they will be able to expand their diets indefinitely following the surgery. She affirmed that, yes, she did, but then modified her claim, saying, “They think it, but they don’t think it in the mind.” This creates an interesting separation between her experience of appetite and those of most other WLS recipients. She (through unspecified means) is presently capable of consciously and explicitly understanding her appetitive limitations, while others make unthinking assumptions about their appetites.

Deirdre echoed this observation when I commented on how much more severe her post-operative appetite limitations seemed to me than other informants’. She looked thoughtfully away for a moment, then suggested perhaps others failed to notice those changes in themselves. “I don’t know, I don’t know if people would recognize it. I mean, you can get those things down,” she said, referring to the consumption of foods she has lost a tolerance for. Who are these unthinkers, these oblivious others? Why don’t they have access to the same knowledge as Deirdre and Rhonda? I do not suggest that Deirdre and Rhonda are demonstrating any abnormal amount of narcissism; in fact, they both struck me as pragmatic, fair, and thoughtful.

Amy spoke emphatically and with insight about how eating is as much social, cultural, and emotional as it is physical, and thus troubled any possibility of knowing if she is hungry. Ruben worked from a similar idea, saying the lack of ghrelin post-operatively meant you were "not truly hungry", implying the existence of some kind of fake hunger. As I discuss in greater detail in the next chapter, Ruben also alluded to multiple levels of appetitive reality when he described vegetables first as something he had learned to now like and then almost immediately as something he did not currently like.

### 4.3.2 Legitimacy

As you may recall from the literature review, WLS recipients sometimes conceive of their newly slim bodies as their "real" selves / bodies or of their still-fat bodies as belying a true, unseen inner self (Joanisse, 2005; Throsby, 2008). This dichotomy may serve to counteract moralizing discourses about fat.

When I introduced Maggie in the last chapter, I described a particular deployment of the notion "real", namely a suggestion that there are real, inherently valid, unimpugnable facts about the body. No further analysis is possible, suggests this rhetorical move.

Rarely do these invocations rely on the word "real", but instead on an over-emphasis of some other word intended to convey its own inherent realness. This is a particularly auditory move I describe here, and a formulaic one. The components of this move are:

- It is deployed as part of an explanation.
- The speaker pauses briefly before using the term.
- The term is clearly emphasized through articulation, cadence, and an increase in volume.

Alexandra described her thoughts about her own body's readiness for pregnancy as follows.

> *As [he] came into my life, and I felt more like I'm going to settle with somebody; I want to have a family with this person, I would really like to try to bear a child. It was the idea of trying to conceive a child that made me realize that I needed to have a healthier* ***vessel****, that I wouldn't have been able to conceive; I didn't have regular menstrual cycles, and I would not have been able to conceive at the weight that I was at.*

Maggie's physician advised her to lose weight in order to become pregnant as well, about which she said to me, "And it was like, okay, so this is what I have to do in order to get my health to a point where this is even something **possible**." The implication here seems to be that, while fat politics are well and good, the primacy of Maggie's and Alexandra's needs for slimness (a need which results from their desire to reproduce) obviated any political analysis.

Deirdre emphasized the word "physical," telling me first that her ill health made climbing stairs difficult, "You know, one flight, and then another flight to go to the library or the office, it **physically** exhausted me," and then emphasizing the word even more firmly when she explained exercise as a necessary component of weight loss: "But then I was putting it back on, cause I wasn't **physically** moving enough." These were experiences with significant emotional content for her, and alluding to the physical reality of them precluded any alternative analysis of those circumstances about which she had such feeling. Star explained "I did it [WLS] to **function**." It was evident from the delivery that in this case, the decision was *devoid* of feeling, but the desire for an impenetrable logic remained.

All of them intend to quash critique before it starts, and, in my opinion, believe the grounds for doing so are the prima facie accuracy of the logic of their experiences. An unimpeachable truth allows for claims to personhood, knowledge, agency, value.

Going hand-in-hand with this is a move several informants made where they responded to stereotypical charges about their health or moral worth from a fat-hating strawman with descriptions of their rich personhood. Clearly this doesn't address the charge directly, so what they are doing is attesting to some "real" worth, inferring that the charge is *really* against their personhood and pre-emptively fighting that battle.

Clearly, the realness documented by other scholars (Joanisse, 2005; Morgan, 2011) with regard to the "self" is appearing in far more facets of this arena.

### 4.3.3 Subjectivity

Another alternative dichotomy is one that Ellen spoke explicitly and repeatedly about: the body versus the head. For Ellen, the issue is central to her experience of her *self*. Ellen describes herself as having been solely a head – that is, categorizing and responding to the world through an intellectual lens and experiencing her consciousness as residing exclusively in her mind. This was a defense mechanism born of a troubled childhood, one that evolved into a tool she used for defense throughout much of her adulthood, too. During those years, she describes only ever having two perceptions of her body – at times, it was large and thus powerful which also served as a kind of defense mechanism for her. She perceived herself as warrior-esque. At other times, her shame and dislike of her fat body led her to see it as a physical emblem of the terrible person she truly was – a deserved marker. This confirms the existing findings about a real inner self; here, though, she does not use the real inner self notion to justify her moral worth in the face of a morally-flawed fat body. Instead, she offers a variation on the satisfied post-weight-loser; she too feels relief at an alignment between her exterior and her interior, feels affirmed in her conviction that she is unworthy by the way her body accurately attests to her "true" self. She is attempting to respond to a world that sees her as nothing more than her body by offering the other extreme, that she is nothing more than her head.

Star referenced *not* her head, but her *brain* repeatedly. She clarified her decision-making as occurring in her brain, for instance, offering this justification for her choice not to get a lap band: "I think in my brain, after all the counseling, the, you know, hesitation, the articles I read, everyone I spoke to, the lap band was for smaller amounts of weight." It seems plain that whether the lap band is for smaller amounts of weight is a fact here in the world and not residing in merely her brain. When she wasn't directly referencing the brain, she was referring to her "personal opinion" or the way she "saw it".

Both Ellen and Star clearly center themselves in their intellects. Such a construction allows one to mitigate the effects of a marked corporeal form *and* to cope with the damage appearance-based stigma can do over time.

## 4.4 Knowledge Production

Despite the enormous amount of energy and effort that fat individuals have to put into proving adequate knowledge in order to stake claims to citizenship or personhood, this same group is also laboring to produce new and unique knowledge about the phenomenological experiences of eating and self-control. There's a tremendous amount of folk knowledge about weight loss, but there are many, many hopeful weight-losers who are not helped by this. Those portions of my interviews that were less structured and contained more small talk proved to be the kinds of conversations that circle around knowledge, attempting to create an actionable and nuanced understanding of their eating, their decision-making, and their self-control to fill in that gap. I am left with a genuine belief that this repetitive, often seemingly inane conversation is the only way for them or me to get this knowledge that they are hungry for.

It came easily to my informants to convey knowledge about their eating, weight, will, and appetite. This leads me to conclude that they regularly think *about thinking* about these subjects. However, as I address in the next chapter, they were generally very reticent to talk about their family roles; the subject hardly ever came up without prompting. This could suggest they aren't aware of all the knowledge they have about themselves as family members, at least not as much as they are aware of themselves as WLS recipients.

### 4.4.1 Ghrelin

One topic that several informants have previously mentioned in this chapter – which may be novel to readers – is the hormone *ghrelin*. I would guess that for most lay audiences who have not had WLS, knowledge of ghrelin ranges from limited to non-existent. Ghrelin is understood in biomedicine to influence sensations of hunger and satiety. Some of the bariatric surgical procedures alter the production or function of ghrelin, and this is believed to be one of the mechanisms by which WLS produces its uniquely high rate of sustained, intentional weight loss (Cummings et al., 2002).

While many informants understand ghrelin production to be (desirably) impaired by the surgery, they are spotty on how or why, collectively inconsistent in identifying which surgeries impact ghrelin, and widely varied in what they believe has changed about their own physiological appetite system. I don't think I heard the same explanation of ghrelin twice. My informants think a lot about their appetites, both how much and what they *are capable of* or *will suffer for* eating. Yet when we had those conversations, very little of them revolved around ghrelin. It came up more often in backstory, perhaps when I expressed surprise about an appetite change, they explained the surgery as altering or removing ghrelin(s) or preventing their bodies from using ghrelin. What I would expect to hear is that, “I am less hungry because I have less ghrelin,” or, “I didn’t really like broccoli before, so now that I have less ghrelin, I have no appetite for it at all.”

I would offer in contrast a hypothetical novice body builder. When our body builder, suffering from muscle cramps, searches for technoscientific explanations, she is seeking a way of producing greater insight and, ideally, solutions. If she knows her muscles hurt because of lactic acid, she might be able to eat foods that help break down lactic acid, she might be able to massage muscles to encourage lactic acid flow, she might seek out exercising conditions that will discourage production of lactic acid, and she can recognize different levels of pain as correlating to different quantities of lactic acid which in turn connect to amounts of exercise and physiological state at the time of that exercise. Whether or not she uses that information to modify her behavior, she can understand muscle pain purely as an expression of this concept, “lactic acid”. (While there may be those, such as chemists or medical researchers, for whom it is a real substance, likely it will remain a concept for most body builders, both hypothetical and real.) What was previously a base, physical sensation can thus be transformed into a potentially workable concept.

Like “lactic acid”, the concept “ghrelin” creates an explanation for internal phenomena that suggests something quantifiable and tangible to others, even if it is not actually quantified or sensed. However, for my informants, knowledge about ghrelin didn’t need to be actionable or even logical. It was like the fact of ghrelin alone was sufficient explanation for their experiences of hunger and satiety. Their voices often demonstrated wonder or relief when discussing the hormone. It seemed that the existence of a physical and/or technoscientific explanation for hunger and appetite transformed their experiences of it, justified those experiences. One likely explanation for that is that the concept “ghrelin” serves as an antidote to moralizing discourses. A substance can hardly be morally adjudged, the thinking likely goes, so its mere presence works to free the hungry from any responsibility for that hunger. Although the lay person can neither measure nor sense[13] that ghrelin which is in their own or another's body, its existence allows for that possibility, lending legitimacy to otherwise "subjective" experiences; the belief that ghrelin is (a) present in the body and (b) has this function renders the phenomenological experiences of hunger and appetite tangible and measurable.

## 4.5 Conclusion

This chapter has investigated four forms of cultural work performed by knowledge and knowing in the arena of bariatric surgery. Biomedical constructions of knowledge create a scenario in which the existence of a knowledgeable fat patient is nearly impossible – though such individuals utilize a variety of strategies to retain access to some amount of power. Outside the biomedical arena, such strategies can get ever more creative as the breadth of available subject positions increases. WLS recipients nevertheless view knowledge not as an oppressive construct, but as a useful asset both in staking political claims and in the operations of daily life. WLS recipients further create new knowledge to continue doing work for them.

Maggie and I first met in the apartment she now lives in with her wife, surrounded by Pagan décor. Her pink hair and a tiny pet cat with an unsettling voice fulfilled the final component – "weird" – of the post-WLS transformation she described. Far and away, though, the greatest evidence of her wholesale escape from the previous life she believes so nearly entrapped her is the way she embraces knowledge in every facet of her life. She is pursuing a master's degree because

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[13] I refer here to the four senses that western science relies on in constructing scientific evidence. Taste rarely being an acceptable sense for a scientist to utilize in laboratory observation, these are sight, sound, touch, and smell. A case can be made that one could directly observe the ghrelin in their own body via the sense of hunger, but that does not produce data that is readily shared with anyone else.

she sees formal education as a useful tool. But it’s not only education, it is the adept redeployment of knowledge that she makes great use of.

She frequently spoke to me almost as if she was in direct conversation with the mainstream discourse about fat. She often lapsed into accusations or rebuttals against some disembodied “you”. She described herself as not being obsessed with McDonald’s. Saying their food disgusts her, despite stereotypes about her fat body suggesting she loves fast food. “But, if you see me walking down the street, you automatically think I have the golden arches in my eyes.” She expanded on that idea, saying, “We need to change up these dialogs to like really understand, it’s not about: fat people just go around eating everything,” then introduced another indefinite interlocutor with her use of second-person pronouns, “I work thirteen-and-a-half-hour days. When do you think I’m going on– My schedule doesn’t allow for the way you think I live my life, in spite of your every waking thought about me.” I suspect Maggie brings such energy to the task of applying and re-deploying knowledge because it allows her to strongly stake and repeatedly defend claims to her own knowing and, by extension, worthiness.

# 5. The Prosthetic Will in Weight Loss Surgery

I joined Laura, Pam, and Alexandra in conversation late one morning in Pam's kitchen. All three mothers to very young children, they had all had WLS at approximately the same time, roughly three years before this conversation. They have lately found each other to be reliable sources of informal support with their efforts at eating and exercise for health and weight loss as well as, I inferred, grappling with life in a young family.

Two of them had brought toddlers, and our conversation was riddled with interruptions from children wanting to know when they're going home, who gets to pick the next TV show, what everyone is doing here, whether they can have a snack – a seemingly endless litany of reasons to need "Mom's" immediate and urgent attention. Laura begins the conversation by lamenting that she has crushed one of the children's goldfish crackers under her shoe, dirtying Pam's clean floors. (Pam assures us that the dog will make short work of any cracker crumbs.)

Though this scene so far might seem more relevant to my discussion of motherhood, I mention it here because, like the labor of parenting, the will is treated as negligible in biomedical WLS discourses; neither is a problem for medicine at all, despite the fact that it's an intricate part of how parents eat and otherwise care for themselves.

While Laura was attending to a toddler-related exigency in another room, Alexandra and Pam compared their partners' respective propensities for bringing calorie-rich and highly appetizing foods into the house: Pam's partner favored chocolate-covered coconut-covered almonds and Alexandra's, Pop-Tarts. For both of them, this causes a strong desire to eat Pop-Tarts and candy, even they also want very much to adhere to a diet that proscribes these foods. Alexandra said, "And I just see them. I see them. And they call to me. I don't eat them, but I really want to. So, every day I'm exercising control to not eat the Pop-Tarts." Pam had been unsuccessful at resisting her partner's candy, so they came to a compromise she expressed great skepticism about: they now keep additional candy in the house that she prefers so, when she eventually succumbs to her desire for candy, she at least won't be eating the chocolate-covered coconut-covered almonds.

This was a problem not just of exposure to these particular foods but the varying resentments that came up around who ate or finished what food, how a couple collaborates on weight loss or other behavioral change, and also the tremendous drain it put on their resources – unseen by these same partners – to repeatedly choose *not* to eat this food they could very well have eaten.

In this chapter, I investigate how will appears in my informants' narratives of their eating, weight, weight loss, and medical & surgical experiences. I next investigate how will relates to appetite, and I then move on to look at a particular effect of WLS on will, that is the use – sometimes excessive use – of alcohol. I explore the meanings of the behavioral health arena, one in which issues of consumption and addiction are often situated. I conclude by offering an alternative framework for behavioral change drawn from the expertise of several of my informants.

## 5.1 (Not) Talking About Will

For a broad variety of reasons, the institution of bariatric medicine ignores the concept of a human "will". Many of these reasons are elucidated by Valverde in her analysis of alcoholism as a disease of the will (1998). In part due to Victorian perceptions of science as at odds with philosophical considerations such as theology and the law, the will has never been wholly appropriated by science, thus may be unavailable to medicine or perceived as irrelevant to medical aims. Modern medical notions like "risk management" depend on probabilities and effects, thus eliding any interiority where "will" is located. Alcoholism, one of the conditions most implicated by discussions of will, has been historically unique in the way that medical debates about the subject question less whether it is a disease than whether it is a valid medical issue (Valverde, 1998). The introduction of WLS as a treatment shifts elements of "obesity" into this same territory: medicine is ambiguous about whether over-eating is within its purview, whether the will is, whether failure to lose weight while desiring or intending to do so is a medical problem. Simultaneously, WLS undergirds medicine's case for "obesity" as a medical condition, thus preventing the same contention surrounding alcoholism in medical discourse regarding its validity as a medical issue.

Bariatric medicine's existence is predicated on overweight being a medical condition that medicine can fix, thus the solutions offered by this institution do not address the will. Yet it would be reckless to claim that one's will is not brought to bear on matters like changing one's diet. Will permeates the conversations I've had with recipients of WLS, yet rarely comes up explicitly.

For instance, Sara, a gentle and timid woman, demonstrated a remarkable history of imposition of her will. She demonstrated tremendous perseverance in adeptly surmounting hurdles to her goals. She had withheld a history of Anorexia Nervosa from the psychiatrist who screened her prior to surgery out of a firm belief that this would disqualify her for surgery. This came up in our conversation because she experiences an incredible tension between her desire to continue in her recovery from Anorexia and to keep her weight to a reasonable level. I commented that her dilemma sounded difficult to an extent I didn't think I could comprehend. She acknowledged nothing about the incredible will she obviously brought to bear on her problems as a matter of course (nor did she do so at any point in our conversation), instead responding to me only by saying, "You just did it, though, you just did it. It's like, you didn- You can't control it. You just do it." This suggests that to even see this as her will at work opened up too much possibility that her will could falter.

I posit that this silence is the result of some internalized moralizing, a desire to avoid addressing one's areas of "failure". Perhaps recipients of WLS have bought into the biomedical denial of will. Many of my informants demonstrated a strong desire to obtain and demonstrate institutionally-sanctioned knowledge about WLS and its effects. Since "will" doesn't exist in the institutional vocabulary, it has ceased to exist in theirs.

One of the causes of this silence is likely shame. As discussed in the literature review in the second chapter, the fat body is abject (Murray, 2008). Throughout these narratives are traces of disgust with fat bodies (as there are throughout all mainstream discourse). A "successful" weight loser is now in Goffman's terminology no longer discredited but discreditable, a shift that brings with it the burden of identity management. Every social connection, every interaction, poses a risk that a slim WLS recipient will be outed as formerly fat and/or someone who "resorted" to WLS, that is, could not do it alone (a prospect much reviled by contemporary mainstream bootstrap-pulling America). For everyone with whom I discussed the topic of disclosure of their history of surgery, the subject was emotionally and intellectually fraught. Many had no firm stance on the issue, but none of them were blithe or neutral about it. Such an emotional charge would be consistent with shame. If a history of struggle with one's own will opens the door to charges of moral failure, it would make sense to avoid the very topic as one means of avoiding being discredited.

Indeed, all actors in this arena are doing ample work to avoid talking about "will". One of the phrases I heard over and over in this research was "tool". Multiple people offered up – seemingly apropos of nothing – that WLS was *merely* a tool. "Tools" are popularly understood as one of the few things that set us apart from other animal life on this planet; they suggest an intelligence, a cunning, and a practical application of those skills. Perhaps there is some hint that those who have gotten WLS had the cunning to procure and use this tool. The term is also strongly associated with work, emphasizing not just that WLS is functional and useful like a tool, but that there is so much effort put into using it. People who have WLS are industrious, this analogy says.

One reason for the popularity of this analogy is its use addressing a fear common to many WLS recipients: that they will be perceived as “cheaters”. This is another form of the identity management I described above. One of the nurses I spoke with described the possibility of WLS being “the easy way out” as a common pre-operative concern WLS aspirants brought to her. Pam told me of the sanctimony with which some of her relatives reported their *non*-surgical weight loss to her, implying their accomplishment was superior to hers.[14] The case being made against them is that, if there was insufficient suffering, the weight loss was illegitimate. Yet WLS is rife with suffering, as I’ve shown throughout this text. The claim really, then, depends on a shift in the form of the suffering. The will has been propped up by way of an altered digestive tract and the suffering rendered physical and no longer moral. This logic supports the idea that WLS is understood by many as a prosthetic, and it reifies discursive constructions of overweight as a moral and not physical problem. That is, if you did not grapple with your will, you have not overcome your moral failings.

Ruben and I spoke the most about his experience of food preferences, because he seemed open to that conversation; he frequently reported voluntarily about his tastes and preferences and how they’ve changed since surgery. He told me he had learned to eat and like vegetables as a result of his WLS. I asked specifically how he did that, and he offered me a detailed, step-by-step answer including things like reading books on healthy eating and what foods he eats more of now, but

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[14] Pam wryly observed that her weight loss had proven longer-lasting than these same sanctimonious relatives.

when it came to the actual question, “How do you change what you like to eat?” he didn’t answer me. In fact, his concluding comment at the end of that litany, immediately following a list of vegetables he now eats, was “Now do I like it? No.” It seems that notions of what he “likes” or even what it means to “like” something are somewhat fluid.

This is an example of something I note frequently in how WLS recipients describe their lives: a slippage between those effects that result from surgery and those that result from the lifestyle change they engage in as a means of complying with medical instruction related to the surgery. Here, it seems unlikely that a food that is much more difficult to consume and digest after surgery would be more enjoyable as a result. However, the forced exposure to vegetables produced by a regimented eating plan does seem like a reasonable explanation for changes in the palate or in food preferences.

Deirdre had nothing to say about the exercise of her will over food except by implication. At the time of our conversation, she identified the biggest barrier to her weight loss as her drinking. Following an initial 108-pound post-operative weight loss, she had more recently gained 28 pounds. She found that the particular inhibition that alcohol removed for her was her restricted eating. She attributed all of her weight gain to eating that occurred following consumption of a bottle of wine or more. This conceptual pairing meant that she could express a lack of concern both for her drinking (which was only a problem inasmuch as it led to weight gain) and for her ability to restrict her eating (something she didn’t struggle with at all when sober).

Maggie found her surgical preparation disappointing in its failure to address any of the phenomenological aspects of the experience such as the will. When I asked her about how she thought her eating would change after surgery, she said, “…what you're told is you'll eat smaller portions, and… that somehow that would correlate to a different relationship with food, and… but

I don't know what I expected as, like, a relationship with food. Because they don't really talk about the emotional content. It’s the quantity. It’s like, ‘As long as your body fits a socially acceptable mold, we don't really *care* how you feel on the inside.’”

## 5.2 Eating & Appetite

The task a WLS recipient faces – at every stage from first contemplating surgery to pre-surgical preparation and through the duration of their post-surgical life – is grappling with food. In most situations I encountered, WLS recipients desires to engage in that task at the same time they loathed or feared it. For most of my informants, food and eating prior to surgery was fraught. Many described experiencing their eating as problematic in some way: a source of obsession or shame, a feeling of being judged or perceived as abnormal by others who observed them eating, a desire to binge eat or eat secretively. Almost all had experienced the frustration of unsuccessful attempts to lose weight via eating modification. The drastic dietary changes immediately before and for many weeks after surgery pose a paradigm shift in the nature of “food”, “meals”, and “eating” that center food and food obsession in everyday life for even those eaters who would previously have been considered the most stable or rational. It is here, where we suffer, desire, seek out the limits of our capacity for change that the will is most relevant to this discussion.

It would be hard to speak meaningfully about food and the will without considering the appetite. Appetite as it is addressed throughout all of my empirical materials is limited to only two facets: out-of-control consumption (something I’ve been offered little direct evidence of, but which is implicit at all times) and post-surgical nausea, particularly specific nauseating foods. This is in contrast to historical notions of appetite which are far more varied. For instance, one early twentieth-century magazine advertisement for Grape Nuts cereal included this confession: “About three years ago my appetite failed me and my food disagreed with me. I got weak, nervous, and dull and entirely unfit for business" (Valverde, 1998, p. 63). This seems to suggest in part that the speaker lacked the appetite to consume sufficient food, but it also suggests a failure to crave the correct foods. He doesn't just have a low appetite, but a failed one. He is "dull" and "unfit for business", descriptors that suggest nutritional deficiency, not mere hunger or weakness.

The management of the appetite is additionally relevant to my broader research because it illuminates the complexity of the politics of desire. Are any desires immutable? Where abjection is one of the avenues by which fat bodies are oppressed, challenging the notion of fat bodies or any kind of body as *inherently* undesirable is fundamental to my politics. Sawicki describes Sandra Bartky on this: "Feminists lack an adequate 'politics of personal transformation'. How one goes about altering one's desires when they appear to conflict with 'feminist' politics or moral principles is not obvious" (Sawicki, 1991, p. 37). This absence is felt in the arena of weight loss as well. Is it possible for a weight loss attempt to be in keeping with one's feminist commitments?

I also wish to consider the out-of-control appetite, the pathological or disordered appetite. Can one be addicted to food? Traditional psychological and biomedical framings of addiction can allow for a "food addiction" in some ways, such as similar patterns of brain activation, but preclude it in others, particularly given that the boundaries of addiction in general are still fluid in biomedical understandings (Volkow, Wang, & Baler, 2013; Ziauddeen & Fletcher, 2013). Throughout this chapter, I make use of sociocultural theorists writing about addiction. Many of the concepts in this realm are relevant to those topics implicated in the WLS arena: weight, weight loss, eating and over-eating. For the purposes of this text, it is not necessary to say whether food addiction is real, only that thinking about addiction is useful for thinking about this topic.

Altschuler, as quoted in Raikhel, defines addiction as a pathological desire for a psychoactive substance with an accompanying overvalued idea of the necessity of consuming said substance

(Raikhel, 2016). Certainly this is the case for the post-WLS recipient (and especially the newly-post-WLS recipient) whose life now revolves around a rigidly-controlled menu and eating schedule and extensive management of appetite and digestion. Both Raikhel and Valverde, writing about late- and post-Soviet Russia and the U.S. and U.K., respectively, describe twentieth century medical framings of alcoholism that focused on treatment of physiological effects of over-consumption of alcohol without significant consideration paid to psychological, emotional, or social facets of alcoholism (Raikhel, 2016; Valverde, 1998). We see something similar in biomedical attempts to frame over-eating as food addiction: most medical interest in the condition pertains explicitly to "obesity" – a bodily state. We see here in medical responses to over-eating the same ahistoricity that concerns Valverde with regards to the will.

One of the most emotionally demonstrative and engaging components of my conversation with Ruben was the depth of feeling he expressed for food. Less than ten minutes into our conversation, he detoured from his explanation of post-operative eating requirements to wax poetic about his love for pizza, mentioning an advertisement he had recently seen for the Little Caesar's pizza chain. He actually cut himself off when he first attempted to describe it to me, saying, "Little Caesar's got that new pizza, that I- oh my goodness," before pausing briefly. His eyes lit up as he then slowly talked me through each of the pizza toppings he had seen in the ad, a thoughtful smile on his face, before concluding, "Oh, my goodness, I look at that and say, oh, I wish I could have one of those," and, after another momentary pause, "But I can't." That silence was laden with possibility. He shifted registers in that pause from an avid food lover to a successfully-reformed and now self-disciplined eater. Why? Was he reminding himself of this discipline he has begun to incorporate into his sense of self? Was he lamenting the sadness that pizza's inaccessibility brings him? Did he have a kind of awakening from his pizza reverie, realizing that I (whether in my role as an expert researcher or an unknowledgeable newcomer to the WLS medical arena) was someone in front of whom he wanted to maintain that identity of successfully-disciplined eater? This was hardly the only time he discussed food in this way. When he wasn't engaging emotionally with the topic, he was sharing knowledge of something – how to cook brown rice, what an air fryer is and why I should get one, novel uses for cauliflower. Perhaps there is something at work here for him where he attempts to insert knowledge into a domain where he struggles with will to serve as its own kind of prosthesis.

At a WLS support group, I was astonished to see how much structural fixation with food there was. The meeting opened immediately with a recipe demonstration that included samples the size of a standard post-operative meal. Once that was over, the attendees went around the room and introduced ourselves by sharing, at the suggestion of the clinical staff running the meeting, our favorite recipes. It seemed to me an almost outlandish food fetishization that was happening in that room. It operated under the guise of a kind of decorum or self-control thanks to the use of nutritionist language and a nutritionist framework, but the fact that the group collectively could never not be thinking about food seemed inescapable. I speculate that WLS allows its recipients to think about food the "right" way, by fetishizing "healthy" meals, by obsessing over calories, protein content, (kinds of) sugar, (kinds of) fiber, carbohydrates, dietary phases.

Will showed up implicitly later in that same conversation. Several support group attendees were sharing some tools that they'd found useful in altering how they eat. One of them mentioned a device called an "air fryer", something new to me that I would later learn dried the outside of food during cooking so as to mimic the effects of deep frying. As soon as it was mentioned, several others joined in to proclaim the benefits of the air fryer. It was so *good*, they reiterated. One person contributed that he had anticipated that giving up fried foods would be difficult for him, but the air fryer had resolved this worry by providing suitable substitutes. The others agreed at most lukewarmly with that sentiment. There is a notable gap here between the enthusiasm with which they describe the air fryer and the dullness with which they respond to a possible explanation for what precisely is so great about it. It seems self-evident to me now that the love for the air fryer is inherently a love for fried food and for anything that can replace it without violating dietary restrictions. There is something going on here about will, a desire not to be seen as exercising will perhaps. No one else was willing to admit to struggling with desires for fried food, but only to be seen celebrating a device that produces *un*fried food, one that conforms to medical requirements, and renders them compliant and disciplined.

It is not only a simple desire for satiation that one must apply one's will to when resisting food. Eating functions in multiple social ways, described here by Erica who lives with only her husband: "So, he decides he needs to eat healthier. So, he went out to the store and bought groceries just for what he needed to eat! …it's like, I could eat the same thing. Or he could eat my same foods. It wasn't that, he needed to go out and get it, but it's just a thing that like, another way it's like, okay, around food that it's not... And does food need to be a social, family activity, or should it be a– a refueling event?" Elsewhere, her silence attested to the complications of social eating. When I asked how her eating affected her relationships, she said nothing and looked pointedly and long at her husband, seated on the other side of the great room from us. She appeared borderline distressed at whatever it was that she wasn't articulating. She was clearly felt the enormity of the topic of emotional eating. She went on to describe other ways food is inseparable from sociality for her, describing traditional Sunday dinners and popcorn around the TV at night and the pressure to have some when her "Aunty So-and-So makes my favorite Pecan Sandie cookies for me for my birthday."

### 5.2.1 Ambiguity

I see ambiguity being used as a tool for appetite management. And by "management," I mean not just inhibition of the appetite but also enduring the experience and effects of appetite. For most of the individuals with whom I spoke, there seem to be levels of compliance involved in post-WLS eating. We see this with alcohol, as I discuss later in this chapter. We also see this with food; there seems to be some middling level of compliance people are comfortable with. They won't risk their weight loss by eating a pizza at a time, but they frequently will risk it by consuming carbonated beverages or eating two portions of a snack instead of one. One interpretation of this is that it is about perception of consequences; perhaps for some, compliance is simply attaining and maintaining weight loss regardless of what they eat. Another is that these are simply ordinary examples of the compromises most individuals make in response to expert advice. However, what I'm interested in here is not *whether* individuals comply, but the nuances of their own sense of their compliance. There *is* some level of non-compliance with expert guidelines beyond which they view their transgression as meaningful and problematic.

Phrases like "I don't deprive myself," or, "It's not like I can't have cheeseburgers," are also employed to ambiguous ends. I heard them when informants endeavored to attest to the normalcy of post-surgical eating life, after which they elaborate that they eat a cookie – never a lot of cookies – or "not that much" of a cheeseburger. This wholly overlooks that one could experience not eating *enough* (according to some internal driver) as deprivation. It suggests to me a somewhat naïve take on what constitutes "deprivation" or "indulgence", but I speculate that that naïveté may in fact function as a tool of some sort. I believe those who tell me they are not deprived, but it seems they have experienced such a shift in that term that it is almost a different word than it is in mainstream usage.

## 5.3 Conceptualizing Will

I would spend some time now considering how other scholars are conceiving of will and how those conceptions can be useful to this project.

Valverde expresses concern about contemporary understandings of “will”, that their ahistoricity means we are reiterating the same theoretical struggles about the will with which the Victorians grappled. How does one accommodate the multiple drives that exist within one individual? What are the limits of an individual’s responsibility for his or her actions? In part, this has been done through historically changing notions of “self”, in part through philosophical grappling with the limits of accountability (Valverde, 1998).

I put forth that Valverde’s troubling of the discrete *self* underlies a number of discourses around weight today. The tension between notions of the weight-transgressor as a selfish burden on a neoliberal healthcare system and as an unwitting victim of a flawed cognitive system suggest different interpretations of who the weight-transgressor’s *self* is. Is the (over-)eater the true self? Or is the self the product of that over-eating? It seems reasonable to suggest that these discourses attempting to parcel out blame for the “obesity epidemic” are building on previous discourses that attempt to make moral assessments of alcoholism and addiction, which may be why Valverde’s framework is so salient here. At heart in her work is the potent pairing of two questions: “Is a lack of free will a valid defense of one’s compromised actions?” (to which she implicitly answers, “yes”) and “What are the other effects of such a conceptualization?”

Cruikshank takes a more remote approach to asking what the will does. Unlike Valverde, she is mainly discussing how the will conceptually produces abstract structuring of the world – constructions like citizens, subjects, and politics. However, she ultimately concludes that the way this happens is personal and microscopic (and messy and often elided). In short, we choose to be citizens, we choose to be governed and governable, we take action to make those things happen.

Fat subjects willingly take on more stigma than most oppressed groups, perhaps in a move to assure citizenship and personhood. Those who elect WLS to further cement their position as citizens and people are taking even more dramatic action to ensure this. A point Cruikshank makes that is particularly interesting to the arenas with which this dissertation concerns itself is that all structured, rigid, systems build in turn on top of messier systems. That is, mess is not something we can get rid of because it is a necessary component of the orderliness we (may) aspire to. WLS purports to fix a disorderliness of both the body and personal habit,[15] to serve an ordering function. But it rests on several massively messy systems: the socioculturally complex practices of human eating, the food systems in which that eating occurs, and the political and socioeconomic limitations that produce inequality. Inequality matters here because it can have effects in individual lives on what is eaten, what is available to eat, access to medicine and other health services, ability or desire to exercise, and investment in mainstream prescriptions about normative bodily appearance.

Is "order" the solution to a flawed will? What is the connection between "dis-order" meaning lack of order and "disorder" meaning disease or maladaption? Many of my interlocutors refer to "disordered eating" on their parts, whether historically or currently. None of them expressly associated weight loss or eating with "order" (or a lack thereof). But, as Maggie evocatively

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[15] What makes this "habit" and not, for instance, "behavior"? Valverde indicates that the concept of habit is sometimes deployed as "intermediary between free act and medicalized compulsion" (1998, p. 193). "Habit" suggests repetition whereas behavior can occur as infrequently as only ever once. This term reflects the notion held by most WLS practitioners and recipients that something endemic to the subject is changed, something that has played a long-term role in a subject's life and that occurs somewhere below the level of overt, explicit, willful intent.

expressed, the practice of WLS does not address disordered eating, only the dis-orderliness of a transgressing body and a presumed out-of-control appetite.

## 5.4 Alcohol and the Will

Both food and alcohol consumption are popularly seen as relying on some sort of will; attempts to restrict them are understood to draw on the will, and excessive consumption is understood to be the result of a flawed or weak will. Among my interlocutors, alcohol use often increases following WLS, and in some cases, it increases in ways that they find problematic to varying degrees. Biomedical conclusions about this phenomenon are contested, but the most recent scholarship has begun to coalesce on a validation of my interlocutors' understanding of gastric bypass as predictive of increased alcohol abuse. Perception of the will by the lay public and medical, psychological & addiction experts has shifted historically; it has informed the types and sources of treatment available to those seeking relief from alcohol use or dependency, their access to such treatment, and the social and legal consequences of alcohol consumption and over-consumption (Raikhel, 2016; Valverde, 1998). In this section, I look at how this may also be occurring with the presumed over-eater (the WLS candidate) and what the occurrence of post-WLS alcoholism says about the purportedly recovered over-eater's will.

Sedgwick defines addiction as "the *structure* of a will that is always somehow insufficiently free" (1993, p. 131), thereby shifting the essence of addiction away from any particular substance or even behavior. This is in line with broader twentieth century shifts in thinking about addiction as an identity and not an activity. The question of specific substance, then, is meaningful primarily in light of cultural constructions of its naturalness; in these constructions, the extent of a substance's artificiality is in direct correlation with one's worthiness of survival or personhood (Sedgwick, 1993). While food might seem inherently "natural", the WLS recipient is doublyindicted on these theoretical grounds by virtue of her unnatural body and eating habits that have been "corrected" in turn by unnatural medical intervention.

Raikhel, in describing post-Soviet Russian use of placebo in addiction treatment, introduces a concept that may illuminate this "correction": that of the "prosthesis of the will". Raikhel describes how this use of placebo – *khimzashchita* – functions outside of any mechanical understanding of human physiology and depends on a belief in future negative consequences. Like *khimzashchita*, WLS depends on an ill-defined mechanism and on a belief that flawed behavior (that is, eating in ways that don't adhere to biomedical requirements) produces the suffering that follows WLS. WLS is treated both by practitioners and recipients of the procedure as another form of prosthesis of the will. As with Raikhel's arena of investigation, the prosthetic model of WLS allows for no interiority (no will, no struggle, no agency) and instead depends entirely on a kind of input/output model of the "affliction". Although it might seem that the procedure of WLS alters the digestive system and not the system's inputs and outputs, if we consider the system that is the entire human body, the restrictive surgeries forcibly decrease consumption, and the malabsorptive surgeries alter the output, namely produce greater output of unabsorbed nutrients.

I set out in this project to understand a more about the role of the will in WLS, initially interested solely in the exercise of will over eating choices, but later coming to realize that what is designated as "the will" plays a significant part in many aspects of the lives of those who elect WLS.

Raikhel also describes another parallel to my arena of interest: the increasing prevalence of "crisis" in post-Soviet Russia. This use of crisis suggests a norm, a potential state to which one might aspire or be restored. The *lack* of a crisis related to body weight stymies many "common-sense" responses to the specter of "obesity". Whether one is considering the weight of a population or an individual, gain is always gradual and incremental, making it impossible to pinpoint the moment that it became problematic or pathological. If one cannot identify when we’ve shifted away from that normal state, we can’t say authoritatively that the state is no longer normal, that is, there is now a crisis. This results in efforts to manufacture that crisis, such as the “obesity epidemic” branding itself.

Sedgwick’s notion of a poorly-structured and restricted will and Altschuler’s reference to pathological desire together tell us that a wanting beyond the wanter’s control is at the core of addiction. No one who has ever found themselves unable to decline an offer of food could suggest this isn’t a fair description of how eating can and sometimes does work.

### 5.4.1 Efficient Drinking: Post-WLS Alcohol Consumption

My interlocutors have in some cases reported significant increases post-operatively in their drinking and in the effects of drinking on their lives. Even more informants have told me about somewhat less influential increases in their drinking and about friends and acquaintances who developed an alcohol dependency after surgery.

I had one informant, Ellen, who whole-heartedly embraced the label of alcoholic (and of recovering alcoholic) and embraced Alcoholics Anonymous (despite the fact that she framed it as “the worst thing” when she first decided to go). Describing it to me, she said, “I love it. I go now, I don't have to go. I go, I love it. Because it's a loving place. It's a safe place… And it's a really comfortable place for me.”

She expressed great confidence that the physiological changes that resulted from gastric bypass surgery caused her alcoholism, that is, that her altered digestive tract was more susceptible to alcohol exposure. She viewed her new tract as more fragile, more permeable, and thus experienced alcohol as more effective at altering her mood than either it or food had previously been. Several other informants also relied on this conceptual framework of the susceptible digestive tract whether discussing their own drinking or the occurrence of post-WLS drinking in general.

Shortly after WLS, she found herself enjoying alcohol for the first time in her life. At that point, she had achieved a sense of equilibrium between her intellectual self (which she considered then to be her entire self) and her physical body, responding to bodily feedback about what and how much she was eating in ways that she said, “worked”. The alcohol, however, interfered with this equilibrium. Discussing this change, she remarked to me, “*Shit*, drinking was way more efficient than eating to blot out bad feelings!” Several years into recovery, now, she is very concerned with promoting awareness of this information and feels that biomedical research and biomedical practitioners do not place enough emphasis on this side effect.

Another informant, Deirdre, also reported an increase in drinking that she found troubling, but she resisted describing herself as an alcoholic and offered evidence of her normal relationship with alcohol in the form of friends who offered contradictory comments in response to the possibility of alcoholism. Other informants described increased drinking that was entirely problem-free. Of course, the space where substance use becomes problematic is tricky to demarcate. One such “non-problem-drinking” informant drinks on a daily basis, experiences alcohol affecting her very differently post-operatively, and is very mindful that she is at risk for developing a habit of drinking that could seriously impact her life, yet she breezily responded in the negative when asked if she was concerned, apparently unbothered by the conversation.

A number of other informants reported drinking increases that they depicted as untroubling. This included one person who developed severe constipation after surgery and found wine to be the most effective laxative for remedying it and a woman for whom WLS had come in conjunction with a number of lifestyle changes including a shift from complete alcohol abstinence to occasional drinking. While Ellen did describe herself generally as an addictive type of person, none of my informants who attribute their increased drinking to bypass gave any consideration to what is sometimes known as the substitute addiction hypothesis: the idea that a new substance (alcohol) comes to replace food due to the subject's need merely for *some* addictive substance[16]. A few informants *did* rely on a frame that alludes to a food addiction quality to their eating, but Deirdre is the only person I spoke to who both uses that framing and has increased her drinking.

### 5.4.2 Biomedical Knowledge of Post-WLS Alcohol Use

Some small amount of biomedical literature also documents patient reports of significantly increased alcohol consumption. Biomedical response to this phenomenon has been light and largely inconclusive. The existing literature is contradictory, in most cases with a corresponding counter-finding for every finding. Alcohol is metabolized either better (Maluenda et al., 2010) or worse (Davis et al., 2012) in the restructured stomach. People are either more (Wee et al., 2014) or less (Lent et al., 2013) likely to increase alcohol consumption following gastric bypass. Effects are more common in groups that either did (Wee et al., 2014; Suzuki, Haimovici, & Chang, 2012) or did not (Lent et al., 2013) previously abuse alcohol. (The studies *do* consistently find that gastric bypass is unique in its impact on alcohol, even if they can't agree at all on what that impact is.) This remains an emerging issue. The phenomenon was first discussed in 2007 at which time an editorial in *Surgery for Obesity and Related Diseases* addressed the lack of empirical data on this patient-reported phenomenon and expressed skepticism that addictions could be "transferrable"

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[16] This idea is frequently proposed to me as explanation by scholars and lay people to whom I describe this facet of my research. This suggests to me an implicit identification of the "problem" as residing in the will and not the digestive tract or elsewhere in the body. This logic would suggest that Raikhel's prosthesis of the will is tacitly understood by the general population, that those who substitute addictions require additional bolstering of the will.

(Sogg, 2007). The most recent findings come to fairly strong conclusions that there is some increase in problem drinking post-gastric-bypass (Gregorio et al., 2016; Mitchell et al., 2015). Studies that compared multiple procedures found that gastric bypass is either more likely than other procedures to produce an increase in problematic drinking or the only procedure to do so (Conason et al., 2013; Hagedorn, Encarnacion, Brat & Morton, 2007; Östlund et al., 2013).

Some of my interlocutors speak noncommittally of food addiction. They posit the possibility that food is an addiction *for them* (avoiding any reference to a generalized food addiction), they wonder about it and sometimes frame tentatively their ideas about themselves and their eating in such terms. (Additionally, a fair number of my informants who did not mention food addiction did describe having a unique and/or problematic relationship with food, sometimes one that has haunted them throughout their lives.)

Deirdre strongly emphasized the way that eating has always been a different experience for her than some (implicitly normal) other. The surgery corrected how she felt about food and how her hormones worked, and she pursued surgery in order to fix some unnamable internal thing that had always lead to weight re-gain following any weight loss. Post-surgically, she shared her decreased appetite to some foods and, in response to my remark that that was the first I had heard of this problem, she pondered whether she was unusually sensitive to these changes, saying, “I don't know, I don't know if people would recognize it. I mean, you can get those things down.” Perhaps related is her energetic defense against any “real” problem with alcohol. She offered both her own evidence and testimony from her social world of various ways that she does normal when drinking.

Collectively, these findings share a logic similar to what is understood about WLS generally: that the mechanisms of the surgery's success are largely unknown and that the impact it has on metabolism and hormonal and nervous system response are major contributors to changes to both appetite and response to ingestion (in the case of both food and alcohol). For people who have had this surgery, this leaves a great deal of room for personal interpretation of their bodily state and for resistance to medical interpretations. Ellen stakes firm claims about how alcohol affects her, and Deirdre clings firmly to a belief that there is some sort of broken, food-related mechanism within her that the surgery fixed.

### 5.4.3 Timely Eating: Biomedical Framings of Digestive Recovery

With Rhonda, the retiree and bird enthusiast, will peaks out in tiny eruptions. Rhonda put forth a very straightforward version of every story she told me, no frills, no complications, certainly no complicated inner life, yet complications arose in all sorts of areas. She happily reported that she had great experiences with a surgeon and surgical team that prepared her adequately for the surgery, but then, in summation, really dwelt on the distressing digestive side effects and vociferously accused her surgical team of wholly omitting information about those side effects from her pre-operative preparation. In the same way, she describes eating and food choices as straight forward, but whenever pressed, talks about her choice to get Invisalign-style braces because they interfere with eating (suggesting she needed support choosing not to eat), and talks somewhat mirthfully and somewhat conspiratorially about her late-night snacking. Even when she offers these eruptions, she again frames the situation at this new level as still simple, still plain on its surface. Does this shed doubt on will playing a meaningful role in her experience of WLS? Or does its role take on such prominence that she avoids thinking about or addressing it?

I've obtained general guidelines for patient behavior following surgery from three hospitals — one of which was an incomplete document. The incomplete document did not include any mention of alcohol. Of the two complete documents, one listed alcohol in several places as a forbidden substance without any further explanation. The other offered a paragraph of explanation, most relevantly saying that "Rapid and substantial weight loss causes the liver to become much more susceptible to toxins such as alcohol." While acetaminophen is known to pose risks of liver toxicity (Black, 1984), no such restrictions are made against it in that document or any other I've examined. A page labeled "Bariatric 10 Commandments", describes only one substance to avoid in the long term: carbonated beverages. I did find a variety of anecdotal sources online saying ibuprofen and/or NSAIDS should be avoided post-WLS because they can irritate the stomach lining (a message I also heard from one of the participants in my project). None of the patient education materials I obtained mentioned this; one of them expressly recommended using liquid Tylenol for pain relief.

The prescribed post-operative eating plan for WLS patients depends on a four-phase regimen. The initial approximately four to eight weeks following surgery is divided into four ranges of time. As the duration of time since surgery enters a new time range, the allowed foods increase in nutritional variety and decrease in ease of digestability. The recovering post-WLS patient is expected to eat only those foods prescribed to them for their current phase. However, healthcare providers and WLS recipients describe to me a wide range of other requirements for transitioning between phases — things like consuming prescribed minimum amounts of food or water, a lack of nausea or pain, and the presence of hunger or just a belief that they are ready for the next phase. Further, WLS recipients report changes in their ability to tolerate food during the *years* after WLS. This use of "phases" in the official depiction of post-operative eating indicates an expectation of a continuous, chronological progression of recovery and digestion that is not in line with the lived reality of human biology and appetite. The clinical expectations inherent in these phases function to construct an ideal patient and behavioral norms by which to measure the magnitude of each patient's inevitable failure.

Failure is an important concept for those laboring in the WLS arena, because the selling point of WLS is that it is a cure for one's history of failure at maintaining a "normal" body weight. Yet to maintain a belief in the efficacy of the procedure, those who still fail following WLS must somehow be assigned the blame – which, recall from the literature review in the introduction, is exactly what happens in this arena (Throsby, 2007, 2008, 2009).

Although WLS recipients and healthcare workers alike are well-versed in these guidelines and WLS recipients acutely aware of their level of adherence to them, of the three clinics I contacted to obtain a clinical source beyond the colloquial and unattributed patient education materials for them, one refused to answer my messages and one blithely denied any knowledge. The latter offered that she assumed the American Society for Metabolic and Bariatric Surgery (one of the accrediting bodies for WLS) was one source, and searches for scholarly literature produce a likely candidate: a piece published jointly by ASMBS and multiple professional associations for endocrinologists and other healthcare practitioners focused on obesity (Mechanick et al., 2013). These collaborators offer seventy-four recommendations for bariatric surgery graded on a scale of A to D, D being assigned for recommendations that had no evidence, no consensus regarding their evidence, or scant evidence with mitigating factors contradicting that evidence. Only one recommendation regarding post-operative eating had better than a D grade, and that was the recommendation that patients meet with a registered dietitian. In short, the support for this phased eating could be called, if we are maximally generous, "flimsy". This suggests that the extensive reliance on these phases must come from the practical and not clinical usefulness of them. That is, they are easy to explain to patients, one's adherence to them is easy to measure, and they seem to provide an unimpeachable framework from which to adjudge a patient as sufficiently compliant.

The use of alcohol is more quietly phased: the documentation is firm — but undramatic — on its prescription to never again consume alcohol. WLS recipients and nurses clearly consider some "late" phase an appropriate place to again consume alcohol. (This is delivered with plenty of subtle caveats about moderation; these confessions are accompanied by phrases like "indulge", "a glass or two", and "I see no reason why you can't.") After sharing this information with a physician associated with one bariatric surgery program, the response was to firmly refute such an idea, showing shock and dismay and finally saying sternly, in response to my description of that approach as "cavalier", that *many* weight loss programs are cavalier.

### 5.4.4 Conclusion

What does the phenomenon of increased alcohol use after surgery say about the relationship between food, will, and WLS? Is alcohol a substitute for food? A crutch in its absence? An iatrogenic weakening of the will? Would such an analysis contradict or confirm my use of Raikhel's "prosthesis of the will"? Clearly, the will has not been sufficiently supported by surgery if it succumbs to simply another substance, but a prosthetic only substitutes for one flawed system. If the flawed system in need of prosthesis is that which enables us to set limits and to stop consuming beyond those limits, then this surgery has not addressed the *will* at all. The WLS recipient no longer needs to eat without limit but still needs to do something without limit. But, to bring it back further, is it true that alcohol consumption is a substitute for eating – one that may result in alcoholism? Ellen, too, asserts bypass predisposes her to alcoholism. So, if that's true, it's more that the prosthesis opened up a new "wound": where the will to (not) eat was shored up, the will to (not) drink was damaged. It's an iatrogenic weakening of the will.

For recipients of WLS and the clinicians involved in their treatment, the susceptibility of the altered digestive tract is transparently obvious. Although the mechanisms of post-operative weight change are actually unclear, this framing is inescapable. While the implications of this for understanding the will vary across positions within this arena, the uneasiness with which will is regarded continues to play an influential role.

## 5.5 Behavioral Health

One of the frameworks that allows biomedicine to intervene in the realms of the social, moral, cultural, and behavioral is that of "behavioral health". The domain of "behavioral health" has long been transitioning to the purview of mainstream healthcare for an extended period of time. WLS is implicated in this shift by virtue of occupying liminal ground that both is and is not behavioral. This shift poses risks to actors' legitimacy and expertise, but also provides opportunities to create new knowledge and logics about a fraught and often intractable realm.

This shift poses a challenge to my analytic attempts, as the "behavioral health" framing itself is an instance of a process which I seek to critique. I offer two major critiques in this section: (a) these kinds of conditions should not be restricted to a medical frame in order to intervene in them or to theorize about them and; (b) the process of constructing something as "behavioral health" is fraught and inconsistent and works to do more than just render certain conditions treatable in a biomedical framework.

### 5.5.1 In Opposition to "Behavior"

The notion of "behavioral health" already imposes a frame on the topic that is a poor fit, that redefines the arena as ready for medicalization. This term, "behavioral health," is the very term that allows medicine to stake claims on otherwise non-medical needs. What was, for instance, "degeneracy" at one point, now is a "health" condition and medicine the one and only tool with which to treat it. I fear that use of this term already signs one on to a medical interpretation of the phenomena in question and precludes many avenues of scholarly inquiry.

The field of Cognitive Science broadly rejects “behaviorism” as an overly-limited means of understanding the human experience. The over-arching goal of Cognitive Science is to fully understand the mental structures (*not* anatomical structures) that are used to organize and store human thought within the mind; this goal is antithetical to the behavioral psychologist's belief that the only thing we can know about the human mind is what behaviors it produces. Cognitive Science positions behaviorism soundly in psychological research’s past, at best an avenue for misguided hobbyists and at worst an irrelevant and discredited pursuit.

While I make no claim about the accuracy of this assessment for the field of psychology, I do assert that medicine cannot afford to treat patients as if they are black-boxed machines that produce behaviors which serve as the only points of intervention. It precludes effective treatment and does direct harm to the patients it constructs as shallow social dupes. The reliance on WLS does exactly this, renders the patient without a meaningful interiority. Surely it is plain to all corporeal humans that our interior has an important effect on what we eat, what we do, and what we look like.

### 5.5.2 Alternative Framings

I would take here a brief side excursion in order to consider framings that might be more productive to address. In lieu of behavioral health, could one address, for instance, a disease classification such as *complex conditions* – like obesity, asthma, and addiction. This very complexity is what allows for the appearance of phenomena of interest to me - medicalization, individualization of society-wide health effects, exclusion of particular social factors from mainstream discourses (such as the impossibility of addressing guns as a public health problem), and perception of some bodily states as immutable and others as mutable. Ultimately, I have to conclude that the transition of “complex conditions” into medical ones is less interesting to me because some “complex conditions” are surely worth situating clearly within medicine (for instance, asthma).

The next question to address, then, is whether these conditions would more rightly be treated as psychological or emotional? (There is of course something of a problem here in suggesting at this stage what the *right* treatment would be. For now, I say only tentatively that maybe these are all psychological problems.) Or would applying such a term simply allow it to do the same work as the term “behavioral”? I posit that what the term “behavioral health” really evokes in this context is some squishiness, messiness, slipperiness; something hard to pin down with ill-defined boundaries, something very human, something that resists laboratory logic and structure.

Let’s instead ask what describing WLS as a behavioral health problem would say. How could modifying the stomach fix a problem with behavior? Alterations in the body’s supply of the hormone ghrelin[17] and the functioning of the vagus nerve are insufficient explanatory factors given that the surgery was not designed to address them and that so little of the talk and work of the surgery now features them. One could also argue that there is a behavior modification by virtue of quicker discomfort upon overeating due to the smaller stomach. However, this is not truly behavioral, since only the stimulus is changed. While the response to said stimulus might seem foregone, this would be a spurious assessment of human complexity. One of my informants described an unpredicted consequence of her WLS. She now identifies her pre-surgical over-eating as a form of self-punishment. Her surgery did not address that underlying problem, but in fact, by making her stomach smaller, made punishment much easier to accomplish; whereas before she only suffered physical pain following binge-eating, she now didn’t even need to consume a

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[17] See chapter four (on knowledge) for more on this subject.

standard serving of food to cause herself the severe discomfort she sub-consciously believed she deserved.

### 5.5.3 How Has This Transition Happened?

While I'm not willing to consign my concerns about naming to mere "semantics," I do want to attempt moving on, to ask about this transition away from one for-now-unnamed category and to that of "medical problem".

It seems likely that the key vehicle for this transition has been the notion that "lifestyle" is the leading killer in the United States. Why? How did this line of thinking (a progressive series of ambitions: healing > healing complex conditions > understanding complex conditions > believing the primary cause of complex conditions is lifestyle-related > believing lifestyle is the real battle to win) come to be? Was there a necessary step in which non-complicated or non-lifestyle conditions came to be seen as solved? How do the terms "behavioral" and "lifestyle" intersect? Do they ever contradict each other?

Perhaps the thinking goes that what matters is not identifying the deadliest thing, but the deadliest thing *that we can have an effect on* (as the categories created with the phrase "leading preventable cause of death" might suggest). Intervention efforts have very little effect on lifestyle, yet this idea persists. However, behavioral health interventions into violence like gun deaths and car accidents – when they are attempted at all – have *not* gained the same kind of traction as those into tobacco use, diet and exercise. They *are* constructed as malleable, as public health problems and/or as appropriate areas for physician intervention, just not as often or as dramatically. Given this, is there some sort of quasi-progression in the behavioral medicalizing of social issues? Is medicine simply lagging behind, for example, violence with regards to how many claims it's staked about diet and exercise? It does seem like we need to interject our question at a different level: “Why are exercise and eating/drinking things that “can” be changed and legislation, public transportation, and social values aren't?”

Is this – “lifestyle” as the leading U.S. killer – true in some sense of the term? I'm hard-pressed to believe so, since so many of these complicated, non-pathogenic conditions (like cancer, PCOS, and diabetes) have correlations with MANY other health conditions, and it seems to be these correlations that are pointed to. If this logic holds, wouldn't living in America at all be as big of a killer as “lifestyle”? The whole essence of these conditions is that we can't point to one cause, that we don't understand the whole “disease process”, yet firm claims are made about understanding this disease process on a *population* level.

### 5.5.4 What Does This Transition Mean?

Because medicine entails the (ideally curative) treatment of disease or disorder, the subsumption of behavioral health under the medical umbrella necessarily suggests the possibility of cure through behavior modification.

It seems particularly vital to consider what behavior modification looks like. Does that change when medicine defines the modification and not another institution? Traditionally, medical solutions are more rigid and demand greater self-surveillance.

I also want to trouble the idea of a straightforward, unidirectional transition. The medical industry largely doesn't allow for an interpretation of behavioral health ever having been outside the system. There is a widely-held belief that it already *is* one system, it's just about differentiating responsibilities within that system. This is made explicit on the website for the 6th Annual Leadership Summit on Integrating Behavioral Health and Primary Care Models, which says in the description for one of its sessions, “Traditional healthcare practices have treated medical and behavioral health separately, creating silos in the healthcare system” (World Congress, 2017). It seems to me there is no meaningful distinction between “medical health” and “the healthcare system”. Does this mean the transition is already complete? Is this siloing a fixation with ontology?

## 5.6 A Portrait of the Post-WLS Experience: Healing Despite Surgery

Several informants’ stories relate a narrative of healing *despite* WLS. For each, this description juxtaposes her weight, her eating, and her life. They paint a portrait of their development in three stages. First (in a kind of neutral starting ground) is their fat, overeating life. They define themselves now in part in reaction to that stage. Next, they sought out WLS, a surgery they found to be more destructive than expected, whether that was physically, emotionally, or to their sense of self. Finally, the stage they inhabit now is one of “mindful eating”.

Ellen describes mindful eating here as she addresses herself: “You have to become more mindful, because if you become more mindful, you can actually make a choice. Do I want to have that cookie on the way to the bathroom? Yes. And then you eat it and you take the consequences of that if there are any. …For me, mindfulness is just getting to choice.” This is a happier, more satisfying, and more self-affirming period of their lives than any other. Mindful eating feels to them like gaining access to more choices. Maggie clearly articulates how much one has to relinquish conscious control (including the will) to adopt this mindset. “And acceptance – this whole long ride has been about that. And part of the healing has been just being in my body. And, like, exercising in healthy ways. And taking care of my body in healthy ways. Just being present in my body was for a very long time, like, unattainable. And my spirituality has been absolutely vital in every single aspect of all of that.”

I propose that this progression works in opposition to a framework based on will. “Mindful eating” does not refer to a repaired or strengthened will, instead it means freedom from perpetually having to impose the will – as well as freedom from the rigorous schedules and dietary restrictions of the biomedical frame. This notion of a co-constitutive healing and a kind of gentleness to the self is closely aligned with Valverde's proposed alternative to the "diseases of the will" framework: a public sphere in which "desires, pleasures, and obsessions" are discussed and which would thus not compel one to "deploy abstractions such as the free will" (1998, p. 205). In saying this, she suggests that, much the way my informants had to become more generous in their approaches to themselves, our broader discourses about will, disease, addiction, and consumption must also allow for an understanding of ourselves as complex, multi-faceted, multiply-driven creatures.

## 5.7 The Intractability of Will in Everyday Practice

When Laura returned to the Pop-Tart conversation, Alexandra very briefly caught her up to speed, and Laura promptly replied, "That would make me want to take that box of Pop-Tarts and *throw* it at his head," before adding that her partner, "…does shit like that, too." Pam proposed that Alexandra's partner keep the Pop-Tarts in his car, but Laura countered that idea, "But see, I would think about it. I would perseverate about the fact there was a box of Pop-Tarts in the car. Be like, [in a strained singsong] I'm not eating that box of fucking Pop-Tarts right now." Desire is woven throughout this conversation, desire none of these women could figure out how to adequately express to partners that have such different emotional associations with food.

Later in our conversation, I asked them what had changed that they were able to, for instance, walk by a bakery window and not be tempted to buy pastries shortly after surgery, a level of self-restraint they no longer had and wished they did. They couldn't answer me. They proffered several possibilities, always quizzically and ultimately unsatisfied. To see people who are by most measures very "successful" WLS recipients, who have thought long and deeply about the task of lifestyle and behavior change, struggle to identify a single difference between successfully exercising the will and failing to do so, suggests that explicit knowledge about even one's own will is very hard to come by.

Obviously, Alexandra, is not without relevant knowledge. Even in just these two brief discussions of mindfulness and Pop-Tarts, she describes feelings of desire, intention, and resistance. This knowledge has not cohered for her in a way that is useful for answering my question, at least not yet.

# 6. Heterogeneity in the Discourse of Choice

When I asked Deirdre, the convivial woman on Cape Cod, how those in her life had responded to her WLS, she revealed that there was a clear distinction between those who knew her over the course of her surgery and subsequent rapid weight loss (her coworkers and long-time friends) and those who had met her since (her new and lively social network in the region she moved to after retirement). She expressed overt astonishment and alluded to a sense of relief and empowerment at the fact that this information, her history of WLS, is hers to control. Regarding a new friend who had teased her about recent weight gain, she said, “And then, after leaving, […] I went home that night, and I went, ‘Oh, my God. Isn't it amazing? He'll never know.’” As she reflected further on her previous decisions about disclosure, she likened them to the disclosure of a past abortion, saying, “you can go through life choosing as a woman to tell somebody whether you had an abortion when you were younger.” Responding to both scenarios, she said, “We can make those choices. Sometimes we do.”

Of note here is the implication that the action of making a choice is somehow virtuous or decisive or transformative. I read this as a suggestion that choice-making can be utilized in order to become that thing which is not othered or stigmatized or debased. Deirdre is offering a refinement of Goffman’s discreditable identity (with its attendant ongoing management); having undergone abortion or WLS (that is, undeserved weight loss) makes one *potentially* stigmatized, but these are different than discreditable identities like an unseen psychological disorder or a physical deformity that can be hidden by standard dress in that they are discrete events which are simpler to keep secret. Indeed, Deirdre’s description of disclosure as something she is wholly in control of shows that she clearly views her own knowledge as the *only* possible source of such information to others.

This chapter endeavors to understand choice. I propose four configurations of choice that are relevant in the arena of WLS. The most obvious reason to consider choice in the context of this project is the Bourdieuian understanding of choice as a means by which one accesses social capital and worth. The fat, already maligned for their “undesirable” bodies and “failed” moral character, are further debased because their weight reveals their lack of socioculturally correct preferences and *choices*. Next, choice is more complex than choosing one thing or the other as it is frequently initially perceived. There is a temporal element. How long-lasting is this choice? Is it reversible? It’s very different to “choose” to keep a secret forever than to choose to disclose it right now. Choice can also be used to justify one's actions by implying a lack of choice. One may defend a bad choice, but citing that it is not the *worst* choice. Or one may defend one’s moral worth by pointing to the fact that all options were undesirable, therefore they have *already* suffered (a lack of choice) and been redeemed through that suffering. This can be done with a questionable framing of the problem. In its final configuration, choice is also constrained along particular, common axes in ways that are often invisible. For instance, the sociocultural meanings of a woman who chooses not to play sports are very different than for a man.

All of us need choice to be available to us simultaneously to defend the idea that we are good (because we make good choices) and also that we had no choice to make. Personhood, virtue, validity depend on both things being true at different times, but the shift from one to the other is often very rapid. One of my informants might argue in the same sentence that they ate the best foods available to them and that it’s not like there were many foods available.

## 6.1 Towards an Ontology of Choice

Choice is more complex than a binary selection between two options. There is a temporal element: am I choosing for ten minutes, forever, ...? Related to temporality is the reversibility of the choice. It's very different to “choose” to keep a secret forever than to choose to disclose it. Choice is used to claim virtue and to justify one's actions (through the implication of no choice). It can be used to re-frame a problem in ways that are more convenient to the framer.

Just as we see the abortion debate framed as a matter of *choice* and not *rights* (Solinger, 2001), so, too is the moral worth that is inferred from our bodies defined by choice. Should I be taken seriously? Am I valid? One could say that individuals are inherently valid by relying on a rights discourse. Yet the discourse that pervades WLS relies overwhelmingly on a choice discourse: a slim body implies a history of correct behavioral choices and thus the individual is moral and worthy.

Let me take, as an example, one of the most oft-referenced choices in my interlocutors’ stories: whether or not to disclose that they have had WLS to someone who does not yet know. Many WLS recipients fear that they will be perceived as having cheated at weight loss, as having illegitimately attained a slim, normative body. We can infer that the moralization of fat lies at the root of these fears. Slim people are perceived as morally virtuous, but if that slimness is illegitimate, so too is the resulting virtue.

Deirdre’s comparison between the decision to disclose WLS with that to disclose a past abortion illuminates that choice discourse disallows the possibility of *not* making a choice. One is always choosing whether or not to disclose, yet she observes that we “sometimes” do choose to disclose, suggesting that there is a temporal element to choice. We're always choosing to stay silent when we are not speaking, but one might choose to never disclose, or one might specifically choose not to disclose when a particularly salient opportunity arises. From the outside, how could we differentiate these two? How even could the choice-maker differentiate them given that they may change their mind at a later date? It is impossible to choose not to disclose, only to choose not to disclose for now. Choice, often interpreted as a binary, is far from it; it is a gesturing towards an infinite multiplicity of moments in which disclosure might or might not occur. And though it is often perceived as occurring at a particular moment in time, choice is far more nebulous than that. For example, Ellen uses choice to talk not about difficult choices but about expanding her number of options – choice in opposition to mindlessness, unthinkingness.

Choice is nebulous in other ways as well. Though ostensibly occurring at some identifiable point in time, further analysis contradicts this framing. Health and lifestyle practices are often long term yet get constructed as short term. For example, a heartless but common response to an air traveler too large to comfortably fit in an airplane seat is, "Well, maybe you should lose weight." Such a response doesn't directly address the problem I've described, yet it feels like a logically valid pair of statements, one that renders the discomfort the subject's fault. The reason for this disconnect is that the heartless reaction solves a different, related problem. Our traveler's problem is discomfort in an airplane seat, but the outside commentator's problem is their own concern about the traveler's discomfort; the outsider's problem could be resolved either by reducing the amount of discomfort experienced or by rendering the discomfort the sufferer's fault, and thus preventing the need for any concern on their part. Using such a strategy effectively temporally mislocates the original problem.

So, too, does choice get mislocated conceptually. Stigmatization limits one's choice, yet those limitations are often invisible to outside observers[18] – particularly in a neoliberal landscape that only allows for analysis at the individual level. If a fat woman fails to express some need in the work place, say for instance, the need for a desk chair that fits her adequately, is she to blame for

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[18] With thanks to Samrin Ali who suggested to me that choice is constrained in the presence of stigma (S. Ali personal communication 4/20/17).

any resulting damage to her lower back? How much blame should be borne by a social system that led her to see herself as unworthy, a burden, and an over-consumer? Stigma, of course, is not the only means by which choice is constrained. It is also different for someone in continental Europe to decide to travel to Germany than for someone in North America, and this distinction, too, can become elided. This could be explained by a Western focus on deciding and action — and a corresponding de-emphasis on the context in which the decision was made — though this seems at best a partial explanation. As with temporal mislocation, this has the effect of simplifying the inconvenience that “choice” poses to those outside the choosing.

A construction that I am particularly interested in is the use of “choice” in defense of oneself. Once again, Deirdre provides an example of such a use of the term. This time, she describes to me that she approached her social group with the possibility that she has developed a drinking problem subsequent to the WLS. Her friends quickly repudiated this suggestion, saying according to her, “We think you can manage it. Sometimes, just like us all. But, you know, you never drive. You always make choices. And you’re never- you’re not what we would see. You've never embarrassed yourself. You've never passed out, and you've never been mean.” Deirdre related this story in part to defend herself against her own suggestion that she might have developed a drinking problem. “Choice” here is grouped with other virtuous behaviors. Deirdre’s friends offered no information about what choices are made or what options she chooses from. This construction is common with “choice” used to indicate virtue by setting up a scenario in which choosing is inherently unimpeachable. To describe it generally, one constructs oneself as suffering from a lack of choices or of good choices (thereby necessitating and excusing a poor decision), thus one is already suffering in this scenario (from a lack of choice), and one suffers further from people thinking ill of one’s poor decision; this allows one to become noble in a story where otherwise they would be vain, indulgent victims of the system, or else positioned as villains who get in their own way to health.

## 6.2 Consumerism

Solinger's investigation into the discourse of choice surrounding reproductive rights offers numerous parallels to WLS. Solinger's central argument is that, by re-framing abortion as being about *choice* for women and not women's *rights,* the discourse becomes consumer-centric. It no longer rests on a fundamental fact about women (such as, they are entitled to control of their own bodies), but instead on a marketplace justification. This choice-based discourse also does a great deal of work to reify existing associations between morality and choice. Among them, that wealth and whiteness (frequently traits of adoptive parents) allow the *choice* to adopt to be a virtuous and valuable one (bestowing one's cultural and financial capital on a "needy" child) while the choice to give up a child for adoption is unthinking or selfish (Solinger, 2001).

In the arena of WLS, we are looking at what is already a consumer issue. WLS is a product, and that product specifically is a thin body. That this is not merely available or offered to potential recipients but is in fact sold to them is evidenced by the copious promotional materials put out by clinics and hospitals performing the surgery.

We certainly also see a strong parallel to the notions of race and income making choices more virtuous. The shameful stereotype of the black welfare queen has easily expanded in the late twentieth and early twenty-first century to the "spectacle" of the obese black woman, made fat by virtue of her ignorance of basic nutrition as well as a morally flawed nature. (In my own city, one need travel no further than the local bus stop and its frequent anti-juice / pro-vegetable PSAs usually featuring cherubic black babies to see how little respect public health institutions have for black mothers' knowledge of nutrition and ability to make sound feeding decisions. The local farmer’s market and its complete absence of corresponding warnings at the local farmer’s market or yoga studio about over-consumption of highly caloric extra virgin olive oil further illuminate the socioeconomic implications of these campaigns.) In both the tropes of the welfare queen and the obese black woman, her offense is, in part, a failure to properly acquiesce to the authority of expertise – the expertise of family planners or physicians and dietitians, respectively. Both are also described as loud, usually literally loud in volume, but “loud” seems also to be used as code for “impossible to ignore” – taking up too much space with an oversized body or an oversized family and too many resources with her or her family’s perceived over-sized appetite. Among other implications of this is the possibility that, for white women, the “redemption” of WLS is more easily accessed. Black women may be unable to shed these constructions of loud, ignorant and selfish even after surgically-assisted weight loss.

For Solinger, a lot of the discursive shifts about unwed motherhood in the mid-twentieth century around race, class, and morality functioned to remove any possible taint a baby might inherit from a birth parent. The ultimate result of these changing social constructions was the increased availability of a product to a market: desirable babies for would-be parents. While the product of WLS may be less overt, these notions of knowledge, morality, and suitable occupation of space work to render formerly fat women as desirable sexual products.

Another construction Solinger identifies is that of hierarchies of choice. She identifies the “failures” (as constructed by mainstream, dominant discourse) of an unwed mother in the mid-twentieth century as the choices to: have sex, have unprotected sex, and not abort or not abort correctly. This construction allows for fluidity in the mislocation of choice (described in the previous section); it allows for the eternal possibility of blaming the choice-maker.

Solinger makes the point that the ability to choose is, first and foremost, dependent on economic resources. While this dissertation project does not attempt to fully account for the economics of WLS, my interviews were riddled with economic considerations. Erica told me of a friend who was ambivalent about pursuing WLS, someone she fervently hoped would elect to get surgery. Towards that end, she daydreamed not about addressing her friend's general ambivalence, but about her own hope to raise enough money to fund this friend's surgery.

I did not probe the circumstances that enabled my informants to comply with these complicated pre-operative processes, but it seems reasonable to extrapolate that various social privileges make compliance easier. Surplus income means one can simply pay for a psychological evaluation instead of applying for a weeks- or months-long waiting list for a publicly-funded service. Flexible work hours allow one much greater access to services that are only available for set daytime hours. Even behavioral changes like specialized diets that are supposedly dependent on one's "character" are more available to people who can afford specialty food items, food waste, gym membership, and leisure time to grapple with the attendant emotional costs of lifestyle change – as well as those who have the resources to prepare and store a variety of foods in advance. The standardized nutrition advice which prescribes a slightly modified mainstream U.S. diet also serves as a barrier to potential WLS recipients from ethnic minority backgrounds for whom such dietary changes would be not slight but radical. For instance, both of the Latino participants in my study bemoaned the wholesale loss of rice and beans from their diets; those staples are proscribed by post-WLS instructions. A shared language – both literally and also a shared cultural or socioeconomic vernacular – enables greater access to needed patience, support, generosity and empathy from workers in the healthcare system.

Thus, the ability to obtain WLS is, as we would expect from the choice-based discourse surrounding it, tightly interwoven with a consumer framing. As of yet, an alternative, rights-based discourse is largely absent from the WLS arena.

## 6.3 Disclosure

One particular choice that recipients of WLS encounter is that of whether to disclose their surgical history. Many recipients of WLS believe they are perceived as cheaters or as having taken the easy way out. This is not their own perception of themselves, but one they fight against. For most, they perceive themselves after weight loss as not merely thin (or “normal”), but as a thin person who was once fat. This is a very particular identity, suggesting that the experience of being fat forever modifies one’s self or relationship with the world. Most of my informants had what I would call modest weight gain from their lowest post-operative weight, and many expressed shame. None of them connected that shame to the surgery, but it seems reasonable that many WLS recipients (perhaps those with more substantial weight gain) might prefer to be seen as always-fat instead of as someone who was offered redemption and failed to obtain it. This means WLS recipients have many aspects to their identity they may wish to obscure to prevent being stigmatized, and so the decision to disclose is a fraught one.

I’d like to take a moment to consider Sedgwick’s assertion that all *closets* from which one might *come out* are inherently queer and what that might say about WLS and weight loss as “closets”. The fat female body is excluded from dominant heterosexual discourse by virtue of being neither the object nor the possessor of the male gaze. The desires marked “neutral” in the West are only those for a white, slim, normative body, and thus desire for any other body is queer (Jones, 2014). So, if fatness is queer, what of WLS? One notion that arose occasionally with my informants is a mainstream notion of the illegitimacy of surgically-assisted weight loss. There is a right way to lose weight (generally assumed to be self-denial, asceticism, and suffering), and all other paths are unnatural, decadent, and enable an unnecessary amount of sensual indulgence. Said indulgence is accepted as evidence of the individual’s weakness of character.

In my own history, I have been struck by the similarities I observed between experiences of intentional weight loss and experiences of transition relayed to me by transgender individuals. So, it was not surprising to me when one of my interlocutors, Maggie, spontaneously offered her own observation of this symmetry. “Any time I'm in trans communities, and I tell my story, there's this simpatico. Like, we get what it's like to literally be reviled because of the bodies we are in." In the case of both weight loss and gender transition, one seeks to transform the body (generally via biomedical solutions) into something that others will perceive the way one already perceives oneself. I don’t mean that those who pursue weight loss see themselves as already-slim, but that they believe they are already worthy, moral, and whole and hope in part that weight loss will better convey that perception to others. In so doing, one must resist discourses that suggest radical self-acceptance is the more appropriate route. At the same time, those engaged in gender transition are enrolled in dominant narratives of a permanent, unidirectional transition between two binary narratives (LeBesco, 2014). Maggie offered a more evocative piece of support for this parallel: “I think we get each other… We get what it's like to literally be reviled because of the bodies we are in.” A final parallel is the theme of this section, disclosure. For those who are “successful”, those who make that unidirectional transition across a dichotomy, those who have become normative and overtly unmarked, they now have a stigmatizable identity that they may seek and struggle to conceal. Those who have lived a whole life with a marginalized identity may also suffer under the experience of sudden normalcy. (Some of my informants conveyed strong desires to publicly proclaim themselves as formerly fat or as having abnormal eating habits because of feelings that their realities were oblique to others due to their normative bodies. Most memorable was one woman who, after a stranger complimented her scarf on the bus, felt driven to explain that the stranger must be mistaken in liking something about her appearance because, actually, she was a fat woman.) This is compounded by what Sedgwick refers to as, "the deadly elasticity of the heterosexual presumption," which means it is arduous, ongoing work to out oneself because a heterosexual interpretation is always so readily available to any who seek it. For those who feel invisibilized by recently-acquired normalcy, the possibility of outing oneself is often precluded by a disinterested public.

I suspect that some of my informants would oppose the suggestion that there is anything "queer" about them. But an aversion to the label hardly precludes it. Queerness always travels with a drive for "normalcy". That is not to say that such a drive is present in everyone to whom the label "queer" may be applied, but the proximity to that drive, the ever-present possibility of the pursuit of "normal" is an unavoidable aspect of the queer experience.

Maggie was one of the latest post-operative WLS recipients I spoke with, having had her procedure more twelve years prior to our conversation. When I asked about other WLS recipients she knows, she observed that she is less generally aware of acquaintances seeking out WLS now because it has become far more common and ordinary than when she underwent the procedure. "No one is coming immediately to mind right now, because I just think it's such a thing that people don't even talk about anymore. Back when I had mine, if people had it, it was just, like, *look*! It definitely was such a spectacle back then, that people did this."

At the start of this chapter, Deirdre describes choices that "sometimes we" make. She alludes to a "we" that includes all who have these kinds of discrete-event-based discreditable identities. However, she's *not* saying that both choices are valid and it is the action of making a choice that does the work. She is talking about only one choice; she says that *sometimes* we make choices, implying that there are other times when we aren't making a choice. If her "sometimes" is when we are choosing *not* to disclose, then any other times must be when we *do* choose to disclose (perhaps also when the opportunity to disclose has not occurred to us). Therefore, we can conclude that the moral maneuver she describes is actually *secrecy*. There is a kind of defensiveness in her description. Her tone was conspiratorial, slightly ashamed, but also assertive. She is apologizing and at the same time holding her head up high *despite* shame. It's a kind of rapid-fire exoneration, performed for the listener. As in the case of her use of "recognition", she uses an evolution framing to stake claims to agency. She endeavors to complicate the depiction of herself.

I refer to plural "decisions" not to mirror Deirdre's discussion of multiple kinds of choice, but because for all of my informants, the decision whether to disclose is one that is made repeatedly throughout the course of a lifetime and at various points in their conversations with me.

One particular disclosure that did not appear in this research was the disclosure of the *intent* to lose weight. While mainstream discourse certainly leaves little room for interpretations of weight loss other than a universal good, there are nevertheless those arenas in which intentional weight loss is devalued, most notably among many fat acceptance activists. There is also a reticence to disclose an intent to accomplish some task for fear that any later failure becomes public through initial disclosure. I did have one informant who was situated in a fat acceptance social group. The topic of disclosure among that group was not a concern in our conversations because her departure from the group seemed to occur harmoniously with her pursuit of weight loss, neither one necessarily causing the other. I would be curious to know what disclosure felt like to her had she remained with that group.

## 6.4 Disgust

There exists a gap in the fat studies literature that is not one I endeavor to fill in this project, but one I would begin explicating here. That subject is *disgust*, and more particularly, a phenomenological understanding of it. In the fat studies literature, the fact of *others'* disgust towards fat bodies is treated as one to be grappled with, one that theory must account for, but not worthy of investigation itself. Disgust is so often managed by treating it as impenetrable: that something engenders disgust is understood as an inherent property of it, whether that something is a body, an object, a practice, a taste or smell, or a concept. A phenomenological approach would allow one to critique that seeming impenetrability. To grapple with one's own disgust means identifying the soft slide from first sensory exposure to something into a partially-formed cognitive response: when does "I am experiencing this smell," become "I am repulsed," and then what happens that moves us to an action? How does a homophobic dislike of effeminate physicality evolve into not just the thought, "I hate," but violent action?

According to William Ian Miller, "we express many of our bread-and-butter moral judgments in the idiom of disgust" (p. 179). Miller demonstrates disgust's connection to contamination / pollution, contempt, sympathy, social status, and morality. Disgust works to manage affective states –inching us towards greater moral rigor in some cases, in others tempering an overdeveloped moral sense (Miller, 1998). Disgust works to create boundaries, particularly the boundary between the self and the other, but it can also blur or transgress those boundaries (Kristeva, 1982).

Disgust matters to this project and my larger research agenda as a whole for a variety of reasons. It is relevant in discussions of choice because the seeming impenetrability of disgust works to construct one as without choice. One cannot be held accountable for the fat bodies one maligns if one's inherent, uncritiquable disgust is so great that one's actions are beyond one's control. This is the classic move in television and movies, where our (cisgender, straight, male) hero is moved to comical lengths by their disgust at the mere possibility of romantic interaction with a fat, ugly, or male body.

In the research for this project, several individuals confided to me their disgust with other fat bodies if I am “in”, as if my body is acceptable enough: appropriately marked like their own and thus trustworthy, but not so marked that they view me as *other*.

Erica’s descriptions of her mother’s corpulence were laced with disgust. Her mother had to call the fire department to get her out of her own house! Erica confided to me aghast. She allowed her *mobility* to be affected! Most evocatively, Erica re-told to me the end of the film *What’s Eating Gilbert Grape?* She spoke tremulously of two characters’ decision to burn down the house rather than suffer the embarrassment of calling for help with extracting their mother’s extremely large body. She spoke about this film and the parallels to her mother’s experiences with great emotion in her voice and it touched me. I felt that we were both afraid of what this film and her mother’s story said about our own bodies and our moral worth. A question, “Is it okay to be horrified of fat? My own? Someone else’s? My potential fat?” seemed to hover in the air between us.

Another informant and friend of Erica’s, Vera, shared comments had even greater affective power. Vera and I spoke only by phone. Though she never saw me, I had cause to allude to my high body weight during the course of our conversation. She responded by asking explicitly, but hesitantly “Oh, you’re- you’re overweight?” to which I replied affirmatively. Describing her four-to-five-hundred-pound sister in law, she said without any apparent shame or even hesitation that “it” gets to the point that it (one’s weight) is disgusting, that you can’t wash yourself. She described her sister-in-law as having “taken herself beyond the point” where surgery is possible. Her tone was somewhat conspiratorial. At the same time, the scorn in her tone was strong enough to suggest that standard etiquette would have precluded this level of frankness if she saw me as part of the same category as her sister-in-law. Both of these facts suggest that somehow, she concluded I did not transgress bodily norms so severely that she responded to me as an *other*. As is often the case when one has the opportunity to be part of the "in-crowd", my impulse was to agree with Vera. I very much wanted it to be true that it is up to each individual fat person to maintain their own hygiene standards; that filth is never the result of a particular weight, only of an individual's choices. However, as soon as our conversation was over, I recognized the problematic neoliberal impulses driving those feelings, that despite disagreeing with her about her friend's redeemability, I was unthinkingly buying into her suggestion that the management of personal filth, the successful containment of one's biological form, is what makes someone morally worthy.

I don't exactly want to write a personal meditation here, but this *is* all deeply personal. I feel like there is an important similarity between Vera telling me about her sister-in-law's presumed filthiness and Erica confiding fears of having to hide her mother's dead body from the world. There is the confessional aspect, the disgust aspect (both conveying one's own disgust and attempting to engender a mix of pity and disgust), the othering aspect – the idea that there is some level of corporeal embarrassment beyond which one is not like another. Perhaps it is that othering, the labor done in order to other, that ties together their narratives. Disgust enables Vera and Erica to feel that their bodies are unlike certain bodies, even as they (we) feel threatened by the possibility of that disgust subsuming us.

What of the disgusting fat body? I see two general schools of thought among those of us who research "fat" (by whatever term we may call it). The fat activists and those sympathetic with fat activist political goals who endeavor through their research to undo the oppression and marginalization experienced by those whose bodies are fat. I would posit that those of us falling into this category hesitate to address disgust for fear of lending even one iota of support to the hateful discursive regimes where it is found. To address disgust at all might suggest lending credence to some unasked question. The second group of scholars researching fat are biomedical and psychological researchers whose disciplines require that they keep an appropriate scholarly distance between their own or their subjects' phenomenological experience and their scholarship. Disgust is too subjective and too emotional to have a place in such scholarship. I find, though, that I *must* address disgust as part of the task of undoing oppression. Disgust is one of the mechanisms by which that oppression occurs. I inhabit a fat body that is thus implicated by conversations of "disgusting fat", so I feel comfortable attesting that the application of that adjective has effects even as I work to reject its legitimacy. And I suspect that my conversations with Vera and Erica were not unusual in our unwillingness to directly address the subtextual disgust of fat and WLS; in fact, they were unusual in being the most overt examples of something that is occurring in many conversations in this arena.

## 6.5 Conclusion

My informants lacked an analysis of themselves as a collective body.[19] Sedgwick suggests that this – a group sharing an identity as opposed to merely a collection of the people who have committed a particular act – is necessary for a successful claim to rights. Solinger suggests that rights discourses tend to be subsumed by choice discourse, the latter being what consumers have. We've seen here how deeply intertwined WLS is with a consumerist frame. I'm led to believe WLS recipients may face substantial barriers to any political claim to rights. The very

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[19] In fact, my biggest methodological frustration with this project was this lack of cohesion. Snowball sampling was much less effective than I'd hoped since so many informants had no connections to other WLS recipients. The only cohering force was the hospital, an institution that, even had it not been so resistant to its use in qualitative, sociocultural research, would have implicitly structured this research in particular ways that precluded some interpretations.

awkwardness of the descriptor I’ve used in this text, “WLS recipients”, belies the difficulty of even just centering them as persons in speech.

Does choice liberate or limit us? For my informants, this question is far from settled.

Throughout this chapter, we’ve seen Deirdre using her successful choice-making as evidence that her drinking is harmless and alluding to a right to make choices as justification for a choice not to disclose elements of her history. She also uses choice as a way of taking responsibility for herself, both when she regrets the choice – “I feel that, for whatever reason, I chose to absorb or suppress and not use whatever tools I might have had at the time to handle things that are stressful, difficult, painful.” – and when she takes pride in it – “I'm most embarrassed by that I let my weight get so out of control that it dominated my life. And I'm most proud of the fact that I chose to do something about it.”

Discourses of choice can render an apparently entropic sequence of events orderly and rational, suggesting the individual is wholly in control. One of the things Deirdre does with her persistent use of “choice” is to find meaning and order in her own history. Recall from chapter three that Deirdre regretted not having children because of the domestic partnership she was in during the latter part of her child-bearing years. In talking about this time period of her life, she smoothly moves from thinking about an in-the-moment choice to eat to the irrevocable choice to spend “a cycle” in a relationship with a man who did not share her goals.

> *So, we bought the house when I was thirty-eight and I moved out, well, he bought me out when I was fifty-one. So, yeah, we ended up a cycle together. We stayed together until I was about 50. So, I think I just never got in touch of who I was. And what I wanted for my life. And when it became uncomfortable to think about it, I chose to eat. So, it allowed us to grow further apart. I think I*

*was ultimately mad at myself and disappointed in myself. That I made this choice.*

# 7. Conclusion

This dissertation has presented a small part of the rich and broad experience that is weight loss surgery, the identities that inform our notions of WLS and those that are in part defined by WLS and weight-reducing behaviors, the biomedical assumptions implicit in the large-scale process of pursuing and recovering from surgery, the avenues along which knowledge and expertise travel from biomedical authority sources into patients' daily lives. This research began as a set of questions about will and personhood, and looked to WLS as one particular site where answers to these questions might be sought. I have offered these research findings in the course of this text: that the influence of post-surgical alcohol dependence is far more significant to recipients than is currently represented in existing ethnographic or biomedical literature about WLS; that family roles are intricately intertwined with feeding, eating, and the moralization of fat; and that recipients of WLS use a variety of innovative techniques to stake claims about their knowledge, will, and personhood – including techniques that resist dominant discourses of these subjects. I also propose three mechanisms by which WLS "works" in its recipients' lives: the experience of the overall process as a crucible, a logic of suffering that equates behavior with surgical (side) effects, and an enhanced belief in one's capacity for change.

As anticipated, the answers to all of these inquiries are complex and multi-faceted. We've seen informants invoking desires to conform, to be constrained, to be relieved of the burden of choice, and we've seen others longing for greater agency and freedom.

The remainder of this chapter will revisit the linkages and themes between these chapters that produce these conclusions to draw a portrait of the complex and sociocultural phenomenon that is WLS.

## 7.1 Review

This dissertation has provided four major organizing concepts for understanding WLS as a sociocultural formation: motherhood, knowledge, will, and choice.

### 7.1.1 Motherhood

I intentionally centered motherhood in this investigation from the start because I saw great emphasis placed on it in WLS marketing, and upon closer investigation of this connection, I saw a number of reasons why we should expect this to be the case. Mothers are apportioned a far greater share of the burden for the development of sound children than other caregivers and relatives. Historically, the long-term project of child-rearing has been the production of healthy, productive, normative citizens. As women, mothers are under significantly more pressure to conform to mainstream beauty standards and make up a disproportionate number of those who receive WLS (Fuchs et al., 2015). Finally, mothers are responsible for the labor of feeding the family and maintaining the health of the family (both through nutrition and through engagement with expert health recommendation). As with so many forms of oppression and marginalization, this labor is obscured and elided even as it is continually extracted, making it difficult-to-impossible to critique or resist. Thus, the whole burden of producing thin future citizens falls squarely on mothers, imposing the burdens of the discourse of the “obesity epidemic” forcefully onto them.

Once I began this research, I found that it wasn’t *just* motherhood that was impacted by the experience of WLS. WLS complicated other family relationships (with parents, partners, siblings), in particular by making the recipients’ diet so dramatically different from the rest of the family’s that shared meals, snacks, and eating habits become impossible. In addition, I observed a kind of metaphorical motherhood imposed by the biomedical system on WLS recipients. In many ways, potential WLS recipients were framed as children and thus as failed mothers to themselves.

Correspondingly, the post-surgical recipient is framed as a new mother (and thus redeemed). This is one of several ways I've shown that a temporal framing is placed on top of WLS. Linear, unidirectional temporality is necessary in order to embrace biomedicine as a solution (or even option).

### 7.1.2 Knowledge

In chapter four, we saw four forms of sociocultural work done by knowledge in the arena of WLS that are of interest to this research project. Biomedicine and knowledge are tightly connected, working to produce the sometimes-problematic power relations reproduced in the healthcare setting. Second, knowledge and power are tightly connected in the sociocultural world, working to render the disenfranchised as unknowing *and* as undeserving by virtue of that lack of knowledge. Undoing the harms of fat-based oppression relies in part on enabling those who fall under the umbrella of "fat" to stake legitimate claims to knowledge. Another form of knowledge in this arena is its deployment as a tool for personal behavioral change. Finally, the experience of WLS allows its recipients to produce knowledge.

The example of this last category that is of greatest interest to this project is phenomenological knowledge of technoscientific theories. I propose two major pieces of knowledge that enable WLS to *work*, that is, to produce desired weight loss. One of these is a logic of suffering, a conviction that any undesired results of WLS – such as pain or vomiting after eating – are also the result of bad behaviors on the part of the surgery recipient. The procedure renders pain a moral barometer. The other is a recipient's very concrete knowledge about *how* to lose weight in accordance with the guidelines of WLS. The ability to adhere to these guidelines and the belief in one's ability to do so is central to WLS *working*. WLS recipients have thorough understandings – grounded in extensive embodied experience – of these two pieces of knowledge, both deeply and broadly.

### 7.1.3 Will

My informants' narratives of their eating, weight, weight loss, and medical & surgical experiences made reference to will in what were generally oblique ways. When I asked directly about it, most found themselves unable to describe their experiences of will, so I was forced to analytically probe their silences to uncover empirical material regarding the will. What I found was that will and appetite often overlap or substitute for one another. Existing literature (Raikhel, 2013; Sedgwick, 1993; Valverde, 1998) shows that addiction and the will are tightly interconnected and that eating and addiction share much in common (including constructions of a substance as having some form of control over and the individual and overlapping notions of moral and physical purity). In clinical settings, addiction and eating have in common that attempts to intervene in them are confined to the realm of "behavioral health", a framing that I challenge. In this research, this came to matter not just for theoretical or analytic reasons, but because for so many of my informants, the specter (and sometimes the reality) of WLS-induced alcoholism played a significant role in how they understood the influence of WLS on their lives.

To come to some conclusion, I turn to several of my informants who draw on a recently available characterization of one type of response to struggles with will, food, and/or addiction: mindfulness. This term is most frequently used to evoke Eastern spiritual practices or traditional, formal 12-step substance abuse recovery systems. In both cases, the intent is to problematize the will, to say that it is a desire to exert one's will over too large a terrain of human experience that produces suffering and confinement. Mindfulness suggests a decision-making that happens at a very microscopic level, that requires full attention in the present and thus a de-prioritizing of the kind of large-scale, hyper-organized, ambitious lifestyle-changes that are as popular among those trying to lose weight or "be healthy" as they are in 21st century project-plan driven workplaces or biomedical expectations for correct eating. For these particular informants, mindfulness provides them a tool that has helped them heal from both harmful, chaotic eating patterns and an experience of destructive WLS.

### 7.1.4 Choice

I’ve proposed four configurations of choice seen in the arena of WLS. The first configuration is a Bourdieuian understanding of choice: a means by which one accesses social capital and worth. This is of particular importance to this project because those perceived as fat are debased because (among other reasons) their weight reveals their lack of socioculturally correct preferences and choices. The next configuration I proposed is that of a nebulous, non-binary choice that is in contrast to the binary framing of choice that is so prevalent in most mainstream discourse. In its next configuration, choice can be used to justify one's actions by implying a lack of choice, or to make claims to a sort of redemption through the suffering on the basis that their lack of choice was punishment enough. Finally, choice is constrained in hard-to-see ways that support neoliberal constructions of choice as wholly individual (and thus the responsibility for those choices as belonging to the individual) while ignoring the many structural limitations on individuals’ choices. As part of this analysis, I also introduced abjection as an important influence on ideas about “choice” and a particularly salient one in the discourse of fat bodies.

By looking at the lack of any notion of a political self or agency among WLS recipients and at the theoretical background demonstrating that a lack of collective identity precludes any claims to rights and that choice is the province of consumers and not citizens, I suggest that current framings of “choice” pose a serious barrier for any claim to political rights or standing for WLS recipients.

## 7.2 Findings

As I began to probe these different concepts, I found them eminently slippery, not only for my analysis but in the lives of my informants. There's knowing and then there's *really* knowing. Making a *choice* often denoted having no choice at all in these conversations. In some ways, this evokes previous findings of notions of an essential, thin self. If we extend that, is there an essential concept underlying every concept? One might understand what "will" is until a new ordeal reveals to them an entirely new understanding of the term. I offer this as a caveat about the following findings; because this research has shown me how easily boundaries leak and classifications escape, I find it harder than when I started to claim that anything is true.

### 7.2.1 Complicating Notions of WLS

This dissertation has addressed four major ideas: the deployment of choice in the spaces associated with WLS, how knowledge functions in the WLS arena, the implication of motherhood – both metaphorically and literally – in WLS discourse, and finally the complex and hidden ways WLS recipients understand and attempt to alter their will. It addresses the largely-unstudied phenomenon of alcohol dependence in WLS recipients and look at the conjunctures and disjunctures of addiction and eating. Both medical science and "common sense" currently fail to account fully for these conditions, and this text has extricated some of the ways that individuals work with this lacuna. The possibility of post-surgical alcohol dependence is far more significant to recipients than this silence would suggest. Further, it illuminates the ways that unidirectional temporal framings of patient recovery and healing post-WLS produce impossible expectations of ultimately "failed" patients; shows that family roles are intricately intertwined with feeding, eating, and the moralization of fat; and documents some of the innovative techniques WLS recipients use to stake claims about their knowledge, will, and personhood.

Some of my informants provided me with a framing that I would propose we need to replicate at a systemic level, that of *mindfulness*. In their own lives, my informants' invocations of mindfulness were about exercising a particular, calm and unconstrained form of decision-making with regards to eating. Writ large, this framing suggests that we not attempt to exercise severe and regimented control over bodies, behaviors, and moral purity, but instead patiently and gently attend to everyday life with generosity and in ways that center values – be those biomedical, philosophical, or otherwise. I would add that suggestion to Valverde's call for a public sphere in which we approach one another with greater tenderness and generosity, because, as she sees it, this may be the only path to recovery from a substance- and structure-obsessed world fraught with "abstractions such as the free will" (Valverde, 1998, p. 205).

Ultimately, this work demonstrates that WLS complicates "traditional" dichotomous positionality like healthy/unhealthy, obedient/oppositional, and fat/slim. It also shows that attempts to apply these dichotomies limits the possibility of constructing WLS recipients as full persons.

### 7.2.2 "Why Does WLS Work?"

A question often posed to me when someone first hears about my research is one that I myself return to again and again: what does WLS actually *do* for its recipients? I would suggest that it does two things, both relating to the production of knowledge.

To start, we must define this idea of "doing" or "working" in this context. Most of the time, the idea implied by WLS "working" is that of weight loss. One pursues WLS in order to lose weight, thus one's efforts "worked" if one loses weight. But for my informants, they find WLS "working" at multiple levels. It works to change behavior, it works to make behavior change feel attainable, it works to change feelings about food or bodies. Perhaps, particularly in the case of those who have arrived at “mindful eating”, it works at promoting happiness and liberty.

I propose three mechanisms by which WLS accomplishes these results. First, WLS is a crucible. A WLS aspirant jumps through endless hoops merely to be approved for surgery. They must satisfy weight requirements and requirements to either fail or succeed at dieting; they must complete health screenings, psychiatric evaluations, counseling, training; all of this must be documented properly to the proper authorities. If successful, this all culminates in a two-week liquid diet leading up to the day of surgery, an experience that is utterly miserable in most depictions. Rhonda told me it was such a severe dietary change, she sometimes wonders if that diet would have been a better weight loss method for her than the surgery. So even before beginning the vast and long-term dietary changes of post-operative recovery, a patient waking up from WLS has already sunk soul and self into this procedure. Most of my informants depict this surgery as a commitment unlike any other they’ve made, and several point to this commitment as the reason for their surgery “working”. The feeling that one has so much on the line by the time surgery begins, that there can be no possibility of failure to lose weight is one expressed by many of my informants.

Second, WLS produces a logic of suffering: eating wrong causes pain, nausea, vomiting, diarrhea, and other suffering. Yet those symptoms don’t necessarily cause weight loss. In this logic, the suffering is not, to offer some other examples, caused by the surgery, nor by a healing or altered digestive tract nor variation in the diet. It is exclusively a failure to eat right as defined by rules set down by biomedical experts. It is the *belief* that bad behavior or failure to adhere to clinical guidelines *produced* these symptoms. The belief that there is logic present is doing the work.

This immediate suffering for wrong eating is treasured by nearly all of my informants. So, for WLS recipients, it is not just that suffering interferes enough with digestion to produce weight loss, it is the fact that the suffering was *deserved* that enables behavioral change that produces weight loss. For most, this is the heart of the surgery's efficacy.

A final key mechanism in the work that WLS does is a belief in capacity for change. The restrictive eating guidelines provide a clear-cut path that often feels easier to follow than uninhibited eating. The technoscientific nature of the procedure suggests a reassuring replicability of results. Even when it is not producing weight loss, a belief in capacity for change can produce happiness, serenity, a kind of freedom.  I observe my informants indirectly describing these attributes as ways that WLS works.

### 7.2.3 "Does WLS Cause Alcoholism?"

As far as alcohol use, I feel a pressure to say whether WLS-induced alcoholism is "real". But I think the elusive specter of "real" would lead us away from our meaningful search with the promise of something that wouldn't ultimately leave us any better off. What I offer instead of an opinion on the *reality* of post-WLS alcohol use is that the *possibility* of iatrogenic alcoholism pervades most understandings of WLS. Regardless of what is happening in the livers, brains, and guts of post-WLS recipients, regardless of their and their providers beliefs about what is or isn't happening there, regardless of whether alcoholism was inevitable, and without offering my own prescriptions for how much or when a WLS recipient should drink, what matters is recognizing that all WLS recipients are implicated in recovery discourses – which preclude the possibility of cure but instead require the ongoing state of in-recovery – and those discourses frame their abilities to be whole persons and "successful" at eating, health, and sobriety.

## 7.3 Limitations and Future Directions

As a dissertation project, this research was designed to be limited in scope so as to be accomplished within the time and resources available. This meant restricting the number of interviews and the extent of participant-observation, limiting recruitment to those informants who were enthusiastic about participation and easily connected to my social network or my network of existing informants, and conducting research within a limited number of geographic locations.

I was unsuccessful at soliciting any institutional access for this project; that is, while a few individual employees were either interested in participating or did participate, any employees who involved their institutional bureaucracy (for instance, by asking their supervisor for approval or checking with HR before signing a consent form) were promptly instructed to have no interaction with me. My impression is not that biomedical institutions were hostile to my research, but that they were hostile to official interactions with any non-employee or non-patient. These institutions function by formalizing all relationships they enter into. This means relationships must be standardized; a student researcher from an unaffiliated university, an interested outsider, and an employee's curious friend are all non-standard relationships and thus can't be accommodated by the system. For my research, this meant I could not experience the clinical setting with any of my informants. In particular, I could not talk to folks immediately after surgery or other key interactions with providers, nor could I get firsthand reports of the post-operative experience; all of my informants' experiences of immediate surgical recovery were filtered through at least several weeks (often several years). Additionally, I could not recruit like I was engaging in a typical clinical research project. (That is, I could not rely on providers to connect me with potential informants, nor could I select informants on the basis of clinical characteristics such as time since surgery, type of procedure, diagnoses or results.)

Well after my interviews were conducted, I realized that there was a glaring absence of any informants weighing *more* than their pre-WLS weight. When discussing this gap, several people (non-WLS recipients) told me of contacts of theirs who met such criteria, but they all expressed extreme reluctance to put me in touch with their contacts out of the belief that this would cause great discomfort their contacts. In planning recruitment for this study, I did not take into account that the amount of weight lost or gained after the procedure might influence willingness to participate in my project or even to stay connected to providers or former patients at their WLS program. If their feelings about discussing WLS are so markedly different from my interlocutors', it suggests I am missing some important perspectives. Rectifying this will require some innovative recruitment strategies.

I plan to revise this dissertation into a book, tentatively entitled *Real Bodies: Identity and Subjectivity Among Weight Loss Surgery Recipients*. This book will expand on the dissertation in two ways. First, I will include greater analysis of similarities and connections between drug and alcohol use and intentional weight loss / WLS, including greater consideration of the conjunctures and disjunctures of recovery discourse in both discursive arenas.

Second, I will expand my pool of informants and the topics covered in my interviews to allow for substantive consideration of race and sexuality. Both of these shortcomings represent knowledge that would be tremendously valuable to this project, and I intend to explore them in future research.

One effect of not recruiting with the intent to produce any particular demographic makeup was a set of informants who are not representative of the general population of individuals who pursue WLS. While the group was unintentionally disproportionately queer (approximately one third of my informants actively identify a lesbian, bisexual, or queer), the limited scope of this dissertation means I devoted relatively little of my analysis to questions of sexuality and non-mainstream family makeup. The present research has revealed overlaps in the experiences of WLS recipients and trans individuals who pursue gender confirmation surgery. I anticipate being able to perform more rigorous and accurate analysis of family roles by interviewing members of so-called "non-traditional" families, that is families with one or more transgender parent, those with same-sex parents, and those with more than two adults in the household.

As discussed briefly in chapter six, one of the ways that WLS works to construct its recipients is with post-operative dietary guidelines, namely ones developed based on a "mainstream" U.S. diet. This research uncovers fewer of these kinds of elisions – elisions of the diversity of household cuisine and other homemaking practices – than I believe exist, because my informants are predominantly white and middle-class and are all current U.S. residents. Also absent here are any conversations about race, racialized standards of appearance, and culturally-situated variations on expectations of bodily norms. Black women, in particular, are implicated in and harmed by "obesity epidemic" discourse and public health attempts to "cure" it, so their perspectives need to be included in the expansion of this research project.

### 7.3.1 Recommendations

I have, since beginning this research, been reached out to by friends for advice on the possibility of their own WLS, an occurrence which has made me distinctly uncomfortable. I do not view my role as providing expert recommendation about any individual's healthcare. I would far prefer my role to be that of one who breaks down existing structures, beliefs, and frameworks that are inaccurate, unhelpful, or harmful so as to create room for collective construction of something new and better. Understanding that it is common for novice academics to feel unqualified at offering prescriptions, I will resist these impulses and offer a small set of recommendations here.

#### 7.3.1.1 Utilization of WLS Recipient Expertise

The most useful strategy I could offer to those considering WLS is to discuss the decision with one or ideally more individuals who have already had it. As this dissertation has shown, the struggles, accomplishments, growth, and changes that are prompted by WLS primarily occur at the level of the everyday. The overarching experience of WLS is produced via an accumulation of mundane and minute practices and struggles. To get even part of an understanding of this experience, one *must* consult those who have lived that. As I emphasized with regards to temporal framings of recovery, the medical perspective on WLS is limited and lacks an appreciation for the pragmatic circumstances to which its recipients' lived experiences testify. For those who seek to know if WLS is for them, I would say the WLS recipients *are* the experts.

#### 7.3.1.2 Expansion of WLS Teams

Provision of WLS and its attendant clinical services always relies on a team of clinical staff, usually organized around a bariatric clinic, center, or program. The teams encountered by (and in some cases participated on) by my informants include at least one surgeon, a nurse responsible for the overall program, and a dietitian. Some of them also included additional surgeons, a psychiatrist, or a primary care practitioner. I would propose that these teams should be larger and more professionally diverse. Patients produce a tremendous amount of information about themselves, their habits, their problems, and also about the surgical procedures. They need teams that are responsive to their own clinical needs – of which they now have so much knowledge – and that can make use of the data they are producing. Instead, patient experiences are often too nuanced for a provider conducting a brief annual check-up to attend to, too outside the realm of any of the professions represented in these teams, or too unfamiliar to the particular individuals[20] working on a given team.

First, every such team should consistently include a counselor, social worker, or other professional whose training prepares them to collaborate *with* their clients to interrogate and respond to the subtle and mundane aspects of lives that often combine to create larger, intractable problems. Second, they need better dietetic and nutritional support. In the course of this research, I heard from WLS recipients who were scolded like children for their eating habits, I read menus and nutrition advice that completely disregarded patients' cultural dietary needs, I watched a WLS expert produce nutrition information by googling blogs, I saw staff repeatedly ply long-term WLS recipients with food they did not want purely out of adherence to social custom, and I spoke with a supervisor of a WLS program who unconcernedly declared that she had no clinical data to support the nutrition guidelines she distributes to every patient in the program she runs. It seems to me that there is a powerful divergence among dietitians from mainstream understandings of food, nutrition and eating; those mainstream understandings are the very thing they must be expert in to do their job. To be useful for WLS recipients, dietitians must have a thorough and nuanced understanding of the knowledge their profession relies on, and they must be attentive and sensitive to their patients. They must recognize which changes will pose a challenge to patients and then treat those changes *like* a challenge. They must engage with their patients on the task of changing food and behavior. (Aphramor and Gingras, who describe themselves as feminist dietitian scholars, make a similar prescription in calling for greater imagination on the part of their profession (2009).) At best, nutrition counseling seems to consist of an over-appreciation for the value of

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[20] For instance, I heard complaints of feeling alienated or misunderstood by clinical staff who were thin and perceived to have always been so.

narrow expert knowledge, and at worst, it relies on scolding and shaming. A respectful and earnest approach to nutrition counseling and education is necessary. What a person eats on a habitual basis is important to them, and dietitians need to have a sincere respect and empathy for that. The proposition that there is anything simple about eating belies patients' entire life histories, not to mention the very fact of the existence of WLS.

WLS teams also demonstrate this tendency for viewing facts as useful in and of themselves. They offer prescriptions like, "Do *x*," without any suggestion for *how* one might in practice do *x*. I suggest that this is caused by two things: many clinicians see this as outside their realm of expertise and thus outside their responsibility and many genuinely don't see room for intervention at this level. That is, the possibility that there is nuance in one's will is frequently disregarded. This can be rectified by adding professionals who *are* expert in this and who can be held responsible for it. This is another reason addition of counselling staff to the team would be such an improvement to the overall care delivered.

For patients, the changes WLS requires them to grapple with are tedious, time-consuming, and difficult. WLS teams – like any profession striving for efficiency – endeavors to structure their work so as not to become involved with those aspects, but in this case, they are throwing patients to the wolves if they say, "We've changed you irrevocably, but you're on your own to figure out how to handle those changes."

#### 7.3.1.3 WLS in Fat Studies

Lastly, I would urge other scholars of Fat Studies and all who are concerned with the oppression of those implicated by the label "fat" to give sincere and earnest consideration to all those who have pursued intentional weight loss and in particular those who have undergone WLS. While it is wholly necessary to the project of liberation to problematize biomedicine (an effort to which I hope I have contributed here) and intentional weight loss, this cannot mean negating the knowledge or personhood of those who, under the yoke of the extraordinarily anti-fat influences of mainstream media and medicine, have grappled with their own oppression in this particular way. Their experiences shed light on the overall fat experience; listening to and theorizing based on those experiences need not interfere with the good work being done to resist hegemonic slimness.

### 7.3.2 Future Directions

As I was engaged in this research, I visited – for purely social reasons – an organic farm run by a friend in a loose collective. While there, I greatly enjoyed a flavor combination they introduced me to: crepes with brie and berry preserves. After a delicious meal of those crepes, I went to bed one night noting with curiosity that our host hadn't refrigerated the brie as part of our cleanup. The next morning, I watched in some discomfort as she ate more of that same brie, still sitting on the table. I reminded myself how much of human history included consumption of unrefrigerated cheese and how Western standards of food safety are not universal standards, no matter how inculcated they are in my own life, but this did not ease my visceral dislike in the direct presence of this habit.

The collective practices human composting – that is, they compost the solid waste their bodies produce, which requires a toilet that stores human feces for roughly two to six days before bringing it to a composting bin outdoors for approximately two years. These were the only bathroom facilities available at the farm, and I found myself trying not to think too much about the whole process as I used them.

These two practices tested the limits of my own desire for sanitation (as defined by an authoritative, scientific source), though I remained mindful during my visit that my own discomforts are not a reflection of the worth or acceptability of others' practices. As we were leaving, we all hugged goodbye and thanked our hosts for housing and feeding us, and my friend said, referencing her deep-seated opposition to factory farming practices, "I love feeding people food that's not poison!" I was struck in that moment by our diverging views on what is poisonous to the body. Like the fat activists opposed to WLS who have come to view doctors not as a *source of* but the *barrier to* cures, like WLS recipients who push back against medical guidelines and restrictions or maneuver dexterously among them, my friend and her community were taking expert knowledge – the dangers of pesticides, methods of farming and preparing food – and deploying it in ways that subvert mainstream uses of that expert knowledge. These all look to me like people staking claims for personhood by the use of knowledge; I know, therefore I am. I began to realize that the deeper question underlying this research project, the foundation for my research agenda, is how do we resist this behemoth that is biomedical knowledge and expertise about our own personal, private, precious bodies in order to be wholly self-actualized and living the full, rich lives to which we aspire.

So, my next project, as a natural progression of this one, will interrogate these alternative uses of mainstream expertise more deeply by studying this organic farming collective and others, and potentially by considering a variety of other groups that I see making the same move. These might include anti-vaccination advocates, fat activists, or Christian Scientists and other groups that abstain from medicine altogether on religious grounds.

## 7.4 Closing Thoughts

My hope is that this dissertation has made clear the tumultuous currents produced by myriad conflicting and reinforcing pressures that come to bear on the WLS aspirant and the WLS recipient. WLS is but one method for coping with the desire to lose weight or physically conform, for responding to a narrow-minded and obsessed biomedical system, for staking claims to agency and personhood, but it reveals something about all of these struggles. The incredible extent of the physical effects of WLS amplifies the philosophical, psychological, and sociocultural effects, making it a particularly useful tool for revealing meaningful information about the workings of all of these phenomena.

I urge readers to question vociferously anything that seems simple about bodies, medicine, and especially fat. The insidious work of dominant discursive regimes is to construct avenues of oppression as simplistic and its own logic as impenetrable. The seeming simplicity of weight loss as (a) desirable; and (b) prescribable badly hurts so many, and makes it exceedingly difficult to see the fascinating mechanisms at play when one grapples with identity, will, self-control.

## 7.5 Boxed Up

WLS, though a seemingly miraculous innovation to many who engage with it on either side of the scalpel, does not directly impose cure or therapy on the body, but instead imposes practices and logics on the lives of those who undergo it. It brings together embodied, phenomenological knowing and abstract technoscientific knowledge. The concept "ghrelin" discussed in chapter four is one such example.

When we first spoke, Laura offered many descriptions of food working like an addiction for her. Later, when we met with a couple of other WLS recipients, she also described how much her life now feels like sobriety. She expressed frustration that others didn't see it that way, that she couldn't decline foods by explaining she was in recovery. Despite that frustration, simply having access to that thinking for herself seemed to give her some sense of relief, provided a desired structure for eating that she had longed for.

At the end of our conversation, Laura describes her post-WLS eating being contained and orderly exactly the way active addictions are not. She discusses the way surgery shifted her thinking from a general knowledge ("I need to lose weight,") to a knowing that is for her more tangible, better defined, more quantifiable, and – in an example of the third mechanism of how WLS *works* – attainable.

> *I like the way surgery set the bar though. So, I always feel like, before I had surgery, it was just sort of this amorphous thing of like, "I'm fat, lose weight." Right? Like, there was no container for it. It could just usurp everything. And now, there's a bar. So, I know what the bar is. I know that the bar is: chew my food to applesauce consistency, sixty grams of protein a day. There's a container which makes it feel so much more doable. Even if I'm not doing it. I'm still, like, okay, I still can live within this box... whereas before, it just felt completely insurmountable to me... I could never box it up, the way that surgery has boxed it up for me.*

Just as belief alone enables the concept of ghrelin and the logic of suffering to influence WLS recipients' lives, what matters to Laura here is not that she *has* attained a particular behavior change or amount of weight loss but that she *believes* it is attainable. These beliefs in logic, order, and capability are key benefits of WLS for its recipients. One could even describe that, to briefly wax sentimental, as "hope".

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