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I'm the Same Me: Communication and Renegotiation of Identity in the Weight-Loss Surgery Experiences of Women

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I'M THE SAME ME: COMMUNICATION AND RENEGOTIATION OF
IDENTITY IN THE WEIGHT-LOSS SURGERY
EXPERIENCES OF WOMEN

by

Heather D. Schild

A Thesis
Submitted to the
Faculty of The Graduate College
in partial fulfillment of the
requirements for the
Degree of Master of Art
School of Communication
Advisor: Leigh A. Ford, Ph.D.

Western Michigan University
Kalamazoo, Michigan
June 2012

THE GRADUATE COLLEGE
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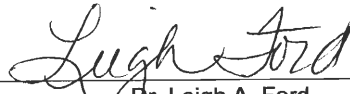
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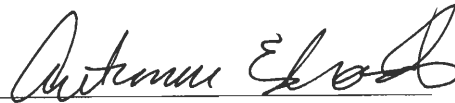
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I'M THE SAME ME: COMMUNICATION AND RENEGOTIATION OF
IDENTITY IN THE WEIGHT-LOSS SURGERY
EXPERIENCES OF WOMEN

Heather D. Schild, M.A.

Western Michigan University, 2012

Adult obesity rates are on the rise in the United States according to the Centers for Disease Control (2009) which has led to an increase in obesity-related illnesses such as diabetes and heart disease. Weight-loss surgery (WLS) has become accepted as a “cure” for obesity by the medical community. There has been a dramatic increase in the number of obese individuals electing to undergo WLS every year; 82% of these individuals are women (AHRQ, 2007). More women may be electing to undergo these procedures than men due to the pressures women face in American culture to achieve social standards of female beauty and thinness (Kilbourne, 1999; Maine, 1999).

This research study focuses on the emotional journeys of ten women who elected to undergo WLS. Qualitative interviews were conducted and analyzed using Fraser's (2004) guide to coding narrative transcripts line by line. Specific attention was paid to the emergence of communication and identity themes. The goal of this research study was to answer the questions of how women who have undergone WLS conceptualize their identities and communicate about themselves during three distinct phases of their emotional journeys: pre-WLS, post-WLS, and 18+ months post-WLS.

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Heather D. Schild

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CHAPTER I

INTRODUCTION

Current obesity rates in the United States are on the rise with the majority of states experiencing adult obesity rates of 25 to 30% (Centers for Disease Control and Prevention (CDC), 2009). The hike in obesity rates has also lead to a dramatic rise in the number of adults diagnosed with diabetes (CDC, 2009). Multiple illnesses may result from obesity; the CDC (2010) lists obesity as a primary risk factor for heart disease, Type 2 diabetes, high blood pressure, certain cancers, stroke, and respiratory conditions. These obesity-related illnesses contribute to rising medical costs; in 2008 the CDC estimated medical costs due to obesity-related illness to be around \$147 billion (CDC, 2010). While as a society we are becoming heavier, the dominant culture continues to stigmatize obesity. The social and emotional consequences of obesity are particularly acute for women (Kilbourne, 1999; Maine, 1999).

Women in the United States experience extreme pressure to be thin. These pressures come from American media in the forms of film, television, advertising and mass marketing images, and pressure from peers and greater society to conform to the unattainable standards of female beauty represented within these forms, a beauty that often is not even possessed by the models themselves whose images have been

airbrushed and Photo-shopped to achieve a producer's or editor's ideal look (Kilbourne, 1999; Maine, 1999). Simultaneously, women are targeted by the food industry and encouraged through advertising to indulge themselves in foods that are seen as luxurious, which generally refer to fat-rich and high sugar products. This indulgence may be represented in advertising as a way for women to connect emotionally, even romantically, escape a hard day, or as a display of love for others (Kilbourne, 1999).

These great pressures on women represent very real dilemmas; even morality itself can be in question of a girl who is viewed as being overindulgent. It used to be that being a "bad girl" referred to a woman who became pregnant without being married; today the "bad girl" is the woman who becomes fat or obese (Kilbourne, 1999; Maine, 1999). Due to anti-fat attitudes in the United States, obese women are 20% less likely to marry, and make an average of 60 cents in comparison to a man's dollar, rather than the national average of 70 cents to a man's dollar of their thinner counterparts (Stunkard & Storenson, 1993). As a result, obese women are at high social risk and have greater risk of experiencing poverty on top of any physical health risks they may be facing due to their of obesity (Kilbourne, 1999; Maine, 1999; Stunkard & Storenson, 1993).

The reflection of a woman's self-hood through society's eyes greatly affects her identity, as identity is co-constructed between individuals and the society within which they live (Goffman, 1959; Inhorn, 1996). For women, obesity is a stigma symbol (Goffman, 1963) that cannot be hidden so it reflects upon the individual, causing the outward stigma to become internalized and the woman herself develops a "stigmatized identity" (Goffman, 1963; Inhorn, 1996). Women are expected to meet social norms by conforming, but when issues of physical make-up, such as obesity, prohibits a woman

from achieving social norms, she is expected to remedy the situation through acts of compliance to indicate that she is working toward the goal of conformance (Inhorn, 1996). For obese women this compliance comes in the form of diet plans, appetite suppressing medications, and exercise equipment and implies “stigmatized identity” (Goffman, 1963; Inhorn, 1996) because the act of compliance requires the obese woman to accept herself as flawed, less than perfect, and in need of remedy.

Women searching for thinness in the United States may embark down numerous avenues in hopes of attaining their weight loss goals. Countless diets pervade the internet and popular women’s magazines. Exercise equipment featured in infomercials and various ads promise results for minimal effort. Various herbal and medicinal sources promise to alleviate hunger so women can starve themselves to thinness. Unfortunately, the average result of utilizing these types of weight loss fads is a legacy of weight loss and re-gain that can have negative health effects for women (Kilbourne, 1999; Waterhouse, 1993).

Today medical advancements offer a more drastic solution to obesity with the option of weight-loss surgery (WLS). WLS has grown beyond the status of being a mere fad in the United States. Between 1998 and 2004, the U.S. saw an increase of over 400% in the rates of WLS procedures performed annually, with 82% of the recipients of these surgeries being women between the ages of 18 and 54 (AHRQ, 2007). In the 12 to 18 months following WLS procedures, women lose dramatic amounts of weight with the average represented by a 60-90% excess weight-loss depending upon the type of WLS performed (See Appendices). The dramatic increase in WLS procedures among women

makes it imperative for researchers to focus attention on the impact these experiences have on women's identities as they navigate this new frontier in their lives.

The effects of WLS may be placed into three categories. The first category represents physical changes that a woman will experience such as changes in her body's physical appearance as well as in the body's physical abilities and performance. For example, as body mass decreases a woman may experience an increase in energy. Body performance is altered as well, hunger may no longer be an issue and physical abilities may increase or decrease depending upon the individual. The second category represents psychological changes that a woman will experience. For example, many women have been trained to use food as a coping mechanism (Kilbourne, 1999; Waterhouse, 1993), and now that eating is no longer an option, they must find new ways to handle their emotions (Odom et. al, 2009). Emotions run rampant during periods of rapid weight loss, partially due to hormonal fluctuations as the body attempts to find some form of balance. Counseling and support groups may prove to be useful resources for women as they experience and rationalize the changes they are going through (Kinzl et. al, 2003; Odom et. al, 2009). The third category is symbolic and represents the process of renegotiating identity that must occur along with the physical metamorphosis a woman experiences with WLS. For example, a woman may begin to see herself differently as she loses weight, often experiencing a dramatic increase in self-esteem (Hrabosky et. al, 2006). As the woman sees herself differently, she will likely begin to communicate differently about herself to alert others to her shift in identity. However, others may continue to view the woman as she previously was or in a different way than she sees herself, and a woman who fails to negotiate her new, highly symbolic, image of self with the views of

others may experience negative emotional consequences such as depression (Jung & Hecht, 2004).

Within this frame of WLS and rapid weight-loss, within which rapid changes occur in physical appearance and emotional state, the role of communication in renegotiating identity has not been examined. The development of identity is a communicative process that occurs over time. In this process, an individual internalizes who and what they feel they represent and then devises ways to project these aspects of self to others around them via verbal and non-verbal forms of communication (Goffman, 1963). These aspects of identity are either accepted or rejected by significant others who may be friends, family, or even new acquaintances who may choose to accept or reject the individual's identity status. As an individual experiences drastic changes, such as rapid weight-loss post-WLS, renegotiation of identity may be a difficult process.

Considering the growing prevalence of WLS procedures among women, the examination of the communication processes necessarily involved in the renegotiation of identity is both highly warranted and timely. Exploring the types of messages that have the greatest impact on women struggling with weight issues may prove useful to the medical and mental health community in assisting patients who have undergone WLS through this period of extreme change. It may also prove useful to women considering WLS and wanting to know what they may expect, as well as assist women who have already undergone WLS in understanding they are not alone in coping with these issues.

This study seeks to explore the uncharted territory of the necessary role of communication in the process of renegotiating identity post-WLS. The unique narratives of ten women, collected during semi-structured interviews are examined via qualitative

analysis in order to identify significant communicative moments in their personal process of renegotiating identity post-WLS. In order to examine the social impact of WLS on women, researchers must begin with the collection of accounts on the individual level in attempt to comprehend all imperative facets that affect these women. Presenting the stories of women who have the shared experience of undergoing WLS, will begin a documented history that may assist researchers, the medical community, as well as these women themselves in developing a greater understanding of the roles communication and significant others play in renegotiating and shaping their identities.

CHAPTER II

REVIEW OF LITERATURE

The following literature review will explore the history of the study of identity from various fields of research: namely philosophy, sociology, psychology, and communication. The formation of identity from all perspectives occurs as the result of social activity that takes place within the context of greater society. In this way, individuals evolve as products of their culture, which is reflected through their presentation of self, self-beliefs, and identity.

Theories of Identity: Philosophical, Sociological, and Psychological View Points

The concept of identity is deeply rooted in the social sciences and the humanities. Examining the historical roots of the concept of identity is imperative to the comprehension of the most recent research. The field of philosophy aims at developing and explicating concepts of the self—its most ancient roots being an examination of man's relationship to God (Descartes, 1637; Foucault, 1977; Locke, 1690; Mills, 1998). The field of sociology defines the self through examining man's relationship in society to

other men via channels of social interaction and exchange (Cronk, 2005; DeFleur, 1964; Goffman 1959, 1963; Inhorn, 1996; Kaufman & Johnson, 2004; Mead, 1934; Simon, 2004; Stryker, 1980, 1987). Psychological studies attempt to understand how the “mind” and its cognitive processes, shape identity. Contributions from all of these relevant fields have culminated in a rich understanding of the concept of identity, and why it is central to understand humans (Fiske & Taylor, 1991; Harwood, 1999; Markus, 1977; Maslow, 1970; Simon, 2004; Tajfel & Turner, 1986). The most basic human question is that of “who am I?” It is only natural that human beings seek an answer to this question, and the pursuit of this answer is the common thread throughout all examinations of identity.

Philosophical Views of Identity

Philosophical viewpoints on identity are not so easy to pin down since they, by nature, consist of a vast array of conceptions of self. One of the earliest known philosophers to tackle the concept of identity was John Locke. In his work, *An Essay Concerning Human Understanding* (1690), Locke concludes that man, in the general term, is a body made up of physical parts that constitute that animal (a man). The identity of the man; however, is made up of a consciousness that man possesses and maintains throughout his lifetime that identifies him unto himself, and himself unto others. This consciousness alone is what distinguishes one man from another (Locke, 1690).

Philosophers have approached questions of identity in a multitude of ways. One aspect that directly applies to individuals who experience stigma based upon physical

factors, such as race, ethnicity, physical handicap, and obesity, is the philosophical examination of power in societal structures. Descartes (1637) explored the foundations of what could be conceived of as “real.” He asserted that he could conceive of his mind as real since thought and rationale provided proof of its existence; however, he could not conceive of his body in the same way, and wondered of its tangibility (Descartes, 1637). Modern philosophy moved more into the focus on social positioning of individuals rather than on the physical animal; for example, Charles W. Mills argues that individuals who are stigmatized as a result of physical characteristics cannot afford this same line of reasoning Descartes (1637) suggests. Mills particular example is the black slave, who due to physical burden, pain, and suffering, could not doubt the tangible existence of the body (Mills, 1998). Individuals who are stigmatized based upon physical characteristics, including obesity, are often socially stigmatized in various ways leaving them low in power and control in the social hierarchy.

In the 1960s to the early 1980s Foucault examined the formation of identity as it applied to status within social hierarchy and power structures. In *Discipline & Punish* (1977) Foucault suggested that identity is formed through a process of coercion based upon social expectations that are set forth by those wielding the most power and status in a society. Individuals are subjected to constant surveillance and those who do not mold themselves into model citizens in appearance, manner, and action are subjected to punishment via social sanctions, which can range from disapproving glances to public ridicule, and even criminal charges (Foucault, 1977). Because humans naturally seek the approval of others, identity is likely shaped based on the individual’s confidence in their abilities to conform to social standards of discipline and avoid punishments.

These modern philosophical views of identity share a common thread. They explore ideas of what identity is and how it is formed based upon one's existence within their given social reality. Each idea also possesses a duality of identity. One aspect serves as a signifier of one's unique existence apart from others while it also places one among others in a system of social belonging that signifies status in the cultural hierarchy.

Sociological Views of Identity

George Herbert Mead, a social scientist from the University of Chicago, is considered to be the father of sociological views of identity. Mead felt that individuals develop their own sense of identity through social interaction with others (Mead, 1934). The construction of self is seen as unique from physical aspects of the human body because it is reflexive in nature (Cronk, 2005; Mead, 1934). Human beings are born into a world of pre-constructed meanings that they shape self around and maintain "consciousness" of (Cronk, 2005; Mead, 1934). Identity is then formed through a reflexive, communicative process as the individual responds to the social world and develops understanding of "symbols" for which people in a society have common shared meanings.

Every individual has their own, unique perceptions of the world around them, but significant "symbols" elicit a similar response in most people; for example, the word "dog" (Mead, 1934). The word "dog" is likely to evoke a different image for most people, e.g. different breeds, sizes, and colors, but for most people the word "dog" will similarly

bring up an image of a four-legged animal with a wagging tail (Mead, 1934). Once an individual develops understanding of many significant symbols, they learn through experience to manipulate the use of these symbols to attain certain reactions or responses by variation of gestures and vocal tone (Mead, 1934). Shared meanings allow an individual to take on the “role of the other” in social role-playing (Cronk, 2005; Mead, 1934, p. 160). Through enacting these roles and engaging in social interactions with others, the individual begins to see herself/ himself through the perceived lens of significant others. This elicits a response, “calling out in the other person something we are calling out in ourselves, so that unconsciously we take over these attitudes” (Mead, 1934, p. 69). The act of role-play becomes complex as the self continues to evolve and multiple ideas of the roles of others are formed, which allows the individual to react to specific others in specific ways. When these multiple roles are compounded to synthesis the “generalized other” is created (Cronk, 2005; Mead, 1934, p. 154). This ideal of the “generalized other” allows the individual to react to society in a general way when the specific “role of the other” has not been identified; for example, meeting someone for the first time (Cronk, 2005; Mead, 1934).

Mead’s theory of identity became known as “Symbolic Interactionism,” and paved the way for further examination of the role social interaction (communication) plays in human relationships. Symbolic Interactionism is an active process and a key concept in understanding how identity is formed. Mead developed the concepts of the “me” and the “I” to explicate this process (Cronk, 2005; Mead, 1934, p. 178). The “me” is constructed through interaction with others and represents the social self (Cronk, 2005; Mead, 1934). The “I” on the other hand responds directly to the unique social situation

and represents the individual's choice of course in the social event itself (Cronk, 2005; Mead, 1934).

Mead's concept of identity is not static, but an ever-evolving process. Individuals are attuned to comprehending the attitudes and opinions of others toward her/him in social interactions. The projected ideas of others play a part in how the individual chooses to interact in a social event and eventually become internalized as a part of the individual's self (Mead, 1934). New experiences with new people, and an ever increasing catalog of significant symbols, cause one to feel there are new social expectations and perceptions of their identity as a person. This may spark significant evolution in identity over the course of time.

Erving Goffman was a student of Mead, and furthered the exploration of identity. Goffman saw the invention of self from a perspective he termed the Dramaturgical Approach (Goffman, 1959). Goffman's dramaturgical approach paints human beings as actors on a stage who perform various roles in order to create a desired perception of themselves for the given audience. These performances generally are created for specific purposes or to control and achieve various objectives. In his book, *Presentation of Self in Everyday Life* (Goffman, 1959), Goffman asserted that the average "individual is likely to present himself in a light that is favorable to him" (Goffman, 1959, p. 7). The desire to be seen in a positive light may explain why individuals create various narratives to assist them in preserving "*face*," which means attempting to keep others under the impression that one possesses certain, desirable characteristics about themselves that detract attention from more undesirable characteristics (Goffman, 1959). This performance is convincing when an actor fabricates a believable "*front*," or act (Goffman, 1959). One example of

preserving “face” may be found in the example of an obese individual who, seeking social acceptance, adopts the social narrative that says “fat people are often jolly,” and hence, decides to fabricate a jovial “*front*” and act out this narrative of joking and being fun to be around. The individual has preserved “*face*” by causing others to focus on socially anticipated values they possess in order to avoid critiques of their physical appearance. Through enacting this narrative, the individual has created a shield against social stigma by presenting their identity in a way that emphasized social behavior over physical appearance in hopes of gaining social acceptance. Goffman would describe this activity as a *protective practice* because it serves to “protect” one from negative inferences made by others (Goffman, 1959).

The individual will alternately utilize performance strategies to “defend” the presentation of self, or “*front*,” they have chosen to perform before others; these are called *defensive practices* and work in conjunction with protective practices to preserve the identity an individual has elected to project to others (Goffman, 1959). After a period of performing certain social roles along with asserting protective and defensive practices, an individual begins to internalize these aspects of self as part of their own unique identity. Once these views are internalized, they become “self-belief” (Goffman, 1959, p.20); which is the key to the formation of identity according to Goffman.

Goffman did not believe that an actor could completely control the presentation of self to others, however. He asserted that an inherent duality to performances exists; that the desired presentation of self co-exists along with that which the individual reveals accidentally during performances. These accidental revealings of inner self are impossible for the actor to control, and may work to discredit the role being performed.

An actor's audience is generally unsuspecting, however, and may choose to tease out details of the performer's identity via further communication. This back and forth communication between actors is an "information game" that is played to help each fellow actor determine their own unique view of others (Goffman, 1959). Though most individuals enter this "information game" free of suspicions, there are *cynics* whom Goffman states are individuals that purposely attempt to convince others that they are something they know they are not. The example Goffman gives of this is of a poor man aping middle class status, which may be troubling to those of middle or upper class status who fear that their social status may be stolen (Goffman, 1959). Goffman points out that "*cynical performers*" may lose their credibility with others as a result of being exposed as charlatans (Goffman, 1959).

Goffman (1963) also discussed the aspect of "*stigma*," and the ways in which stigmatized individuals would attempt to manage their face identities if they should become "*spoiled*" by "*cynical performance*" (Goffman, 1959). Goffman (1963) recognized that "*stigma*," defined as possessing any physical characteristic or the performance of actions that would detract from, or ruin, social status, impacted the lives of individuals with minority status, as well as those with reputations that went against the grain of social norms, such as, prostitutes, homosexuals, and substance abusers (DeFleur, 1964). Persons not possessing stigma were labeled "*normals*," according to Goffman's (1963) ideology, and these non-stigmatized individuals held the power to discriminate against others of stigmatized status.

Not all stigmatized individuals, however, suffered the same level of discrimination. Some individuals possessed "*stigma symbols*," which were highly visible

and subjected them to greater discrimination, where others with less visible forms of stigma, were sometimes able to “*pass*” for non-stigmatized individuals and avoid discrimination (DeFleur, 1964; Goffman, 1963). The concept of passing is often used to describe individuals who identify as GLBTQ who strive to pass as heterosexual, particularly in public spaces, in order to avoid discrimination in hetero-normative society, for example. In contrast, obesity is a highly visible stigma symbol (Goffman, 1963) that even wearing larger clothing cannot disguise, making passing impossible and damaging identity. For women, obesity reflects upon the individual, causing the outward stigma to become internalized and the woman herself develops a “stigmatized identity” (Goffman, 1963; Inhorn, 1996). Women are expected to meet social norms by “conforming,” but when physical make-up, such as obesity, prohibits a woman from achieving social norms, she is expected to remedy the situation through acts of “compliance” to indicate that she is working toward the goal of conformance (Inhorn, 1996). For obese women this “compliance” comes in the form of diet plans, appetite suppressing medications, and exercise. In order to better understand how stigma affects stigmatized individuals, Goffman suggests adopting a focus on relationships between individuals rather than examining the actual stigma symbols or stigmatized attributes stigmatized individuals may possess (Goffman, 1963; Kaufman & Johnson, 2004).

An individual may be taken in by their own act and experience a sense of shock when others refuse to accept their projected self (Goffman, 1959). This example Goffman would coin as a case of mismatch between *appearance* and *manner* which has created inconsistency in an individual’s *front* (Goffman, 1959). Given that *appearance* is a portion of *front* that works in conjunction with social performance to create identity, an

individual experiencing rapid weight loss would have to contend with constant flux in this aspect of identity. During this period, the presentation of self would change whether or not the individual wished it. In regard to Goffman's theory of identity, individuals undergoing this process of rapid physical change most likely contend with some extensive social stresses on a daily basis as they attempt to re-negotiate their identities and gain the acceptance of their surrounding audience.

Identity theory (IT) (Stryker, 1980, 1987), a more recent sociological theory, seeks to combine aspects of both Symbolic Interactionism and Role-Theoretical perspective. Viewing identity as the complex result of a complex society, IT postulates that individuals maintain multiple identities which are reflective of the multiple roles they occupy in their every day lives. These multiple roles co-exist in a hierarchy of importance based upon personal levels of commitment to the performance of that role; each role also maintains a certain level of salience within the hierarchy that is motivated by interactive response (Stryker, 1980, 1987). The greater the level of interactive affirmation an individual receives in response to a performed role, the more likely they are to commit to that role and recognize opportunities to perform it; hence, the role achieves greater salience within the hierarchy (Stryker, 1980, 1987).

Mead's and Goffman's theoretical frameworks lay the foundations for many other theories of identity. In fact, from a Sociological standpoint, two main areas of theory exist. One is based in Symbolic Interactionism, and the other is Role-Theoretical perspective where socialization is dependent upon the independent roles each of us act out as part of the whole in society, thus enveloping Goffman's Dramaturgical Approach (Simon, 2004). All Sociological theories share the concept of the self being identified via

some process of socialization which occurs through communicative interaction with other individuals and social organizations within society; thus, communication plays a key role in the formation of identity.

Psychological Views of Identity

Psychology offers a multitude of contributions to the study of identity and the self with primary focus on the internal cognitive processes involved in development, maintenance, and evolution of identity and the self (Fiske & Taylor, 1991; Markus, 1977; Maslow, 1970; Simon, 2004; Tajfel & Turner, 1986). The social/ interactive aspects of these processes are recognized as an important aspect of this development. Tajfel and Turner's Social Identity theory (SIT) (1986), for example, examines ways of defining one's self concept via identification with the social in-group to which we belong and have an emotional attachment. In other words, individuals tend to act similar to others they view as successful members of the social group or community to which they belong. A large part of this identification process is work to differentiate ourselves from members of out-groups, or social groups to which we do not belong. This builds up self-esteem and positive self-concept (e.g. adolescents behaving in a manner similar to their adolescent friends, while assuring this behavior is completely different than that of their elderly grandparents). Because of this identification process, individuals actively seek out similar others with whom to interact, as well as similarly behaving others to view in media venues. Comparing one's self-concept to these similar others serves as a form of positive

reinforcement that an individual is modeling themselves after something perceived to be good (Harwood, 1999). This seeking out of similar others also serves to protect members of low-status and minority groups from injuries their self-identities may suffer as the result of too frequently comparing themselves to others of higher economic or social status (Leach & Smith, 2006).

Turner examined the development of identity with Self-categorization theory (SCT) (1982). SIT focuses on the development of self as part of a collective, the “we” aspect of self. SCT additionally focuses on the ways in which individuals develop unique, independent characteristics to differentiate themselves from one another within their in-group, the “me” aspect of self. SCT adds to the understanding of self by recognizing that self-concept is never static, but rather is a reflexive process open to considerations, reflection, and evolution (Simon, 2004). This makes SCT a much broader psychological theory that extends the scope of SIT in the development of self.

Psychological theories of identity additionally assert that self-concept is formed via internalizing external events and stimuli individuals encounter in their environment. Markus (1977) examined this internalization process recognizing that individuals must organize all this internalized stimuli in some way; she dubbed these organizational tools “self-schemas.” These self-schemas assist individuals in retrieving important information about who they perceive themselves to be, as well as in determining behaviors that would or would not be consistent with current, relevant views of self (Simon, 2004).

Other important areas focused on by psychologists examining identity are self-regulation, self-enhancement, and self-actualization (Simon, 2004). Self-regulation involves tasks such as setting goals for oneself and doing the cognitive work necessary to

see it through (Fiske & Taylor, 1991; Simon, 2004). Self-enhancement allows an individual to feel successful in their chosen identity or self and works to create and maintain bonds within one's social in-group (Simon, 2004). Self-actualization, from a humanistic perspective, speaks to the individual's ability and desire to strive for improvement and evolve (Maslow, 1970; Simon, 2004). All of these psychological theories of identity illustrate the flexibility of identity and the individual's ability to renegotiate aspects of their identity when deemed necessary. If an individual relocated, for example, according to SIT (1986) she/he would need to choose another in-group to conform their identity to (Harwood, 1999). The individual would also need to adapt successfully to stimuli provided in their new environment, as well (Markus, 1977).

Theoretical Bridges: Emergent Definitions of Identity

Though there are many differences and unique nuances between social science theories of identity, several common threads exist. All theories examined from philosophical, sociological, and psychological fields of study recognize that identity is a malleable entity that is shaped and formed through interactions with others. Because of this focus on interaction, identity is a co-constructed part of every human being, capable of adapting to new ideas, experiences and responding to new environments and alterations in our beliefs about ourselves.

Arguably the key medium through which individuals co-construct their identities, present ideological changes in concepts of self, and gain important feedback from others

is via communication. Communication is present in every interaction human beings engage in with other human beings and yields the power to shape our views of ourselves and others around us. Communication plays a central role in forming humans' relationship to society; examining this fundamental role of communication may assist social scientists in developing better understanding of the process of identity renegotiation for women who have undergone WLS. The following section will explore communication theories that illustrate the inherent roles communication plays in the formation of identity.

Communication Theories of Identity

As has been demonstrated through exploration of various fields of identity theorizing, the majority of theories of identity recognize the importance of social interaction in the development of identity and self. Identity has long been viewed as a product of the social process, as is illustrated by Mead's Symbolic Interactionism (1934) and Goffman's (1959) Dramaturgical Approach. In the discipline of Communication, communication itself is seen as the key component to which scholars should turn their focus. Two useful communication theories through which to explore the fundamental role of communication are Communication Theory of Identity (CTI) (Hecht, 1993) and Eric Eisenberg's (2001) theory of identity.

Communication Theory of Identity (Hecht, 1993) explores communication *as* identity, rather than merely seeing communication as a venue to developing identity

(Jung & Hecht, 2004). The argument Hecht posits is that, "...social relations and roles are internalized by individuals as identities through communication. Individuals' identities, in turn, are acted out as social behavior through communication" (Jung & Hecht, 2004, p. 266).

CTI examines communication as identity via four frames of identity; personal identity, enacted identity, relational identity, and communal identity (Hecht, 1993). *Personal identity* is made up of self-concepts that an individual feels represents their personal identity. *Enacted identity* consists of aspects of identity that are acted out; these aspects are communicated, hence are identity itself. There are four levels of *relational identity*: the first looks at how others perceive an individual based upon ascribed status; the second examines identity based upon personal relationships, the third examines how multiple roles and identities interact, and the fourth examines how collectives and in-group status affect identity (Jung & Hecht, 2004). *Communal identity* examines the impact of memberships and a sense of collective history within that in-group that defines who an individual is and how they are to interact, thus cultivate their identity with others.

Jung and Hecht (2004) elaborated on CTI by identifying gaps that exist in how individuals interact within these four frames. To assist in filling in these gaps, they examined the distance between personal and enacted identity and personal and relational identity (Jung & Hecht, 2004). The first of these gaps, *personal-relational identity gap*, identifies the distance between the way an individual views themselves and how they perceive others view them (Jung & Hecht, 2004). The second gap, *personal-enacted identity gap*, identifies the distance between the identity people maintain and the identity they express, or act out, in the presence of others (Jung & Hecht, 2004). The smaller

these existent gaps are, the greater communication satisfaction an individual should feel (Jung & Hecht, 2004). Larger gaps may represent emotional pain; for example, if an individual is attempting to communicate their identity to others and they are unsuccessful, the individual may feel misunderstood and become depressed. Higgins (1987) addressed this issue of depression in Self-Discrepancy Theory (Jung & Hecht, 2004). The picture of identity Jung and Hecht created will help to explain the role of communication within the development of identity post-WLS, as well as ramifications for failing to communicate identity to others; however, gaps still remain.

Eisenberg addresses these gaps in the development of identity by accepting the great complexity of forces at work. Eisenberg posits that a new theoretical context is necessary to allow room for the complex web of factors that come into play when examining the connections between communication practices and identity. Eisenberg (2001) suggests consideration of a cycle of three interactive processes: an individual's communicative choices with their personal narratives, an individual's personal narratives with their physical experiences, including mood and emotional factors, and the impact of the first two interactive processes on environmental factors that allow an individual to create and sustain their personal identity (Eisenberg, 2001, p.563). By considering all of these factors, Eisenberg (2001) feels current beliefs regarding the relationship between communication and identity that have proven to be restrictive will be revealed to be predominantly self-reinforcing, and the field will become more open to new ways of conceptualizing the relationship between communication and identity.

Eisenberg (2001) refers to the sum of an individual's environment, including their social world and experiences, as "the surround." The surround is positioned as an insular

capsule around three interrelated identity processes that assist an individual in making sense of their environment and roles within it, hence shaping their personal identity. The three identity processes consist of mood, personal narrative, and communication (Eisenberg, 2001). Mood is considered a key factor in the development of identity because one's mood, or emotional state, elicits biological responses which frame an individual's interpretations of their past and present life experiences, environment; these interpretations impact the individual's communicative choices (Eisenberg, 2001). The second identity process, personal narrative, or life experiences as the individual has interpreted them, will assist in sense-making and choosing responses to others. The interpretation of one's personal narrative may also determine emotional response to events (Eisenberg, 2001). The third identity process is communication; an individual's communicative choices are largely determined by the ways in which an individual has interpreted their personal narrative and biological emotional responses to others and the surround (Eisenberg, 2001). The three identity processes Eisenberg (2001) has suggested are interrelated, and should not be viewed as separate from one another. All three identity processes are also subject to influence by the environmental factors of the surround as it affects the individual (Eisenberg, 2001).

Eisenberg's (2001) theory of communication and identity lends understanding to the intricate web of complexities surrounding issues of identity; however, this complex structure may also work to complicate any potential understanding of factors that directly impact the renegotiation of identity, such as the process seen in individuals who have undergone WLS. Qualitative research methods may be employed to assess the unique narratives of individuals to seek out contributing factors in the identity renegotiation

process. It is likely that a multitude of contributing factors will be located, and Eisenberg's (2001) theory of communication and identity may serve as a guide to locating some of these contributing factors.

Theoretical Bridges: Contributions of Communication Theories to Definitions of Identity

Communication theories of identity help bridge the studies of philosophy, sociology, and psychology by identifying the roles of communication within the process of co-constructing identity. Communicative exchange is an integral part of social construction because it is the vehicle through which individuals generate their views of society; for example, messages communicated via mass media venues that shape ideas of what is socially acceptable. These adopted attitudes are then communicated from individual to individual via interpersonal lines of communication. This communication may be verbal, such as telling a family member they need to cut back on food intake due to recent weight gain, or nonverbal, such as making a face when a friend asks if she looks heavy in a certain outfit.

Communication plays a role in obese women's lives on a broad social level as social norms are implied to them through media, treatment by peers, and public reaction to their appearance. Communication also plays a role on an interpersonal level as obese women maintain relationships with family, friends, co-workers, health professionals, etc. These individuals may express their thoughts regarding the woman's obesity, affecting her thoughts and feelings about herself. These internal thoughts and feelings are

developed and communicated to oneself through the vehicle of intrapersonal communication. Self-talk may reflect social norms, as well as attitudes absorbed through communication with others.

The social ideals that greater society communicates to women regarding their weight and appearance is a problematic one in a capitalistic society where sex sells, and is the pre-dominate form of marketing products from car sales to cosmetics. This social focus and preoccupation with women's bodies can be harmful to women's emotional well-being. This makes the examination of how obese women are viewed in U.S. culture imperative to understanding how obesity creates a "stigmatized" identity for these women and impacts social and emotional aspects of their lives.

Obese Women in American Culture

Women in United States culture are more likely to be obese than women in most other countries. They become part of a cycle created by media and corporate America to attack their self-esteem and emotional selves by communicating to them that they must constantly seek out beauty and male approval above all else (Kilbourne, 1999). Currently only about 5% of media sources are owned by women and individuals of color so messages in media about women and their bodies are prescribed by white males (Howard & Giles, 2005). Women are encouraged to purchase diet products and exercise equipment in order to achieve and maintain socially acceptable standards of slimness, as well as a slew of body creams and cosmetic products that promise to keep them young and

beautiful. These products are costly, which keeps women's purchase power low, and they are time consuming, which keeps women's focus off their careers and keeps their earning power low (Howard & Giles, 2005). The focus on female beauty is an intense drive for women who are continually engaged in self-monitoring practices. Berger (Jones, 2005) asserts that in American culture, women are defined through their appearance and gestures because she is continually the subject of the masculine gaze which objectifies her. The ways in which she is evaluated by men around her will determine how these men will, in turn, treat her. Because of this, women continually engage in self-monitoring activity by envisioning themselves and how they perceive they appear to others, attempting to alter aspects of themselves they perceive to be unappealing to the social, masculine eye (Jones, 2005).

While the appearance of women's bodies is valued above all other contributions they make, including contributions to her family, work, and community (Maine, 1999), women also are encouraged to engage in emotional relationships with food (Kilbourne, 1999). Messages of this nature are communicated through mass media such as television sitcoms, advertisements, and even print ads. Women are encouraged to indulge in foods high in sugar and/or fats to treat themselves, help them cope with chaotic schedules, stress, and any number of other emotional events that may impact them on a daily basis (Kilbourne, 1999). Women indulging in food is also often viewed in a sensual, sexual light; for example, a woman being fed chocolate dipped strawberries and engaging in sensual mouthplay (Kilbourne, 1999).

Studies show that by fourth grade 80% of American girls are dieting or have been on a diet illustrating that messages of prescribed thinness for women are culturally

instilled at a young age (Griffin, 1994). Children of this age level were shown silhouettes of people of various body shapes sizes and were then asked to give descriptive characteristics for these make believe people. Consistently the obese silhouette was given the descriptors of stupid, dirty, lazy, or mentally slow (Griffin, 1994) illustrating that even young children understand the implications of stigma related to obesity that are readily communicated to them by social ostracization, among other social sanctions, ascribed to the stigma symbol (Goffman, 1963) of obesity. Due to the existence of these stigmatizing (Goffman, 1963) stereotypes and the fact that obesity is considered sinful or immoral in American culture, the practice of weightism, or weight prejudice, has been allowed to continue unchecked which lends greater impact to social sanctions for obesity. Supporting evidence of this may be found in mass media of multiple types (e.g. music, sitcoms, advertising, etc.) that posit obesity is socially unacceptable and that anyone has the ability to change it by simply purchasing the right pill, gym membership, or exercise equipment. Further proof of obesity-related stigma (Goffman, 1963) may be seen in the fact that in single-mother households where the female head of the household is obese have an annual income approximately \$6,710 dollars lower than single-mother households headed by a thin female (Stunkard & Storenson, 1993). Obese women are also 10% more likely to live in poverty and 20% less likely to marry than their thin counterparts (Stunkard & Storenson, 1993).

Considering the impact of social sanctions on women who do not or can not achieve the mediated view of body perfection, it is not surprising that women turn to extreme means of achieving this perfection, as if the struggle may somehow buy redemption for their moral character even when they come up short. Some of these

extremes may be seen in the dramatic increase of women who undergo plastic surgery; an increase of 153% in number of cosmetic plastic surgery procedures performed since 1992 (Gimlin in Taylor, Whittier, & Rupp, 2007). The pursuit for cosmetic surgery stems from dissatisfaction with one's body and many participants expect positive impact on self-image and social performance as a result, expectations that may or may not be realized (Askegaard, Gertsen, & Langer, 2002). This trend to "fix" body issues surgically may help explain why women are flocking to WLS to help resolve their struggles with obesity.

The Weight-Loss Surgery Phenomena

The stigma placed on women who are overweight, or obese, in this country has been the driving force behind the sales of weight loss and exercise products; most of which are geared toward female consumers. The majority of these products require drastic reduction in food intake or rigorous workout schedules in order to achieve success. For a woman who is obese and contending with the triad of common stressors: work, family, and household maintenance, the time and energy commitment may be impossible. Many women also utilize food for emotional purposes to assist them in coping with a myriad of feelings and stressors. In these instances, dieting itself may become virtually impossible to manage due to physical hunger as well as unmet emotional needs. When WLS was introduced, it offered an answer to these issues, and women represent the largest percentage of WLS patients.

WLS is becoming a trend in the United States today; in 2008 over 200,000 patients underwent WLS procedures (American Society of Metabolic and Bariatric Surgery, 2009). The American Society of Metabolic and Bariatric Surgery (ASMBS) as well as the American College of Surgeons (ACS) have set up guidelines for bariatric centers to follow. These guidelines help to ensure that only well-qualified surgeons are able to perform WLS procedures and to protect patients by requiring bariatric centers to undergo rigorous steps to attaining ASMBS or ACS accreditation. Without accreditation, insurance companies are less likely to approve patients for surgical procedures (Drew, 2008). Some of the guidelines focus on patient welfare such as standards for psychological examinations prior to WLS, and certain types of nutrition counseling for patients.

In order to solicit the large number of clients bariatric centers need, most centers have turned to internet marketing. These websites contain specific content geared to frame WLS as the answer to prospective clients,' predominantly womens,' problems. "These sites construct morbid obesity as an intractable disease with serious physical and emotional consequences that are remediable only by surgical intervention (Salant & Santry, 2006, p. 2449)." According to Salant and Santry's (2006) study of bariatric websites, obesity is defined as a *national epidemic* in 63% of sites, a risk factor for future illness in 89% of sites, a cause of death in 67%, and out of a person's control in 41% of sites. In order to illustrate the transformative results of WLS, images of butterflies and metamorphosis are frequently used, as well as patient testimonials, and before and after photos of the most successful patients (Salant & Santry, 2006). Bond et. al (2004) discuss issues of framing WLS to prospective patients. They appeal to the use of the

“new lease on life” analogy, as it tends to remove negative stigma of past lives and experiences prospective WLS patients have faced and allows them to create a mindset open to transformative change. This also frames WLS as the patient’s responsibility to make the necessary changes that should assist them in attaining successful outcomes. All of these health messages and promises of certain weight loss and metamorphosis attract women who are already under social pressure to lose weight and conform to socially constructed standards of beauty. WLS is often seen as an easy cure for obesity, but in truth most WLS patients experience a cyclical pattern of weight loss and weight gain after the initial “honeymoon” period of weight loss and will likely always struggle to lose more weight or maintain a certain goal weight (Bond et. al, 2004). Considering the fact that media and society continually bombard women with messages that they need to be thinner and maintain unrealistic beauty standards, it is possible that women may not be able to find satisfaction in their body weight or appearance post WLS.

The American Society for Metabolic and Bariatric Surgery (ASMBS) gives a list of criteria for all possible WLS candidates. In order to be considered a candidate for bariatric surgery one must have a body mass index (BMI) of 40 or greater and have at least one co-morbidity considered to be life-shortening or threatening such as sleep apnea, high blood pressure, diabetes, and asthma (ASMBS, 2008). Many of these individuals are dissatisfied with their quality of life going into the WLS process. Often these individuals describe themselves as unhappy due to suffering from the exertion of lugging around excess weight as well as displaying issues in relation to body image dissatisfaction (BID). BID is a psychosocial problem most commonly related to obesity that appears to be impacted by low self-esteem, eating disorders, body size and weight-

related childhood teasing (Rosenberger, Henderson, & Grilo, 2006). For women, the drive for perfectionism was noted as a strong predictor in BID (Rosenberger, Henderson, & Grilo, 2006). Because BID is a psychosocial disorder, it manifests itself in many troublesome aspects that may have many negative consequences such as, “depression, disturbances in interpersonal functioning, impaired sexual functioning, poor self-esteem, and diminished quality of life (Hrabosky, et. al, 2006).” The consequent root of BID and other disorders obese women experience likely stem from society’s ill-acceptance of women whose bodies don’t represent impossible to achieve social norms of thinness. Obese women bear outward “stigma symbols” (Goffman, 1963) in the form of curves and rolls that are not able to be hidden; even the use of spandex to shape women’s bodies and baggy clothing are not enough to allow most obese women to “*pass*” (Goffman, 1963) for thin, making it impossible for women to escape the social sanctions she may feel related to societal views of her weight, presentation of self, and appearance.

Hrabosky, et. al (2006) examined how individuals who have undergone WLS procedures and engage in rapid weight loss experience change in BID. According to their research, body image improves dramatically within the first six months and further improves by a period of twelve months, even though many are still overweight or clinically obese. The findings further indicated that body “normalization” could occur for patients psychologically even when ideal weight was not achieved (Hrabosky, et. al, 2006). This spike in self-esteem and body image is encouraging along with the health benefits WLS patients experience by losing significant amounts of weight. This spike reflects the initial high that WLS patients feel from immediate success in weight loss, which for many, may represent a life-long endeavor finally realized. However, research

of internet blog sites shows that the phenomena of “regain depression” often plagues WLS patients further out of surgery. Regain is a fairly common issue for WLS patients after the first 18 months post-surgically. Weight loss may continue for as much as two to three years, but eventually the body’s system levels out and weight maintenance becomes the focus over weight loss (GHP, 2008). The patient becomes able to consume significantly more food so making good food choices becomes increasingly important, and old habits can easily creep back into the picture causing weight regain which may lead to depression and BID.

Often individuals experiencing large amounts of weight loss can be disappointed with their physical results (Granberg, 2006). Years of being overweight can damage skin and weight loss, in general, does not always occur where an individual may wish it to occur. Further, individuals often have great social expectations that are not realized when they succeed in losing the excess weight (Granberg, 2006). Dealing with these unmet expectations requires the individual to undergo a process of reconciling their expectations with their outcomes (Granberg, 2006). An example of this may be losing weight and having to cope with sagging skin on the upper arms. This could have a negative impact on body image and self esteem, but an individual could reframe this image of self to see sagging arms as a badge of honor and proof of their achievement of major weight loss and the health benefits that go along with it. Granberg (2006) notes that individuals are most likely to be satisfied with their weight loss results if their expectations involved experiences that the individual could participate in prior to losing the weight; such as a cyclist desiring to lose weight and compete in a cycling marathon. Expectations based on

social desirability, however, such as becoming popular with the opposite sex, are the least likely to be realized (Granberg, 2006).

In summary, women post-WLS will face significant challenges as their bodies and lives change. They will need to cope with physical changes; for example, looking differently may cause people to treat them differently evoking positive or negative emotions. Emotionally women will face multiple challenges post-WLS, as well as navigating relational shifts that may occur as friends and family take in their physical and behavioral changes. All of these factors will play a role in the ways women renegotiate their identities post-WLS.

Roles of Communication and Identity Renegotiation Post-Weight-Loss Surgery

Eric Eisenberg argues that there is no single, fixed meaning in our communication endeavors; that all communication events seek to achieve multiple goals (Eisenberg, 2001). Communication allows individuals to tease out issues of identity and explore their relationships with others.

In this way, individuals who have undergone WLS may utilize communication to maintain relationships between themselves and influential others such as family, friends and co-workers, etc. A relationship also must exist between the individual and society and the social demands the society posits. These relationships are continually stressed as an individual engages in rapid weight loss. For example, family narratives play an important role in the development of identity. A woman who was previously obese

possessed a stigmatized (Goffman, 1963) identity, and she can renegotiate her view of herself, and work to communicate this ideological change to others; however, identity is a co-constructed process and she is unable to control whether or not others elect to release her from her stigmatized identity (Hecht, 1993).

Individuals strive for a sense of belonging so they categorize themselves as belonging to a certain ingroup (Gaertner & Dovidio, 2000). Individuals may perpetuate negative family narratives, such as over-eating and obesity, and adopt an identity of themselves in this light that is also mutually viewed as a factor of “belonging” by their other family members. Because of this adopted identity, individuals may seek out similar others as friends and acquaintances that also accept this identity and assist the individual in maintaining the identity as okay, or not flawed. In this sort of instance, losing weight may appear to be a betrayal of family “identity” or ingroup “identity” among friends who endorse over-eating, obesity and other negative lifestyle choices. Position in the social hierarchy may also change. For example, the individual who has undergone WLS may no longer be the “fattest” member of their family or peer group. Causing these “marker characteristics” to change creates a need for identity renegotiation among the ingroup members. By making a positive change in her own life, the individual may also give cause to family members and friends to evaluate their own negative habits and attitudes making them face their own identities in an uncomfortable way which may evoke negative feelings, and hence, stress these relationships making it difficult for the friends and family members to express support and genuine congratulations to the individual who is engaged in rapid weight loss and lifestyle changes.

This does not mean that relationships must be severed with friends and family members who are struggling to accept the individual's decision to undergo weight loss surgery. It does require, however, that a period of renegotiation of identity occur between the individuals in order for the relationship to continue. For example, a family member who has always used "food" to express "love," will need to find an alternate method to express the emotion. These identity renegotiations require much time and dedication to the communication process between the two individuals. This process is made exponentially more stressful because the renegotiation of identity must occur between the individual who has undergone WLS and all of their influential others at the same time.

Often new interpersonal relationships are forged during this period of identity flux. An individual who has undergone WLS may meet new influential others in the form of medical staff, fellow support group members, and new acquaintances as a result of lifestyle changes, such as fellow members of a gym or fitness center they may frequent. In these new relationships there exists pressure to communicate to the new influential other the new person the individual who has undergone WLS feels they have become, or are becoming. Communication Theory of Identity (CTI) (Hecht, 1993) recognizes that each individual holds a certain internal idea of their "personal identity" that they seek to transmit via communication to influential others. The identity that an individual performs or expresses to others CTI labels "enacted identity" (Hecht, 1993), and in instances where an individual fails to successfully transmit their "personal identity" to others via their "enacted identity" Personal-relational identity gap (Jung & Hecht, 2004) occurs. This occurrence may lead the individual who has undergone WLS to feel misunderstood or that their communication skills are inadequate leading to feelings of depression (Jung &

Hecht, 2004). For an individual in the process of renegotiating their own identity continually, post-WLS, the phenomena of personal-relational identity gap (Jung & Hecht, 2004) could prove to be a tremendous source of stress and a major contributor to depression issues individuals who have undergone WLS face.

The renegotiation of identity process exists in the interpersonal relationships an individual who has undergone WLS maintains; it also must occur within the individual's relationship with society as a whole. The individual, for example, may have accepted their status of obesity, existing outside of societal norms, and accustomed to experiencing the resulting social sanctions. Undergoing WLS may open the door for these individuals to attempt to conform to societal demands of thinness, but in reality, the average individual who undergoes a WLS procedure such as the roux-en-y gastric bypass may expect to lose 60-65% of their excess weight over a period of 12 to 18 months, with an average re-gain of 15% of lost weight five years post operatively (GHP, 2009). These statistics illustrate that it would be unlikely for an obese individual to achieve weight loss results that would allow them to conform to the societal demands women in American culture face for ultra thinness. So, at a time when an individual who has undergone WLS is experiencing rapid weight-loss, possibly opening up the door to hope for social acceptance and desires to achieve thinness, real expectations for results must also be evaluated. The reality is that without achieving exceptional results, super thinness often will not be achieved, and years of being obese followed by rapid weight loss may have physical repercussions such as sagging skin keeping the individual from achieving model'esque thin results that they desire. Because of this battle with appearance and the desire to conform, many women will undergo plastic surgery to help repair the effects of

rapid weight loss. Most women do this as a result of poor body image or self esteem, with the idea that the plastic surgery will assist them in achieving physical or social goals which may or may not be realized (Askegaard, Gertsen, & Langer, 2002).

The greater questions to focus on in this study then should focus on the role of communication in shaping women's conception of self, and how this conception changes after experiencing dramatic weight-loss as the result of WLS. In order to find out how previous conceptions of self have changed, it will be necessary to gather a chronology of data in the interviewing process. The research questions for this study seek to collect a historical narrative from each participant to help determine whether or not similar themes in the renegotiation of identity process may be uncovered.

RQ1: How do obese women considering WLS conceptualize their identities and communicate about themselves?

RQ2: During the phase of rapid weight-loss post-WLS, how do obese women conceptualize their identities and communicate about themselves?

RQ3: After the initial period of rapid weight-loss has ceased, how do women who have undergone WLS conceptualize their identities and communicate about themselves?

CHAPTER III

METHODS

Interpretive Paradigm

This study has adopted an interpretive paradigm through which to view the phenomena of identity renegotiation among women who have undergone weight-loss surgery (WLS) procedures. It is the appropriate lens because it has allowed me, as a researcher, to exercise my own subjective viewpoint to lend interpretation and understanding to the narratives of my participants (Lindlof & Taylor, 2002). Interpretive research queries the social understandings that exist beneath the surface of communication by asking questions such as, “What kinds of things are going on here? What are the forms of this phenomenon?” (Lofland, 1971 in Lofland & Taylor, 2002, p.19) These questions aim to get at the underlying currents of social existence that are essential to making sense of social phenomena.

When dealing with sensitive issues for women such as WLS, weight issues, sense of self, and its impact in their lives, it is necessary to possess some comprehension of these lived experiences prior to conducting the research. As a researcher who has also

experienced WLS, my subjective viewpoint may be more finely tuned to capturing important details and key themes in the narratives of the individual, unique, and courageous women that will be examined in this research study. At the same time, I recognize that my subjective views may color my interpretation of participants' narratives—particularly in instances where a participants' experience may appear to be similar to my own.

Narrative as Method

Utilizing narrative as method involves collecting the stories of individuals' lived experiences. St. Augustine asserted that the value in narrative could be found in its representation of three facets of individual lives; their memories, or past, present experiences, and expectations for the future (Onocko-Campos & Furtado, 2008). An array of existing literature presents ideas of what it means to be an obese woman in U.S. culture, and as a researcher on the subject of WLS experiences among obese women, it is imperative that I strive to understand social, cultural, and political structures that surround the subject of female obesity (Fraser, 2004). Obesity among U.S. women, though on the rise, is a deviation from social norms; however, it is difficult to understand what being an obese woman in U.S. culture feels like given that marginalization. Narrative holds the key to transform social theory into tangible reality by relating the biographies of real women as they are positioned in real life (Onocko-Campos & Furtado, 2008). These narratives essentially become social and historical markers, and may be

utilized to explore social phenomena and isolate themes in social discourse (Onocko-Campos & Furtado, 2008). In a health related context, narratives hold the power to reveal thematic content in patient realities that may otherwise be ignored (Onocko-Campos & Furtado, 2008).

Methods of Data Collection

During the first 12 to 18 months following WLS, women will rapidly lose weight (GHP, 2008). After this point, many women begin to plateau in their weight-loss (GHP, 2008). It becomes more important to have adopted healthy, new eating habits during the initial weight-loss phase in order to maintain weight-loss, and continued weight-loss may take a greater amount of effort than during the initial period of weight-loss post-WLS. This may be addressed by exercising strict portion control, a low fat and high protein diet, and staying physically active (GHP, 2008). This time frame may well mark the end of rapid weight-loss and an end to dramatic changes in the woman's body. It is the goal of this research to uncover the ways women's conceptualization of their identity has changed as a result of WLS and rapid weight-loss they have experienced, as well as examining how satisfied or unsatisfied these women are with their post-WLS results. How women communicate about themselves and how satisfied they feel with their post-WLS results may be important indicators of how they have renegotiated their identity.

Participants for this study were sought out via snowball sampling. As a woman who has undergone roux-en-y gastric bypass myself, I have personal friends and contacts who have also undergone WLS. I approached these individuals and requested that they

pass along the word that I was seeking to interview women who had undergone WLS, were over the age of 18, and who had undergone WLS more than 18 months ago. In order to avoid potential coercion issues, individuals I was closely acquainted with were not interviewed. My contact information was passed along to these women who then voluntarily contacted me at their convenience and were briefed on the participant criteria, time commitment, and purpose of this research. If they were still interested in being interviewed, an appointment to meet face to face was arranged at their convenience to go over the Informed Consent documentation. The majority of participants elected to conduct this initial meeting in their homes; however, one participant chose to meet at a local restaurant, and another participant, fearing familial distractions, elected to meet at the home of a relative. The process of collecting participants for this study proved to be rather lengthy, and since most participants resided an hour to three hours commute from my home, the majority of interviewees requested that their interviews be conducted immediately following the signing of the Informed Consent documents, though the option of conducting the interview at an alternate time was offered. Participation in the interview was on a strictly voluntary basis, and participants were informed that they were welcome to stop the interview at any time during the interview process though no requests were made to stop during any of the 10 interviews that were conducted.

The interviews were captured via a digital voice recorder, which was approximately 1" x 4" in size and was relatively unobtrusive. The questions asked of participants were based on a list of guiding questions (see appendix) that were developed to collect the information required to allow the research questions to be fully examined. The guiding questions attempted to split the participants' experiences with WLS into

chronological order. The chronological categories included questions about the pre-WLS experience, the post-WLS experience, and finally, how the participant perceives their experience with WLS today, more than 18 months out of surgery.

As an interviewer, I recognized the importance of demonstrating an understanding of cultural impact, which I attempted to do throughout the preceding literature review. I did my best to consider and prepare for possible questions that participants may ask of me, especially since I myself underwent WLS four years ago. The fact that I have also undergone WLS allowed me to be considered an insider by many of my participants, but to that effect, I took precautions not to take any liberties in understanding of language and emotions the participants expressed so as not to impose my personal frames upon them. Throughout the interviewing process, I attempted to exercise the interview skills Fraser (2004) outlined including: fostering good communication skills, actively listening, being sensitive to participant time constraints, treating participants with respect, protecting confidentiality, fostering trust in participants, being open to sharing results of the concluded study with participants, and having resources available for participants should they experience emotional duress related to the interviewing process.

Foster's (2004) guidelines were implemented by utilizing my knowledge of how to be an effective communicator and listener throughout participant interviews. Participants were asked prior to commencing the interview process whether they had any time constraints. The majority of participants seemed most comfortable warming up with a little bit of "getting to know each other" chat prior to commencing the interview. The majority of participants also wanted to ask questions of myself or about future research I will be conducting in regard to WLS. I responded to this need by allowing ample time for

interviews so that I would not be rushed in any way by my own time constraints. The offer was made to participants to receive a copy of this research project upon completion; 8 of the 10 participants happily accepted. All participants received a list of counseling and WLS support resources along with the Informed Consent documentation in order to assist them in coping with any emotional distress which may have resulted during the interview process. And finally, in order to preserve participant confidentiality, all interviews were transcribed by myself in a private area. The participants were all given pseudonyms and any names within interviews were also changed in order to protect participants from any potential of recognition. Once transcribed, the interviews were encrypted using Trucrypt and have been stored on a USB flash drive that remains in a locked drawer when not in use. The audio files were erased upon completion of the transcription process. Once this research study has been concluded, the encrypted files will remain with my thesis committee Chair, Dr. Leigh Ford, for a period of three years in compliance with Western Michigan University's HSIRB protocol.

Methods of Data Analysis

The data collected in this research study was in the form of participant narratives that grew out of response to a set of guiding questions (see appendix) asked by myself, the researcher. The guiding questions were set up to assist the participants in being able to recall key moments and experiences that impacted their experiences with WLS in a chronological fashion. Interviews ranged from 30 to 90 minutes in duration, and all

participants seemed happy to share their experiences. My own positioning as a researcher and a fellow obese woman in U.S. culture who has also undergone WLS may have assisted in providing a sense of commonality and comfort to my participants during the interview process. My personal familiarity with the WLS experience seemed to intensify the emotional expressions of my participants for me so throughout the collection of participant narratives, I utilized a journaling process to help sort out these emotions and helped me keep them in check. The journaling process also helped ensure that I developed awareness of my personal biases and avoided casting my own personal feelings onto the views of my participants.

Participant narratives were disaggregated in a chronological fashion to facilitate the coding process. The three categories that data was disaggregated into were: Pre-WLS, Post-WLS, and Today, 18+ months post-WLS. This was done in an attempt to decipher identity shifts and communication patterns that have occurred over time in response to events and body changes that took forefront in the participant's lives prior to and following their WLS. Each participant narrative was analyzed line by line on an individual basis, isolating key aspects of each individual experience. I then sought to "scan across different domains of experience" (Fraser, 2004, pg.191) by isolating overarching themes that appeared in more than one of the participants' narratives, and cross-coding all participant narratives according to that thematic content. Using this method I was able to isolate emergent themes, which may provide evidence of the influence of social structures and popular culture within participant narratives (Fraser, 2004) as well as help determine identity and communication shifts that may commonly occur among women during their experiences with WLS.

Participants

A total of 10 participants were interviewed in this research study. All participants were female, Caucasian, and resided in the state of Michigan. All of the participants had undergone the roux-en-y gastric bypass procedure more than 2 years ago. Each participant was unique and their varied backgrounds deserve some attention here.

- *Tina* is a 40 year old college professor. She is engaged and currently has no children. Tina's biggest health issue prior to her roux-en-y gastric bypass surgery four years ago was sleep apnea, which she still struggles with today. Tina began her weight-loss journey just over 300 pounds and though she experienced some weight regain has maintained a 130 pound weight-loss.
- *Lacy* is a 50 year old baker and artist, currently retired due to disability following a major car accident. She is divorced and currently has no children. Lacy's biggest health issue prior to her roux-en-y gastric bypass surgery nine years ago was uncontrollable diabetes, which has been resolved since her weight loss following WLS. Lacy struggles today with sodium level deficiencies as a result of her WLS, and has undergone several back surgeries as a result of a major car accident. Lacy began her weight-loss journey just over 400 pounds, and though she has experienced weight fluctuations since her initial weight-loss, has maintained a 180 pound weight-loss.
- *Melissa* is a 52 year old non-profit organization worker. Her husband passed away leaving her a single mother to their children. She is currently engaged to be

remarried. Melissa's biggest health issues prior to her roux-en-y gastric bypass surgery two years ago were diabetes and chronic back pain. Melissa's diabetes has greatly improved today, but her back pain has intensified due to continued deterioration of her spine. Melissa began her weight-loss journey near 300 pounds and has maintained her initial weight-loss, but indicated she is still attempting to lose another 30 pounds.

- *Tracey* is a 52 year old business administration employee. She is married and has two children. Tracey's biggest health issues were chronic hip and knee pain, which she reports have been greatly improved since her roux-en-y gastric bypass eight and a half years ago. Tracey began her weight-loss journey just over 300 pounds and though she has experienced some weight regain, has maintained a 100 pound weight-loss.
- *Tricia* is a 36 year old office assistant. She is a divorced mother who has recently remarried. Tricia's biggest health issues prior to her roux-en-y gastric bypass surgery 4 years ago were chronic swelling, joint pain, and hypertension which kept her from being able to work. Tricia began her weight-loss journey around 450 pounds and though she has experienced some weight regain, she has maintained almost a 200 pound weight-loss.
- *Marie* is a 60 year old retiree currently residing in an assisted living facility. She is a divorced mother of two. Marie's biggest health issues prior to her roux-en-y gastric bypass three years ago were diabetes and mobility problems, both of which have been resolved. Marie began her weight-loss journey just under 300

pounds and has maintained a 100 pound weight-loss that was slowed by a breast cancer diagnosis. Today, she is cancer-free and plans to lose another 35 pounds.

- *Pam* is a 64 year old social worker. She is married and looking forward to retirement with her husband. Pam's biggest health issues prior to her roux-en-y gastric bypass surgery five and a half years ago were hypertension, acid reflux, pre-diabetes, and joint pain, all of which have improved since her weight-loss following WLS. Pam began her weight-loss journey around 280 pounds, and has maintained her weight-loss of over 120 pounds.
- *Sarah* is a 61 year old, retired home/health care worker and church volunteer. She is a married mother and grandmother. Sarah's biggest health issue prior to her roux-en-y gastric bypass surgery eleven years ago was mobility problems, which were greatly improved through her weight-loss post-WLS. Sarah began her weight-loss journey at around 430 pounds and lost over 200 pounds. Sarah has experienced a significant amount of weight regain, but maintains a glowing positivity that she will lose the weight again.
- *Darla* is a 57 year old, disabled homemaker. She is divorced and remarried. Darla's biggest health issues prior to her roux-en-y gastric bypass surgery seven years ago were depression, diabetes, thyroid problems, and chronic back pain, most of which were resolved through weight-loss following her WLS. Darla began her weight-loss journey just over 260 pounds and lost down to around 120 pounds. She has experienced some weight regain, but has maintained over a 100 pound weight-loss.

- *Samantha* is a 43 year old college professor. She is unmarried and has no children. Samantha's biggest health issues prior to her roux-en-y gastric bypass surgery three and a half years ago were chronic back pain, asthma complications, and hypertension, all of which have improved since her surgery. Samantha began her weight-loss journey around 280 pounds and though her weight has fluctuated, she has maintained a 140 pound weight-loss.

From these brief introductions to the participants that were interviewed for the purposes of this research study one can see a familiar pattern emerge. All of the participants were not only obese prior to making their decisions to undergo WLS, they also suffered from an array of obesity-related illnesses that they hoped would improve through weight loss. Once the participants' underwent WLS, they did experience extreme weight loss, and in most cases, saw improvement in their obesity-related illnesses. The weight loss that occurred rapidly was, in most cases, followed by some weight regain with participants experiencing varying levels of success in maintaining their weight-loss.

CHAPTER IV

FINDINGS

The following sections will focus on the detailed content within the participants' narratives in order to examine ways that their identities evolved throughout the stages they experienced during their WLS journey. The roles of communication within the evolution of identity process will also be examined in order to ascertain what communication patterns reinforce or negate newly established identity concepts. In order to create a basis for comparison, participant narratives have been chronologically divided based upon the guiding interview question protocol into the following categories: Pre-WLS, Post-WLS, and Today, 18+ months Post-WLS.

Identity and Communication Pre-WLS

The decision to undergo WLS is not one that most women take lightly, and the journey to the affirmative decision is often rocky at best. The following section will explore the motivations of women electing to undergo WLS procedures and illustrate how they conceptualize their identities and communicate their feelings regarding their

upcoming procedures. This portion of the WLS journey often comes after many years of weight-loss attempts that have resulted in failure to lose weight or maintain weight-loss, a process that has necessarily impacted the individual's self-esteem and self-image in harmful ways. For many, WLS opens the door to renewed possibilities for success in achieving health, social, and weight-loss goals.

In discussing the pre-WLS experience, women had multiple concerns associated with why they were considering weight-loss as crucial to their lives. Single women appeared to be the most concerned about not fitting in socially as a result of their obesity. Obesity itself is discussed by these women as an insurmountable "flaw" that represented the object of their ridicule and the source of their difficulties in maintaining rewarding social relationships. Lacy illustrated these points when she was asked to elaborate on the way she recalls speaking about herself to others when she was younger:

I would say, 'Look at this new outfit I got...for school.' And I would say, 'These are old lady clothes, just futty duds cause I'm nothing but a fat slob and I can't buy regular clothes.' Ya know...I mean, I was my own worst enemy. I would look in the mirror and it would just disgust me, but it never would click in my mind er...I never would dare think that it was something (obesity) I could conquer, or that I could even do anything about. That's just who I was meant to be... -Lacy

This type of self-deprecating comment may have served as a defense mechanism for Lacy as she negotiated the identity she wished to project to others versus the identity

she felt others expected from her. For women who have been obese since childhood or young adulthood, being publicly ridiculed for being overweight becomes an expectation that goes along with one's social role. There is the choice in some peer groups of continuing to be made fun of and laughed at, or to engage in self-deprecating humor, making oneself the butt of jokes before others do it for them. In this way, the individual is able to take a small amount of control over what jokes are made, when they are made, and allowed to laugh with others. Also, appearing as humorous may potentially present themselves in a more positive light to "preserve face" (Goffman, 1959) and increase the likelihood of acceptance within the given peer group.

Married women, on the other hand, seemed to be less concerned about fitting in socially. They already had families and children to provide social connections in their lives. These social/familial connections may have served as a buffer of sorts for these women against experiencing some of the social sanctions obese women tend to be subjected to in U.S. culture. When asked about whether or not these women had a "safe place" where they felt free to be themselves, all answered similarly. They felt comfortable and accepted at home with their spouse and children. When asked if she had a "safe place" Melissa replied,

Yeah, it was with my family. With family I could always be myself, and with my late husband I always felt I could be myself...he never judged me. And my kids, you know, they loved me for who I was...I never had to really worry about it.

-Melissa

Obesity did concern married women on an additional plane; however, several mentioned concerns of being able to fulfill their social/familial roles of “mother” or “grandmother”. Sarah discussed this concern when asked about what motivated her decision to officially pursue WLS, “I didn’t have grandkids or anything yet, but I was hoping (laughs). I wanted to be able to keep up with them when they came.”

For almost all of the women, suffering from low self-esteem was a common thread. A couple of women mentioned being ridiculed as a child as a painful experience that they associated with their obesity. A few others, like Marie, had experienced public ridicule as adults as well, which kept them restrained from social activities out of such concerns. Other concerns that kept women feeling restrained from social activities included concerns about fitting accommodations for their size; for example, seating that would fit them being available in others homes or in restaurants.

I didn’t want to be around people because I...I feel that they were looking at me, and I just was very uncomfortable...I feel that it wasn’t very good (self-esteem) because, like I said, when you go into a store, people look at you and point at you...and sometimes they make fun of you. –Marie

Obesity is a visible “stigma symbol” (Goffman, 1959), and obesity is a physical condition that is extremely difficult to change, because of this, obesity itself becomes an ascribed attribute of obese individuals that is bestowed upon them by greater society carrying with it stereotypes such as those carried by other ascribed attributes such as race, ethnicity, gender, and socioeconomic status. These ideas of greater society can be

extremely stigmatizing to individuals coping with obesity. Marie, like many other obese women, desired people to see her based upon who she was inside, but being subjected to public displays of weightism most of her life likely generated much pain and identity confusion. In Marie's case, she may have struggled with personal-relational identity gap (Jung & Hecht, 2004) where she felt the way she viewed herself differed from the ways others perceived her. This communication and identity gap may explain some of the emotional pain and depression she felt. The focus on blaming the outward stigma symbol (Goffman, 1959) of obesity as the culprit was likely an influential factor in why Marie elected to undergo WLS.

A common thread among almost all of the women interviewed was that they experienced significant health problems as a result of their obesity. This finding is in itself not surprising because a significant level of negative health impact needed to be present in order for these women to become approved by their insurance companies to undergo WLS. These health issues were shared as reasons behind women's desire to lose weight, as they felt losing weight would lead to greater physical comfort and health. Because of this, eight of the ten participants perceived themselves as having poor health prior to having WLS. This perception of poor health led these women to visit their doctors on a regular basis where they were subjected to a battery of medical testing, and diagnosed with needing to take a variety of medications to counteract the ill effects of obesity on their physical bodies. It is therefore, not surprising to note that the most common factor women related as being a "key turning point" in making their decision to undergo WLS was the recommendation of their physician to have the procedure.

Probably it would have been in the doctor's office when I looked at the size of my file from all the visits I had been to the doctor, all the tests that I had...all the different things I had to go through being heavy. My blood pressure was always high...I had problems, acid reflux...allergies...pre-diabetic...and I thought that probably....my health was going to continue going downhill. The doctor asked me about thinking about it (WLS). I think that was the time when I started thinking that was something I was going to have to consider. —Pam

The medicalization of women's bodies is nothing new, and neither is the idea of female beauty being correlated with thinness. However, the medicalization of obesity is a more recent development—obesity is considered the catalyst of a multitude of illnesses such as diabetes, heart disease, several types of cancers, etc. (CDC, 2009; Salant & Santry, 2006)—and WLS has become considered a “cure” for the disease of obesity. Doctor recommendations carry an extreme amount of weight—particularly for women who have been raised to obey the commands of doctors, who are predominantly male (Ehrenreich & English, 1973). Part of the authority that is leant to doctors by women is based on the fact that doctors are assumed to have the best interest of their patients at heart and the role of women as patients is based on the assumption that the woman shares this desire for her eventual wellness and concern for her health (Ehrenreich & English, 1973). There is also the more coercive aspect of “legitimate power” (French & Raven, 1973) that adopts the view that the doctor is highly educated and therefore is not communicating on an equal plane with their patients, and are not to be questioned. Because of these factors, the recommendation of a woman's doctor to consider WLS as a

potential cure for her obesity and co-morbidities may have great impact on a woman's decision to undergo WLS.

Women expressed a variety of expectations and feelings associated with the prospect of their upcoming WLS. All of the women interviewed held the expectations given to them by their doctors that they would experience rapid weight loss and have improvement in their health. Once the women had approval for the surgery through their insurance companies and had decided to go through with the procedure, their outlook for the future changed. Most maintained a hopeful outlook for the future, and reported becoming less preoccupied with their current physical appearance and limitations and began to visualize what they would look like and feel like after losing weight. The ways the women who were interviewed framed their experience differed greatly, which may be illustrated in the accounts of Lacy and Sarah.

Dying on the table is a concern of many individuals facing major surgery, but WLS carries the added risks of being performed on patients who are obese and often suffering from health problems, which may add greater risk to WLS procedures. Lacy recognized this risk, but still maintained her hope for a better future,

I went into it (WLS) from the very get go with my mother, and I said, 'Mom, the only one I want there is you because only you know what I've went through...all the pain and how much this stuff has...affected me that say at my funeral just this, 'She went out trying' (to lose weight and improve health). –Lacy

Others didn't acknowledge the risks as they focused on their vision for the future. Sarah; for example, discussed her shock at learning that everyone in her family was afraid for her when she underwent WLS, but Sarah reports having no fear of her own because she was entirely motivated and focused on the prize of a slimmer body and improved health.

He (Sarah's husband) was afraid of it (WLS)...he was afraid, and I didn't know how afraid he was for me until after I had it. He had angina attack just before I had my surgery...worrying about me. I was never worried! Once I made my decision, I never worried! –Sarah

Some of the women interviewed had friends or relatives that had undergone WLS, but the majority of women did not know anyone who had experienced WLS. Because of this, the vast majority of information women had about WLS procedures, risks, and outcomes came from their doctors, bariatric websites, and the bariatric clinics they had their WLS procedures done through. Bariatric clinic websites and the literature provided by bariatric clinics often gives examples of before and after patient photos and commentaries, which work to set expectations for future WLS patients. These before and after accounts are often of patients who have experienced better than average post-surgical results, which may create logistical issues for WLS patients down the road, if they do not achieve similar results for themselves (Schild, 2011).

As the women interviewed prepared for their WLS procedures, they were hopeful for positive outcomes, particularly for the better than average scenario they witnessed in

before and after WLS accounts, to become their reality. There was also a clear sense of trepidation of the unknown post-WLS lifestyle. These women tried to open their minds to an uncertain future and attempted to visualize their bodies as in a temporary state, preparing for the metamorphosis that would come with rapid weight-loss. This mental preparation was a necessary step in altering their identities from the “failure” role to the “successful” role in regard to weight-loss, which they viewed as one of the greatest forces in their lives that negatively impacted their health, mobility, and social lives.

Identity and Communication Post-WLS

Following their surgical procedures, all of the women interviewed entered a phase of rapid weight-loss. The following section will seek to explicate some of the identity and communication shifts these women experienced. Important social bonds with significant others began to change as well as both parties were forced to shift their relational roles. During this phase it was difficult at times for the women interviewed to explain how and why relationships and their identities were changing, but this is likely because they were going through so many life changes that it was difficult to focus in on any single aspect.

The women interviewed reported handling this period of rapid weight-loss post-WLS in different ways. Some women looked forward to the weight-loss and change in their physical appearance by habitually purchasing smaller clothing to shrink into, while other women focused on health improvements, such as getting off of medications and being able to walk farther without losing their breath. Either way, rapid weight loss

occurred for all of the women over the first 12 to 18 months following their WLS procedures causing them to face many issues along the way and forever altering their identities.

Tricia; for example, talked at length about the camaraderie she shared between her sister, father, and herself surrounding food. This camaraderie and company was described as her “safe place”. “I guess, you know, the safe place, like I said, was probably with my dad and my sister and the whole camaraderie around food.” When Tricia could no longer consume food as she had done before, she struggled with her new reality and rebelled against it by chewing, but not swallowing forbidden foods. In such a case where bonds surrounding food are central to close relationships, taking away the connection surrounding food may lead to a sense of loss. Tricia described feeling less connected to, and feeling less understood by her family members post-WLS than she was before her surgery.

Part of the loss of connection Tricia described was likely related to her shifting “communal identity” (Jung & Hecht, 2004) which was based on her collective history with her family, whom she held in-group status with based on certain patterns of communication and behaviors. When these behaviors center around food, which is necessarily altered through WLS, new ways to build connections with the in-group must be established. The initial phases of this process are likely wrought with uncertainties which may generate discomfort until new roles within the in-group are accepted and solidified through building new patterns of collective history (Jung & Hecht, 2004).

Other issues cropped up for women concerning the reactions of family and friends to their rapid weight loss. U.S. culture tends to position women in competition with one

another, and with great emphasis placed on female appearance; women tend to feel changes such as rapid weight-loss acutely as it alters the dynamics of their close female relationships. Tina; for example, spoke of her weight-loss as being an unmentionable thing between her close friends who also struggled with weight issues. Melissa spoke of this shift in relationship between her sisters and herself as she began to lose weight after her WLS:

Um, I think there was a little bit of jealousy where other family members were concerned that are still heavy. Even my skinnier sisters didn't like it because I was starting to get skinny for the first time...you know, cause we were always the fat girls (Melissa and her sister), and they started to gain weight and here we had lost it. They would say things like, 'We gotta catch up to you!' And so that was kinda like a negative thing. —Melissa

There is likely a period of stress experienced by women as they rapidly lose weight post-WLS that may stem from a mismatch between “appearance” and “manner” that creates an inconsistent “front” (Goffman, 1959). For some women, as their bodies physically become lighter, they may begin to “feel thin”, and therefore attempt to communicate an identity of themselves as thin that others may not accept—this denial of acceptance may stem from the fact that these women are still physically obese or overweight by social standards, or from the fact that others are not yet willing to see them as thin because the relationship feels more comfortable if it remains static. Other women may become thin, but still “feel obese” and not be able to cope with making the shift

from their old identity as obese to a new “thin” identity. Many of these stressors come to light in women’s closest relationships, and may be even more difficult to cope with when familial and friendship supports are weak to begin with, or grow weak as these women evolve through the process of rapid weight-loss.

Most of the women interviewed; however, perceived their rapid weight-loss post-WLS as a freeing experience regardless of emotional and relational duress that was incited by the fact that they were quickly changing. Most had felt unable to lose weight all their lives and felt that their obesity stigmatized them. When Pam was asked how she would describe herself prior to her WLS, she said, “...definitely low self-esteem, unworthy...didn’t live up to other’s expectations...ashamed of appearance and unhealthy...kind of trapped by my weight.” When Pam began to lose weight rapidly post-WLS, she viewed the experience as positive and was elated that she was changing. When Pam was asked to describe how she felt about herself after having her WLS, she shared, “...kind of like a butterfly emerging from a cocoon. I was shedding the weight, and I was shedding, you know, the pounds and many of the negative feelings about myself through that.”

While rapid weight-loss was a freeing experience, physically, for most of the women interviewed, it also created dilemmas in renegotiating identity at such a rapid pace. For some, losing the weight represented losing a disguise or safety net that kept them invisible to the world, and often the opposite sex. Tina relates,

I found it very terrifying cause...I must have reached a weight that men started to find me visually attractive again, and I found it terrifying being gawked at and

looked at like a meal...I've been invisible to men for so long...that to catch men staring at me was shocking and disturbing. -Tina

Because women in American culture are routinely objectified, obesity may serve as a form of protest for women against cultural norms (Orbach, 1978). This may be particularly true when mothers try to instill the pursuit of thinness in their young daughters as a means of attracting a future husband (Orbach, 1978). As women grow older, obesity may become a way to shield themselves from the responsibilities of domestic family life, unwanted male attention, or a means to allow them to focus on other pursuits. Some women may not recognize these feelings until the weight-loss has become significant and then must shift through the new meanings this transformation will have on their lives and identities.

Lacy similarly experienced difficulty with her rapid weight-loss, and in her case, was unable to see the marked difference in her appearance that everyone else seemed to notice. This frustrated her and caused her to struggle with renegotiating her identity in a way that her mind would allow her to recognize and identify. When asked to share a story about herself during the first few months following her WLS, Lacy related,

...it was very hard cause I was like losing this weight, but I couldn't see it. People would say, 'My God, have you lost the weight!' But in my eyes, I didn't look any different so I knew I had to keep struggling...finally, I was able to start buying clothes...at a local store and it was like, 'Okay Lacy, you are losing the weight.'

-Lacy

Sarah also experienced difficulty with recognizing herself and visualizing herself as she had become. She shared,

I have to say there was a time afterwards (after WLS)...I didn't recognize myself. I could be walking by a window, and I'd see this person, and I didn't know it was me, and then I had to look again and I said, 'Oh my God! That's me!' -Sarah

Most individuals take it for granted that they will be able to look in a mirror and recognize themselves, but most individuals are not faced with losing large quantities of weight at a rapid pace creating an effect of rapidly altering physical appearance. Having a different appearance on a weekly or monthly basis may well create an identity crisis for women, especially considering the way women in U.S. culture are evaluated on the basis of their physical appearances. Mead (1934) discussed identity as an ever-evolving process that is formed partially through making sense of the ideas others project about who an individual is, and this in turn influences the social roles individuals choose to play and eventually internalize. Others react most often on the basis of the superficial, or appearances—when appearance is in flux, or an individual is unable to recognize rapid changes that are occurring in their physical appearance, the reactions of others may become difficult to read and understand. This may be why the period of rapid weight-loss post-WLS represents one of the most emotionally draining times of the weight-loss journey for women who have undergone WLS.

On the positive side, women seemed to experience a great boost in energy and self-esteem as they rapidly shed weight during the first few months following WLS. They

experienced improvement in mobility and health issues, and in most cases received a multitude of compliments and awed reactions from others who witnessed their progress. This, of course, lead to the need to begin rapidly shifting identity in response, which sometimes proved to be problematic, but all of the women interviewed related being thrilled overall with the results of their WLS and weight-loss. So much so that a couple of women mentioned getting a “self-righteous” attitude toward weight-loss and WLS, feeling that they had unlocked the key to losing weight and wanted to share this information with the world. The regimen that must be followed post-WLS is rigorous and time consuming so it proved easy for the women to become obsessed and consumed by them. Melissa discussed this,

Yeah, you know, I got a little self-righteous. I think everybody does. You’re like, ‘Oh yeah, I did this, I lost this weight and I feel good about myself.’...I think I started realizing that I was talking about it too much, and um...even me myself, I was getting sick of hearing myself...so I kinda cut it out... -Melissa

But there may be value in this constant attention to the metamorphosis of self, attention to body changes, health, and attitudes. The act of communicating about their WLS experience may provide a space for women to talk through the complexities and break them down; not only to describe their experiences to others, but also to assist women in sorting out these complexities for themselves.

During this phase of their journey through WLS, the women interviewed experienced much change and upheaval in their lives. Their eating habits were forced to

change, altering their daily routines and the ability to use food as a means to cope with emotions and life events. At the same time, once stable relationships with family, friends, and close others often began to change as well altering support systems that may have been taken for granted as being there. In some cases, these women visualized changes in themselves that others were not yet prepared to accept, and for others, people around them began to see and comment on their changing appearances that the women who had undergone WLS were not yet emotionally ready to see in themselves. All of these elements likely make this period of the journey through WLS the most tumultuous and often emotionally painful. At the same time, the feelings of personal success and triumph these women gain through realizing their weight-loss can be extremely rewarding.

Identity and Communication Today, 18+ Months Post-WLS

It is in the aftermath of rapid weight-loss post-WLS that women interviewed began to become more self-reflexive and self-evaluative as their weight-loss slowed. For many women who undergo WLS procedures, this period marks the end of their overall weight-loss. By this time, these women are expected to have developed the new eating habits they will carry with them throughout their lives. This also marks the point where old eating habits are physically able to be resumed, and continued weight-loss and maintenance of weight-loss becomes much more effort. Many of the women interviewed had not reached their desired goal weights by this point so they were left to struggle to achieve their goals, which can prove to be frustrating. For others, just recognizing where

they have ended up weight and appearance-wise is a separate journey in and of itself. For many the biggest point of contention is the fact that the average person who undergoes WLS will regain 15% of the weight they have lost by the time they are 5 years post-WLS (GHP, 2008). Many women struggled with depression as a result of coming to terms with weight regain and difficulty in attaining their weight-loss goals. This section will explore these issues as they relate to the women interviewed in this study.

Today, after the phase of rapid weight loss has ceased, the women interviewed have had the opportunity to settle into new lifestyle patterns and their new identities with a variety of reactions. Though none of the women claimed that they were unhappy with the results of WLS, all but one woman interviewed had regained some of the weight they had initially lost, and felt they were in a constant struggle to lose more weight. Only two of the women had reached their anticipated goal weights during the phase of rapid weight-loss, and most had returned to their surgeons for advice on how to lose more weight. The physicians emphasized following the program more closely, with a standard high protein/ low-fat 1,200 calorie a day diet, and exercise. These recommendations put the power back into the patients' hands to control their weight, and as a result, women tended to blame themselves for failing to reach their desired goals. This sense of personal responsibility caused some of the women to feel badly about their own resolve and inability to achieve their desired results. This held great impact for Tricia,

...I had a lot of confidence issues before, but...I'd almost say that it's more today than I ever did before. And partly because I failed, and I did the final thing (WLS)...like the most radical, drastic thing you can possibly do in society to lose

weight, and it didn't work...it did work in that I lost weight, but I mean, it didn't make me thin. -Tricia

Other women continued to struggle with food addiction and the concern that they were a disappointment to others due to weight regain.

This portion of women's journey through the WLS experience often marks the end of their frequent visits to the bariatric surgeon's office; however, it often does not mark the end of the emotional journey they will face. Greater understanding of the emotional journey women who undergo WLS procedures experience may assist bariatric clinics in preparing women considering these WLS procedures in what to expect and assist them in framing any emotional upheavals they encounter. Simply communicating the normal trajectory of weight-loss post-WLS may assist women in setting realistic goals for their weight-loss and post-WLS appearance (Schild, 2011). Also, understanding that renegotiating of identity, shifts in communication patterns, and emotional responses to these processes are normal may assist women in achieving the higher levels of success in maintaining long-term weight-loss while feeling good about themselves and their accomplishments.

This is not to say that the majority of the women interviewed were unhappy with their results because most perceived positive changes in themselves and in their social lives as a result of shedding some of their excess weight. Melissa shared,

...I felt ugly because of my weight so as my features started to come out more, I felt better about myself. I felt confident, I got out and met a terrific guy!...where

before I never thought I was good enough to...date anybody that was worth anything. -Melissa

Two of the women also related that they felt perceptions of others toward them had changed significantly. Socially, “fat” was referred to as an “armor” of sorts by several of the women interviewed that made them invisible to others, particularly to the opposite sex. For Lacy and Pam this barrier of “fat” was very much a social barrier that kept them from sharing their opinions, which they felt others perceived as being without value. As they lost weight, they felt the perceptions of others toward them had changed, Lacy related,

I finally felt like I wasn't 2 or 3 people trying to stand there. That I was actually a viable person to the conversation, and in general, just to the people around me that they were listening to me. Before it was like, ‘Why listen to the fat girl?’ -Lacy

Pam had similar feelings, and discussed the position of “appearance” in greater society and the interplay of how an individual feels about themselves versus perceptions put on them by society:

...there's nothing that feels as good as feeling like your opinion matters, and I think um...probably before bypass surgery, I wouldn't have felt that what I had to say mattered that much. I just...it's how you feel about yourself that plays a big role in it. We all say, well, it shouldn't matter what you look like, but you know,

in reality it does matter. It matters whether people accept you, and even if they're not trying to be judgmental, um...appearances do matter. That's how we form some of our opinions, and sure, we can change some of our opinions later when we get to know the person, but, you know, appearances do matter. –Pam

So, as weight-loss re-positions the individual's perceived relevance in society, the reactions of others to that individual also begin to change. For single women, this social reaction was received in a positive way the majority of the time, like in the example of Melissa who entered the dating world after losing weight and attributes meeting her fiancé to her improved self-confidence. For others, this alteration in social reaction inspired a sense of discomfort, as Tina related in her reaction to men noticing her being a “terrifying” experience. Tina felt this attention from the opposite sex was what led her to regain weight, and put some of her “armor” back into place. She also shared that these altered perceptions of others and her discomfort level with their reactions has led her to dress more conservatively than she did before. On this subject, Tina stated, “I dress very conservatively now. I used to show off “the girls” (motions to breasts) because I thought they were my best feature...Now today, I dress down a heck of a lot more. I dress more ‘guarded’.”

Lacy regarded the changed reactions of others with anger at first. She was unhappy with feeling that losing weight caused her to be deemed more socially valuable. For her, living in a small town, the difference in how others began to perceive her was blatantly obvious; particularly the ways she was viewed by the opposite sex. Lacy shared this experience,

I went to our local gas station and a guy held the door open for me. Before, the door was practically pulled shut er...left to close right in my face...and I started realizing, 'You S.O.B., why are you looking at me now? Why are you holding the door open for me now because 6 months ago you wouldn't have?' And so I...dealt with a lot of anger... -Lacy

Over time, Lacy was able to reconcile these feelings and she looks at it today as coping with the flaws in the perceptions of others, recognizing that she herself was always valuable.

For women who have undergone WLS and struggle with their changing appearances and the changing reactions of others the only guidance that exists may be in the form of shared experiences from others they meet who have undergone WLS as well, or in the form of counseling services through bariatric clinics, which are often quite costly and rarely covered by insurance. Some also have the option available of attending WLS support groups which may or may not address their areas of concern. Some may have access to counseling services through their insurance policies if they seek counseling from other sources; however, it is difficult to locate counselors trained in the areas of specific need and interest to WLS patients. Not to mention the fact that little research has been done in this field resulting in a general lack of understanding of the emotional journey women experience pre and post-WLS. Given this fact, the ability to train counselors to give efficient counsel to individuals who have undergone WLS may not currently exist. With the ever increasing number of individuals opting to undergo

WLS as a cure for obesity (ASMBS, 2008) the demand and need for counseling support and guidance specific to individuals who have undergone WLS is great and should continue to increase.

The reaction to altered social perceptions of married women differed greatly from those of single women. The married women who were interviewed focused more on their increased energy to perform familial tasks and work outside the home. The way society viewed them seemed to be less important, as all of the women interviewed had strong support systems at home. It is interesting to note; however, that a couple of the women mentioned their spouses sharing a level of discomfort with their weight loss. In both cases, the partner was male and reportedly began to feel threatened that greater attention toward his wife may cause her to dissolve their marriage in search of better prospects. Tracey spoke of her husband's allusion to these concerns,

...my husband used to crack jokes, and I'm not sure whether half the time he was joking or not...he would crack jokes that I was going to lose weight and get beautiful...more beautiful than what I was according to him...and go find another husband. -Tracey

These partner concerns can have great impact on a relationship and create a sense of instability that may be difficult to overcome. In the cases of the two women interviewed, their marriages did remain intact, but there was likely a period of renegotiating identity and roles within the relationship for both partners involved. Another shift that could potentially be facilitated through better understanding of these

dynamics and the availability of counseling services specifically tailored to the unique needs of individuals who have undergone WLS.

All of the women experienced resolution to the majority of health issues that had troubled them prior to having their surgeries so they all related feeling more energy in their daily lives as a positive result of their WLS. Excess loose skin remaining after weight-loss did trouble several of the women interviewed and many planned to seek plastic surgery to correct these cosmetic issues. Even so, almost all of the women reported feeling more confident and comfortable with themselves today than they felt prior to their WLS. When Marie was asked about how she feels she has personally evolved from who she felt she was prior to her WLS, Marie related, "...more positive, more sure about myself...able to get around better and do things...wanting to be around people instead of hiding."

WLS appeared to yield positive physical and social outcomes for most of the women interviewed, but it did create a roller coaster'esque journey as well. There were a lot of growing pains and relationships to reconcile along the way, and renegotiating identity as quickly as necessary was not always possible, leaving women feeling emotionally raw and even evoking feelings of fear, discomfort, and anger at times. The general roller coaster of emotions seemed to span from depression and upset over their physical and social predicaments prior to WLS, to ecstatic joy during the phase of rapid weight-loss post-WLS, to a mellowing out today as women came to terms with their results after the initial period of rapid weight-loss ended. They realized that their health and physical appearances were often improved according to their perceptions, but possibly still did not meet social acceptability standards or their desired level of results.

The concept of how closely they had come to achieving what they saw as socially acceptable standards of thinness was particularly acute for single women interviewed, who were actively seeking life partners. For others, familial pressures could be painful when it was made clear that significant others had vested interests and expectations for weight-loss success and maintenance. For example, when asked to share a story about herself, Tina related,

...when I first saw my Mom after losing all the weight she cried and said, 'Now my daughter is beautiful. Now you are so beautiful.'...and she put it in a way that made me realize she never saw me as beautiful before and so...it scares me now that I'll see her when I've got 40 more pounds on me from the 160 that I was.

—Tina

None of the women interviewed regretted undergoing their WLS procedures, but it is clear that many have struggled with perceptions of themselves and with the perceptions they feel others have of them. The feelings associated with these perceptions can range from general discomfort to painful, as in the pressures Tina experienced coming from her Mother. The end of the phase of rapid weight-loss post-WLS, does not mark the end of identity struggles and issues that women who have undergone WLS procedures experience. In many ways, the phase 18 months or more post-WLS marks the beginning of putting one's identity back together after having it completely fractured through the period of rapid weight-loss post-WLS. From a feminist perspective, much attention to self-care and self-nurturing may be important to facilitate these women in

developing healthy self-image and assuming positive identities. It is also important for these women to recognize that their struggles with weight-loss, weight maintenance, and health do not go away after having a WLS procedure. Simply maintaining weight-loss achieved during the post-WLS phase can be a time and energy consuming concern that will last a lifetime, and comes packaged with large doses of social pressures and connected perceptions, of themselves and others, attached to their success or failure at this task. Needless to say, thinking that WLS procedures will “cure” obesity in a way that the individual will never have to concern themselves with weight issues again is faulty, and one of the best ways to prepare women to cope with the realities that come with WLS procedures is to be upfront with what they may expect from their experience. Part of being able to be honest and upfront; however, is to first explore the experiences of others to find the trends and commonalities. This knowledge will also be important in making adequate support available for individuals undergoing WLS procedures, which may be key to their success in navigating their WLS journey.

Interaction Ritual Chains and the Benefits of Support

Of the women interviewed, the normal trajectory of experience seemed to be experiencing a level of body dissatisfaction, which became coupled with health complications, and led them to seek medical treatment for their obesity. Prior to having WLS these women found themselves beginning to see a glimmer of hope for a future of health, and for bodies that were no longer imprisoned by excess weight. Directly

following their WLS, these women felt an excited realization of their physical transformation and for the possibility of achieving goals they had mentally set. After the initial period of rapid weight loss post-WLS ceased; however, most of these women had stopped losing weight short of the goals they had set for themselves. This left these women struggling to lose weight and feeling that they should have/could have done better. Exacerbating these feelings was these women's return to the images of success stories of WLS that they had seen on bariatric websites (Schild, 2011) and in their surgeons' offices that did not reflect the average experience of women who have undergone WLS. Many of the women had experienced weight re-gain, which had caused them to approach their surgeons who instructed them to adhere more closely to the WLS post-diet. These suggestions by their surgeons put the responsibility to lose weight on these women, causing them to engage in self-blaming practices and feel that they had somehow failed the WLS program by failing to experience the above-average results they had adopted as the normal WLS experience (Schild, 2011). For example, Melissa related,

I'm a little disappointed that I haven't lost more than I have...I went to the old bariatrics site...online...and I was watching before and after (videos) and I was thinking, 'How come I don't look like that?' A lot of those people are really, really slim...and you would think that after you had bariatric surgery, you would get that way too, but not everybody I guess gets down that far... -Melissa

Upon sharing with several women that their WLS experience was well within the normal expected range of 60-65 percent of excess weight lost during the first 12 to 18

months post-WLS with a regain of approximately 15% of weight lost after 5 years post-WLS, they seemed to feel relieved and became less somber in relaying their experiences.

Of the women interviewed in this study, one woman proved to be an exception to this pattern, which is worthy of some attention here. Pam was heavily involved in WLS support groups through her bariatric clinic. The WLS support group services for this bariatric clinic were quite comprehensive, providing several different levels of support based on duration of time that had elapsed since the patients had undergone WLS. Utilizing this concept, the members of the support group that were further out of WLS surgery were expected to mentor members of WLS support groups who had undergone WLS more recently. Different information was shared with the WLS patients based upon how far out they were from their WLS. Pam did not share the specifics about these WLS support group discussion topics, but gave the example that right out of WLS, most patients need to focus on nutrition, where farther out of surgery, exercise habits and maintenance of weight-loss become more important.

It may be important to mention that Pam had local access to a bariatric surgery clinic, where most of the women interviewed were rurally located and had to travel 2 to 4 hours to reach their surgeons' offices. Pam maintained her WLS support group attendance and mentoring throughout the 5 and a half years since her WLS. She has also strongly felt that she is a role model to other women who have undergone WLS and for this reason adheres to a strict regimen of exercise at a local fitness center. Pam is proud of her weight loss, and of all of the women interviewed, has maintained her initial weight-loss the longest, experiencing little regain.

Elakkary et al. (2006) followed 38 WLS patients over a period of one year and concluded that the patients who attended WLS support groups regularly following their WLS procedures lost more weight than their counterparts. Bond et al. (2004) discussed stages that an individual must go through before they are ready to implement life-altering changes in their lives. The “experiential stage” is the first of these stages where a process of consciousness raising is experienced and individuals acknowledge that a problem exists, but they are not yet ready to commit to making a lifestyle change (Bond et al., 2004). The second stage Bond et al. (2004) describe is a period of “dramatic relief” where negative consequences are suffered by the individual as the result of their lifestyle. For the majority of the women interviewed, these negative consequences took the form of health and mobility problems that resulted from carrying their excess weight. During the period of “self-re-evaluation” individuals begin to examine their lives and environment in the realization that a change must be made (Bond et al., 2004). The next stage of “social liberation” is then experienced as the individual implements change in their lives, and it is at this point that social support becomes important, and “helping relationships” are sought out to assist the individual in making the desired lifestyle change (Bond et al., 2004).

A deeper examination of social support systems and why and how they function and become meaningful to individuals is necessary to begin to understand why Pam may have had a significantly different WLS experience than the other women who were interviewed in this study. Framing Pam’s experience utilizing Interaction Ritual Chains (Collins, 2004) may provide helpful insight.

Goffman (1971) discussed ritual and laid out certain qualifications for rituals to form (Collins, 2004). First, there needs to be situational and physical presence of more than one individual (Collins, 2004; Goffman, 1971). These individuals exert pressure on each other to conform to the group's norms and apply social sanctions when these ritual norms are broken (Collins, 2004; Goffman, 1971). And finally, rituals center around "sacred objects" that hold a place of social value for group members (Collins, 2004; Goffman, 1971). Interaction Ritual Theory builds off of these central concepts and examines the process in which these sacred symbols are created between group members through rituals (Collins, 2004).

Interaction Ritual Theory (Collins, 2004) involves a process of emotional entrainment. Two or more individuals create a group complete with in-group and out-group barriers (Collins, 2004) and share mutual focus over a sacred object that is able to create a shared emotional response for the in-group members (Collins, 2004). WLS support groups fit this model because multiple individuals attend the group to find support. In-group status is defined by allowing only members who have undergone WLS into the society. Experiences and feelings are shared with the understanding that "no one else knows what WLS patients experience, except for other WLS patients." This feeling of belonging to the in-group can be very strong. The sacred object shared by in-group members may change over time so it may be to the WLS patients' benefit that the bariatric clinic offer separate WLS support groups based on time elapsed since undergoing WLS.

For example, early into the WLS experience, the sacred object may well be the number of pounds lost. The individual can attend the WLS support group and report their

progress in number of pounds lost and receive congratulations and kind words from other members that may create an emotional response—happiness for others who have experienced significant weight-loss and hope for continued personal weight-loss for the listener and encouragement to continue losing weight for the individual reporting the loss. After 6 months post-WLS, rapid weight-loss begins to slow and continued weight-loss may require the implementation of an exercise routine. At this point, the sacred object is likely still the number of pounds lost, but may be seen as directly related to an individual's success with an exercise program. At this point, the main WLS support group may break up into smaller sub-groups outside of meetings as they link up with others for walks, hiking, bike rides, and meetings of those who share memberships to the same gym, etc. Still later, after the initial period of rapid weight-loss post-WLS has ceased (12-18 months post-WLS) the sacred object may shift to maintaining pounds lost. In Pam's case, members of this WLS support group of individuals more than 1 year post-WLS are asked to serve as mentors and sources of inspiration to others more recently out of surgery. After graduating through three levels of WLS support groups with the same group of individuals, in-group status has likely become quite strong and members share a deep level of emotional entrainment with each other so the final step of proffering themselves as examples of success to others more recently out of surgery may be seen as a monumental motivation for these individuals to maintain their weight-loss and continue adhering steadfastly to the WLS diet and exercise recommendations.

I went to some support groups and...would hear it month after month...that you had to incorporate that (exercise) so, I knew it was a matter of time before I

needed to do something about it...a few months after I had the surgery, I started going to Curves...and I finally found my niche. I have been true to that for close to 5 years, and so I'm almost more proud of that than I am about the weight-loss...I keep a positive attitude about it and I go whether it's 96 degrees out or whether it's 3 below...and people have learned to depend that I'm going to be there even if they're not there. So, I feel that's kind of an inspiration to other people too...and so we...make friends there. -Pam

In conclusion, WLS support groups may be beneficial to women who have undergone WLS by providing systems of social group norms that assist them in making sense of their WLS experience. This social space may also allow these women to feel a sense of membership and belonging that contributes to overall weight-loss and weight maintenance post-WLS. Interaction Ritual Chains (Collins, 2004) may provide a useful lens to begin examining the effectiveness of WLS support groups and their functionality in greater depth.

CHAPTER V

CONCLUSIONS

Pressures on American women to attain socially acceptable standards of female beauty and thinness (Kilbourne, 1999; Maine, 1999) and the stigma (Goffman, 1963) American women face for not achieving and maintaining these goals may be at the root of why so many obese women are turning to WLS as a solution to their, often life-long, struggles with their weight. Most of the women interviewed in this research study alluded to experiencing these pressures in their comments. For example, Lacy and Pam relating feeling that others didn't listen to them or value their opinions as much when they were obese women. However, rapid physical changes that occur post-WLS may create a sense of discomfort and confusion as these women try to successfully renegotiate their identities. Because of this, it becomes imperative for these women to find core elements of themselves to hold onto; elements that define them as individuals, and not just as women who have had WLS. Due to this need, a recurring theme of "I'm the same me...only better" frequently cropped up in their narratives.

I'm the Same Me...Only Better

The sentiments of the majority of participants in this study reflected their feeling that they had not changed on the inside, that they maintained the same values, sentiments, and emotional selves as they did prior to undergoing WLS. The changes they recognized occurred on the outside, enveloping only their physical selves. Participants did point out that changes in their perceptions of their identity had occurred, such as experiencing increased self-confidence, higher overall self-esteem, improvement in physical ability, and a deeper sense of self-awareness:

I don't know if I've changed, or was changing...I'm more confident in myself.

-Tina

I'm pretty much the same person except more confidence...probably higher self-esteem. -Pam

I'm still me...I am. I still do the same stuff that I did. I still have bad eating habits, but I know how to control them, and I know how to monitor them, and I know what's bad about them so...I'm still me. -Tracey

I was just a better me...I was able to do more, I was more energetic, I was just a better me! -Sarah

Participants did, however, perceive changes occurring in their communicative desires, abilities, and styles in relation to their experiences with weight loss.

I was friendly (before WLS) and always had kind of a bubbly personality, but I think that I'm way more outgoing (today) than I ever was. –Melissa

I think I changed...all of a sudden I was a happier person...when I started feeling better about myself it was almost like my head went up...and I was standing proud. For the first time, I would talk to strangers where before (WLS) sometimes I couldn't even talk to people I knew. –Lacy

I think I've changed quite a bit in terms of being uh...being more approachable. I'm not so guarded now...I'm much more of an outgoing person. –Tina

I think that I'm not as afraid to speak to people. I now like to be around them, and speak with them, and fun with them...it's just...it's different. –Marie

Realistically, it is impossible to separate the concepts of identity and communication. Hecht's (1993) Communication Theory of Identity illustrates this by asserting that communication should not be seen as "creating identity", but rather, as identity itself because the two are ever-evolving in tacit with each other and inseparable. Eisenberg's (2001) communication theory of identity also suggests that true understanding may only come from comprehending communication and identity as

formed through interrelated processes, all encompassed by the great “surround” of social and environmental factors.

It is the goal of this study to analyze the experiences of women who have undergone WLS on a micro-level. On the micro-level of analysis, isolated trends are more easily able to be separated into categories of identity and communication, though on the meta-level of analysis this task is nearly impossible. To assist in the micro-analysis of the concepts of *identity* and *communication* the difference between these two integral parts of the self shall be defined as follows: “identity”— the complex emotional/psychological factors that allow one to define and separate oneself from others, and “communication”— the culmination of channels through which the individual expresses their identity to others.

Identity and WLS

WLS is a decision that bariatric surgeons advise women not to take lightly as the physical metamorphosis these women undergo as they experience rapid weight-loss post-WLS requires effort and dramatic lifestyle changes in order to maintain the outcome. Long-enduring outcomes rely primarily on making healthful lifestyle changes, doing the necessary mental-work, and successfully navigating the identity shifts that are required along the way. Thus far, aside from offering counseling services, in which not all patients can afford to participate, there has been no guide created for how women are to cope and deal with these issues so, aside from closely attending WLS support groups and actively

learning from the experiences of others, there is no model available for women. This may affect women's physical and mental outcomes post-WLS.

It is imperative to remember that obesity may have been initially utilized as a form of deviant embodiment by women fighting mainstream social norms (Orbach, 1978). Pushing oneself to the outskirts of society purposely may have initially represented a sense of claiming personal space or avoiding traditional societal norms such as expectations to marry young and raise families as their mothers did before them (Orbach, 1978). As women grow more mature, they buy into a normalized pre-occupation with dieting and exercise, which may have led to and solidified friendships, familial relationships, and even romantic relationships that revolved around weight-loss attempts. They also may have developed a deep-engrained sense of membership in the category of U.S. citizens who feel they need to lose weight and are willing to go to extreme lengths to succeed. Realistically, succeeding may be a frightening thing; however, because it would mean friendships, family, and possibly even romantic relationships would need to become uncomfortable as they were renegotiated.

Maintaining obesity may also have served the role of embodied resistance for women seeking to thumb mainstream society, and specifically for women who wished to avoid being sexually objectified via the "masculine gaze" (Berger in Jones, 2005; Orbach, 1978). For these women, the decision to undergo WLS was generally in response to health concerns and meant that they would finally have to adopt the mainstream occupation with weight-loss and become pre-occupied with nutrition, exercise, and ultimately weight-loss. Both of these scenarios of obesity as embodied resistance would require extreme identity shifts in order to realize and embrace new habits, physical

appearance, and lifestyle ideals. The troubling part is that, for many, WLS results in a healthier, lighter person who may still be obese or possess physically stigmatizing attributes such as sagging skin that may keep them from fully realizing a new self-identity that they can be satisfied and comfortable with.

The women in this study had all reported giving up on diet and exercise programs prior to undergoing WLS because they felt they had failed at so many of these programs they had attempted previously. Following their WLS procedures, these women experienced a renewed desire to take care of themselves and gain health. For many of these women, the initial weight-loss gave them a renewed sense of ability to achieve weight-loss where before they had given up on seeing results based on a long history of failed diet and exercise programs. Many of these women had reported being obsessed with their weight, recognizing the physical limitations it presented for them and understanding the associated health risks, but they felt powerless to do anything about it. The outcome of WLS for them was a new pre-occupation with exercise, eating more healthily, getting the prescribed quantities of protein, counting calories, and fat grams. All of these steps, coupled with the initial results instilled a greater level of confidence for these women in themselves, which greatly impacted their identities as able-bodied individuals. Proof of these new pre-occupations could be seen in the open-discussions that occurred before or after every interview, which almost always led into talking about how these women were either succeeding at the moment or needed to do better—these assertions were qualified with the fact that they are eating much healthier than they used to—and often a detailed account of how they do eat on a “normal” day today, 18+ months post-WLS, followed. Most of the women were proud of dietary changes they

categorized as successful and admonished themselves openly for any dietary habits they possessed today that they categorized as “bad”, or as holding them back from further weight-loss success.

During the phase of rapid weight-loss directly following their WLS procedures, the women interviewed were validated when others mentioned their obvious weight-loss. These moments caused most of the women to respond more positively toward their success and kept them on the path toward reaching their health and weight-loss goals. This time frame was also coupled with anger and identity confusion for some. This was related poignantly in the narratives of Tricia, Melissa, and Lacy. Both Tricia and Melissa had felt camaraderie with their families that were solidified by recognition of mutual struggles with obesity and a preoccupation with food and eating as symbolic of family care-giving and an expression of familial love. Because of this deep connection between familial membership and care, they were taken out of their personal comfort zones which elicited fears of losing familial support, and in these two instances family members did not respond well to the changes that these women were experiencing. Left to cope with these rapid changes on their own, there seemed to be an intense fear of failure, as they both wanted to prove to their families that they had made the best decision. In every woman’s case, there existed a fear of failure that they attributed to wasting of opportunity or wasting their personal efforts on something that wouldn’t allow them to achieve the goals they sought to achieve.

For Tricia and Melissa, the thought of failing in their own eyes was particularly harrowing considering the fact that they had experienced a loss of closeness with their families, and in both of their cases, a sense of competition was set forth by their siblings.

This sense of competition was also mentioned by Tina and seemed to emerge from the desire of each sibling to attain and maintain the title of the “thinnest sibling” in the family. This title represented self-identity as well as position in a family hierarchy defined by weight and body appearance. This sense of competition may have inspired the desire to achieve success in order to validate their decision to undergo WLS, yet not achieve too much success, in order to avoid threatening close others that held significant places in their lives.

For Lacy, the anger response was evoked by validating comments others made toward her in regard to her obvious weight-loss. This anger response was triggered by feeling that she was becoming viewed as a more valuable person than she had previously been as her body changed. Though Lacy enjoyed the comments and attention of others, particularly when they came from the opposite sex; she was still in the process of rebuilding her identity and seemed to feel torn. On one hand she was able to acknowledge her own physical improvements, but as was related in the affirmation, “I’m the same me...only better!” she did not want to see her value as an individual increased in response to her reduction in weight. In her mind, if she made someone laugh today, she could have made someone laugh before if they had only given her the chance and had given her the same value as a person and taken the time to know her. The things that she emphasized as having changed about her were that after the weight-loss, she felt physically better and was able to get out more and therefore, socialized more frequently. She also felt that as her weight went down, her self-esteem improved, causing her to feel more confident in expressing herself. This was expressed to her through an ability she claims to have developed, which may represent a possible coping mechanism, to see the

“true” beauty in nature. She began to see even the weeds as being as beautiful as the flowers—a definition she applied to herself. She gained the view that her obese self was seen by others as a weed, and that the value others had placed upon her today was the result that now they could see her as the flower she always was inside. Once she adopted this way of viewing the attitudes of others, she reported that her anger toward their attention to her weight-loss lessened significantly. Other aspects of Lacy’s personality remained the same as before her weight-loss such as her hobbies and love for her mother.

In this way, the separation of identity into the categories of “that which is outside”, which represents all things that others can see, and “that which is inside”, interests, thoughts, personality, likes, dislikes, etc., may have allowed these women to cope with their respective physical changes, altered responses from others, and still maintain the idea that as individuals they had not changed and were the same on the “inside”. In reality, many things did change for these women; they related shifts from introverted personalities to more extroverted personalities, among other things such as increased confidence levels that allowed them to express themselves more fully and openly. Physical health improvements allowed these women to experience new things and to join in activities that previously they had turned down. These women also experienced freedoms from worries that had previously consumed them such as whether or not they would fit into restaurant seats, on carnival rides, or comfortably sit in airplane seats. These freedoms greatly expanded their ideas of what they could accomplish and experience from their lives. These shifts in perceived barriers to new experiences represents an immense identity shift for these women that may allow them to lead more fulfilling lives and continue to grow and evolve as individuals.

Communication and WLS

For women who undergo WLS, communicating what they are expecting and experiencing is important throughout all stages of their WLS journey. At the beginning, when they are still contemplating WLS, women interviewed often bounced their consideration of WLS as an option to assist them in weight-loss off of friends and family. The reactions they received varied greatly from extremely supportive to extremely unsupportive. Mothers stood out in particular as being unsupportive of their daughters' decisions to pursue WLS. This may be because of the risks that come with undergoing any surgical procedure as an obese individual. At the same time, many of these mothers also emphasized the importance of losing weight to their daughters. This appeared to leave the daughters in a quandary of feeling unable to please their mothers by achieving weight-loss through diet and exercise. These women already felt immense social pressures to lose weight and align themselves within the standards of social acceptability; the culmination of these social and familial pressures made WLS appear to be the most viable option for them to achieve their weight-loss goals.

When the women interviewed officially decided to undergo WLS, their responses to the guiding questions asked of them, indicate that at this time they tended to communicate with others about aspects of the WLS procedure they were learning about, post-WLS nutrition and exercise plans, and most importantly what their personal goals were. Most women interviewed reported being nervous yet excited about their upcoming WLS procedures. They bought into the ideas communicated to them through bariatric center preparatory appointments and websites of WLS being a new beginning for them, a

“new lease on life” (Bond et al., 2004), an opportunity to become “normal.” These information sources also tend to emphasize the health and mobility ramifications these women will suffer should they opt to continue about their lives as obese individuals (Salant & Santry, 2006). So, as they mentally prepared for their WLS procedures, these women discussed their future plans in terms of what they anticipated from their experience, their goals, and qualifying to others why it was necessary for them to undergo WLS at this point in their lives. For example, Marie stated that she told her family,

You...know my health problems...if I don't have this done I could die...I need to do this so I can live longer...I need to do this so the diabetes will go away, so that all this will be better. -Marie

From this statement it is made clear that Marie's decision to undergo WLS was tied to her expectations for positive health outcomes, and fears that she had of what would become of her if she opted not to undergo WLS.

For the individual, being able to discuss the qualifications of why they want to undergo a radical change, and being able to discuss what they anticipate the change will look like for them, and what ends will be achieved may be a powerful step toward preparing their minds for the sure changes that are to come. It may serve to help prepare others as well in what they can expect from the experience their friend or family member is about to go through so that they may be able to provide a better support system.

As the individual progresses through their WLS procedure and beyond, they tend to become preoccupied with the WLS process. This is likely a natural progression

because for women who undergo WLS, the days of the first 6 months post-WLS are consumed with the task of nourishing and hydrating oneself with the required micro meals every 2 to 3 hours and drinking as much water as possible in between, being sure to avoid drinking 20 minutes before and 45 minutes after a meal. There are nutrition graduations from a diet of all liquids through soft and semi-solid foods, and finally, to solid foods as the surgical healing process progresses. There is also the prescription of various types and amounts of exercise. Not to mention the frequent trips to the scale to tally the rapid weight-loss that is occurring and the need to continually find smaller clothing as the body begins to decrease in size. It is this stage that women interviewed reported becoming obsessed with WLS and the process of losing weight. At times they are ecstatic that others are taking notice and not so happy at other times. Relationships begin to shift and change as the individual's attention is set predominantly on their role in their physical and mental metamorphosis. Some relationships may suffer from less time and attention than may have previously been paid to them. The dynamics of these relationships may also change as identity shifts occur for the individual who has undergone WLS causing relational roles to shift with them.

Both of these time frames pre and post-WLS are full of communication and identity gaps that may create feelings of discomfort, uncertainty, and even generate depression. Jung and Hecht (2004) explored the concept of personal-enacted identity gap, which occurs when distance exists between the identity an individual maintains of themselves and the identity they communicate to others. This may be seen in the experiences of Lacy when she could not comprehend the physical changes that were occurring as her body weight rapidly decreased post-WLS. In her mind she appeared the

same and had to actually reach the point of needing to purchase smaller clothing to begin to realize the changes everyone around her was seeing. The comments others made to Lacy during this period regarding her weight-loss created a general state of angst for Lacy that she stated was comprised of disappointment in her own failure to visualize her weight-loss results and anger over the fact that everyone around her felt free to comment on her new appearance, likely bringing her overall frustration over the situation to the forefront of her non-verbal, if not verbal communication. The way Lacy's appearance was changing altered her physical appearance and the way she was communicating non-verbally. Lacy also stated that she had been getting out of the house more during the phase of rapid weight-loss because physically she was beginning to feel better and was experiencing decreased symptoms from her diabetes and back injury that had previously kept her homebound. These two non-verbal factors of communication along with the fact that Lacy mentioned beginning to feel others were listening to her and actually valuing what she had to say indicates that her verbal communication was changing through speaking more to others, expressing her thoughts and feelings more often, and as she felt her thoughts were being more greatly valued, expressing them in a more confident way. The disconnect between how Lacy perceived her own identity as unchanged and the Lacy she was actually communicating to others is apparent. Such large identity gaps Jung and Hecht (2004) assert may lead to feelings of identity confusion, feeling misunderstood, and depression.

Lacy's identity struggle in the period of rapid weight-loss post-WLS may also be understood through Eisenberg's (2001) communication theory of identity. Eisenberg (2001) attributes the formation of identity to three interrelated processes of mood,

personal narrative, and communication—all of which are encapsulated and influenced by the “surround” made up of the social world and environmental factors. In Lacy’s experience, her mood, or emotional state, was characterized by intense feelings related to not being able to visualize her own weight-loss results causing the comments of others to frustrate her. At the same time, Lacy was feeling better physically and more confident as others began to validate her opinions and ideas. This confusion of mood was impacted by Lacy’s personal narrative, or life experiences, of being ignored and discounted by others, and growing up as an obese child and becoming an obese woman—an experience that caused her much emotional pain and to view her physical body in a negative way. The surround (Eisenberg, 2001) likely impacted Lacy’s personal narrative by lending messages of dominant cultural ideals for female bodies; ideals that Lacy felt were beyond her power to achieve. These aspects of Lacy’s post-WLS experience necessarily impacted Lacy’s communicative choices and the constant challenge of renegotiating her identity as her physical body, mood, and personal experiences changed manifested in confusion and emotional duress until her period of rapid weight-loss ended and she was able to reach a point of stability.

Even though Lacy related struggling on a daily basis to maintain her initial weight-loss and lose more weight, since she did not quite achieve the goal weight she had in mind when she underwent WLS, she emphasizes that she has changed in positive ways,

...something as simple as someone would say, ‘Look at that old weed...,’ and it’s got a beautiful flower on it. I see the flower, I don’t see the weed...I feel that

the butterfly has become a symbol to me...and just...coming alive on the outside and looking at things differently for the first time. I seem to be more observant...I guess I would have to say that I'm finally holding my head up. –Lacy

Jung and Hecht's (2004) concept of personal-relational identity gap explains the gap that occurs when distance exists between the way individuals see themselves and the way others see them. In Tricia's experience, personal-relational identity gap has remained a struggle even 4 years post-WLS. In her case, her highest weight was around 450 pounds and though she achieved a 190 pound weight-loss, she is still socially regarded as obese. This leads to tensions between Tricia wanting to feel proud of her accomplishments, yet feeling socially sanctioned by others for remaining an obese American woman. For most overweight and obese American women, qualifying the fact that they are at least making strides toward losing weight (e.g. attending a gym, trying a new fad diet, jumping onto the trend of new weight-loss medications, etc.) buys them some lenience in society. The problem is that the majority of these diet and exercise attempts fail leading to their conditional social acceptance being revoked, leaving the woman to find the next weight-loss venue through which to qualify their efforts. In Tricia's case, she underwent WLS, which is currently the most radical weight-loss method available. Though Tricia was successful in her weight-loss, she like many other women, has remained obese causing her to suffer social sanctions through communication with others. She has struggled to communicate her pride and confidence in her achievements, but others have rejected her vision of personal success because she has not met with social acceptability standards. This has led to much emotional pain and identity confusion in Tricia's experience, and

because of this experience, she often refers to herself throughout her interview as “failing” at doing WLS. Much as individuals are expected to “do gender” (Lorber, 1994), women who undergo WLS are expected to “do” or “perform” their WLS experiences in certain ways in order to achieve socially acceptable outcomes.

A space for understanding the influences of society on Tricia’s, and others, exists in Eisenberg’s (2001) communication theory of identity. Eisenberg’s (2001) concept of the “surround” factors of society (social expectations) and environment as coloring all lived experiences through communication and contributing to the mood of individuals illustrates Tricia’s difficulties in forming a positive identity that would allow her to celebrate her achievements. Upon being asked to share a story that characterizes who Tricia feels she is today, she related,

I’m a person who feels like I deserve more credit than I get...I tell people that I’ve had bariatric surgery today and a lot say, ‘Oh really? How long ago?’...and I say, ‘4 years ago.’...and they say things like, ‘Oh, so it’s harder than it looks, huh?’...I can see their clockworks going, ‘Oh my god, she’s still really, really fat...how fat was she before?’...I get a lot of reactions like that and its really annoying to me...Most of society expects you to be a size 2, but if you’re like a size 10 and under you’re probably gonna have...all the acceptance you need...but I think I’ve done well considering who I was... I used to wear a 7X shirt. I wear a 2X now and that’s a big difference. –Tricia

Both Jung & Hecht's (2004) theories of personal-relational and personal-enacted identity gaps and Eisenberg's (2001) theory of the surround interrelated with mood, personal narrative, and communication create spaces through which communicologists may become better able to understand the roles that communication plays in women's journeys through WLS. The work completed in this project; however, represents a mere fraction of the research that is needed, and warranted, in order to gain deeper comprehension of the issues women undergoing WLS face and facilitate them in navigating the challenges they will indeed face in their journeys.

Conclusions

This study has sought to analyze the narratives of women who have undergone WLS, and specifically explore how they renegotiate their identities and communicate about themselves during the three distinct stages of pre-WLS, post-WLS, and 18+ months post-WLS. In these examples it is clear that complex identity shifts are part of the emotional journey that women who undergo WLS will experience. As these identity shifts are taking place, women who have undergone WLS appear to separate and isolate their core values, beliefs, and personality traits in order to maintain a sense of constancy in who they are as individuals.

Communication shifts also occur in tandem with the identity shifts that women who have undergone WLS experience. Some women may feel more socially validated as their weight decreases causing them to become more outgoing and confident.

Communication also plays an imperative role in social support, which may be a key element to achieving and maintaining long term weight-loss results post-WLS.

Given the dramatic increase in the numbers of women electing to undergo WLS annually (AHRQ, 2007), the subject of women's emotional journeys through the WLS experience is a timely and important topic that deserves the attention of social scientists. The renegotiation of identity process and the roles of social support are two important areas that warrant further study and attention.

Limitations and Recommendations for Future Research

There are multiple limitations to this research study worthy of note. The first being the small sample size. In order to properly honor and evaluate participants' narratives, a small sample size was desirable; however, it also limits the scope of the findings. A second limitation to this study is that all of the female participants were Caucasian. A similar limitation may be found in the limited geographic area in which the female participants of this study reside. A broader geographic scope may uncover a greater range of differences in WLS experiences between patients. For example, if a geographic area only offers a small number of bariatric surgical clinics for patients to choose from, the rhetoric stemming from the educational and support systems those clinics operate may well frame the patient experience based upon what they are taught to expect.

An additional limitation that should be noted is that participants were being asked to relate the nuances of their WLS experience in retrospect. Often, individuals tend to remember things, or perceive events as occurring in ways that may not necessarily be in keeping with the actual sequence of events. This does not mean that narratives given in retrospect should be discounted; however, because an individual's perception of events will frame their thoughts, emotions, and actions made in relation to the event, and therefore, provides the context necessary to better understand participant reasoning and motivation.

It is the responsibility of communicologists, as well as other social scientists, to continue to strive to understand the experiences of women who have undergone WLS. Focus on physical metamorphosis is a portion of gaining understanding of these women's journeys, but it is only that, a simple lens through which to view a complex web of factors that may contribute to women's overall success in navigating the dramatic changes they experience as a result of electing to undergo WLS. It is further the responsibility of the medical community to look beyond medical and health literature to begin to understand the emotional aspects of the WLS journey as well. Through this understanding they will become better surgeons and physicians, and grow to possess better skills for helping their patients navigate emotional struggles they will encounter on their WLS journeys. This benefit is two-fold, for women electing to undergo WLS, information will be available to coach them in what to expect from their experience and an understanding that it is okay to struggle and ask for help with an assurance that professionals will be available who may be able to understand what they are going through. For surgeons, physicians, and other professionals in the field of bariatrics, they

will develop the tools necessary to gain better adjusted clients who may be able to achieve results they are happier with than the previous decade of WLS patients.

REFERENCES

- Agency for Healthcare and Research Quality (AHRQ). (2007). *Agency for healthcare and research quality*. Retrieved from <http://www.ahrq.gov/>.
- American Society for Metabolic and Bariatric Surgery (ASMBS). (2008). *American society for metabolic and bariatric surgery*. Retrieved from <http://www.asbs.org/>.
- Askegaard, S., Gertsen, M.C., & Langer, R. (2002). The body consumed: Reflexivity and cosmetic surgery. *Psychology & Marketing*, 19(10), 793-812.
- Bond, D.S., Evans, R.K., DeMaria, E.J., Meador, J.G., Warren, B.J., Shannon, K.A., & Shannon, R.M. (2004). A Conceptual application of health behavior theory in the design and implementation of a successful surgical weight loss program. *Obesity Surgery*, 14, 849-856.
- Center for Disease Prevention and Control (CDC). (2010). *Obesity: Halting the epidemic by making life easier*. Retrieved from <http://www.cdc.gov/chronicdisease/resources/publications/aag/obesity.htm>.
- Collins, R. (2004). *Interaction ritual chains*. Princeton University Press.
- Descartes, R., & Maclean, I. (Trans.), (2006). *A discourse on the method: Oxford world's classics*. USA: Oxford University Press.
- Drew, Patricia. (2008). Weight loss surgery patients' negotiations of medicine's institutional logic. *Research in the Sociology of Health Care*, 26, 65-92.

- Ehrenreich, B., & English, D. (1973). *Complaints and disorders: The sexual politics of sickness*. New York, NY: The Feminist Press.
- Eisenberg, E. M. (2001). Building a mystery: Communication development of identity. *Journal of Communication*, 51, 534-552.
- Fraser, H. (2004). Doing narrative research: Analysing personal stories line by line. *Qualitative Social Work*, 3 (2), 179-201.
- Gaertner, S.L., & Dovidio, J.F. (2000). *Reducing intergroup bias: The common ingroup identity model*. Philadelphia, PA: Psychology Press.
- Goffman, E. (1959). *Presentation of self in everyday life*. Garden City, NY: Doubleday Anchor Books.
- Goffman, E. (1963). *Stigma: Notes on the Management of Spoiled Identity*, Prentice-Hall.
- Granberg, E. (2006). "Is that all there is?" possible selves, self-change, and weight loss. *Social Psychology Quarterly*, 69(2), 109-126.
- Grand Health Partners (GHP). (2008). *Grand health partners: Specializing in surgical and medical weight loss*. Retrieved from <http://www.grandhealthpartners.com/default>.
- Griffin, M. (1994). Building blocks for children's body image. *BITF Newsletter*, 1-4.
- Harwood, J. (1999). Age identification, social identity gratifications, and television viewing. *Journal of Broadcasting & Electronic Media*, 43(1), 123-136.
- Harwood, J., & Giles, H. (Ed.). (2005). *Intergroup communication: Multiple perspectives*. New York, NY: Peter Lang Publishing, Inc.
- Hecht, M.L. (1993). 2002- A research odyssey: toward the development of a

- communication theory of identity. *Communication Monographs*, 60, 76-82.
- Hrabosky, J.I., Masheb, R.M., White, M.A., Rothschild, B.S., Burke-Martindale, C.H., & Grilo, C.M. (2006). A Prospective study of body dissatisfaction and concerns in extremely obese gastric bypass patients: 6- and 12-month postoperative outcomes. *Obesity Surgery*, 16, 1615-1621.
- Inhorn, M.C. (1996). *Infertility and patriarchy: The cultural politics of gender and family life in Egypt*. Philadelphia, PA: U. of PA Press.
- Jones, A. (Ed.). (2005). *The feminism and visual culture reader*. New York, NY: Routledge.
- Jung, E., & Hecht, M.L. (2004). Elaborating the communication theory of identity: Identity gaps and communication outcomes. *Communication Quarterly*, 52(3), 265-283.
- Kilbourne, J. (1999). *Deadly persuasion: Why women and girls must fight the addictive power of advertising*. New York, NY: The Free Press.
- Kinzl, J.F., Traweger, C., Trefalt, E., & Biebel, W. (2003). Psychosocial consequences of weight loss following gastric banding for morbid obesity. *Obesity Surgery*, 13, 105-110.
- Leach, C. W., & Smith, H. J. (2006). By whose standard? The affective implications of ethnic minorities' comparisons to ethnic minority and majority referents. *European Journal of Social Psychology*, 36, 747-760.
- Lindlof, T.R., & Taylor, B.C. (2002). *Qualitative communication research methods: Second edition*. Thousand Oaks, CA: Sage Publications.
- Locke, J. (1690). *An essay concerning human understanding*. England.

- Lorber, J. (1994). *Paradoxes of gender*. Yale University Press.
- Maine, M. (1999). *Body wars: Making peace with women's bodies*. Carlsbad, CA: Gurze Books.
- Markus, H. (1977). Self-schemata and processing information about the self. *Journal of Personality and Social Psychology*, 35, 63-78.
- Maslow, A. (1970). *Motivation and personality*. New York, NY: Harper & Row.
- Mead, G.H. (Ed.). (1934). *Mind, self, and society*. Chicago, IL: The University of Chicago Press.
- Mills, C.W. (1998). *Blackness visible: Essays on philosophy and race*. Cornell University Press.
- Moore, P. (2011). *North Eastern Weight Loss Surgery*. Retrieved from <http://www.melbourneobesitysurgery.com.au/sleeve-gastrectomy.html>.
- Odom, J., Zalesin, K.C., Washington, T.L., Miller, W.W., Hakmeh, B., Zaremba, D.L., Alattan, M., Balasubramaniam, M., Gibbs, D.S., Krause, K.R., Chengelis-Barry, D.L., Franklin, B.A., & McCullough, P.A. (2009). Behavioral predictors of weight regain after bariatric surgery. *Obesity Surgery conference paper, presented June 16, 2008*. doi: 10.1007/s11695-009-9895-6.
- Onocko-Campos, R.T., & Furtado, J.P. (2008). Narrative: Use in qualitative health-related research. *Revista de Saude Publica*, 42 (6), 1-7.
- Pateman, C., & Mills, C.W. (2007). *Contract & domination*. Cambridge: Polity Press.
- Rosenberger, P.H., Henderson, K.E., & Grilo, C.M. (2006). Correlates of body image dissatisfaction in extremely obese female bariatric surgery candidates. *Obesity Surgery*, 16, 1331-1336.

- Schild, H. D. (2011). *Bariatric websites: Marketing strategies, social constructs, and ethics*. Unpublished manuscript, Department of Sociology, Western Michigan University, Kalamazoo, Michigan.
- Simon, B. (2004). *Identity in modern society: A social psychological perspective*. United Kingdom: Blackwell Publishing.
- Stunkard, A.J., & Storenson, T.I.A. (1993). Obesity and socioeconomic status: A complex relation. *New England Journal of Medicine*, 329(14), 1036-1039.
- Stryker, S. (1980). *Symbolic interactionism: A structural version*. Menlo Park, CA: Benjamin/Cummings.
- Stryker, S. (1987). Identity theory: Developments and extensions. In K. Yardley & T. Honess (Eds.), *Self and identity: Psychological perspectives* (pp.89-103). New York, NY: Wiley.
- Tajfel, H., & Turner, J.C. (1986). The social identity theory of intergroup behavior. In S. Worchel & W.G. Austin (Eds.), *Psychology of intergroup relations* (pp. 07-24). Chicago, IL: Nelson-Hall.
- Taylor, V., Whittier, N., & Rupp, L.J. (2007). *Feminist frontiers (7th ed.)*. New York, NY: McGraw-Hill.
- Turner, J.C. (1982). Towards a cognitive redefinition of the social group. In H. Tajfel (Ed.), *Social identity and intergroup relations* (pp. 15-40). Cambridge, England: Cambridge University Press.
- Waterhouse, D. (1993). *Outsmarting the Female Fat Cell*. New York, NY: Warner Books

Appendix A

Guiding Interview Questions

Before WLS

Script: "I would like to ask you to think back to the time period before you had bariatric surgery. Try to see yourself as you were then and please answer the following questions to the best of your ability."

1.) What words would you use to describe the way you felt about yourself prior to having bariatric surgery?

a.) Could you tell me the story of the moment when you officially decided to pursue bariatric surgery?

b.) Did you talk about your decision with others? If so, what did you tell them about the procedure and the results you hoped to achieve?

2.) How did you talk about yourself to others at this point in your life?

a.) Could you tell me about a time when you used this language to describe yourself to another person? Where were you? What were you and the other person doing?

b.) Was there a “safe place” where you felt free to be yourself during this time in your life? If so, did this “safe place” include other people you could talk to? If so, did you talk about yourself differently to these individuals? Could you give an example?

Immediately Following WLS

Script: “I would like to ask you to think back to the first 2 or 3 months following your bariatric surgery. Try to see yourself as you were then and please answer the following questions to the best of your ability.”

1.) What words would you use to describe the way you felt about yourself directly following your bariatric surgery?

a.) Could you tell me a story about yourself during this time period that illustrates one of the challenges you faced?

b.) Did you discuss these types of challenges with others in your life?

If so, who did you talk to about them?

c.) Were there any messages you received from others during this time that you recall being especially supportive or unsupportive?

2.) How did you talk about yourself to others at this point in your life?

a.) Could you tell me about a time when you used this language to describe yourself to another person? Where were you? What were you and the other person doing?

3.) Could you explain to me what your mindset was like during this period directly following your surgery? What were your expectations?

a.) Did you discuss these expectations with others? If so, could you give me a example of a situation where you shared these expectations with someone else
What did you say to them?

4.) Do you recall thinking or feeling that you had changed from the way you were prior to having surgery? If yes, in what ways did you feel you had changed or were changing?

18+ Months Post- WLS

Script: "I would like to think about how you feel today, more than 18 months out of bariatric surgery, and please answer the following questions to the best of your ability."

1.) What words would you use to describe the way you feel about yourself today?

a.) Could you tell me a story about yourself that characterizes who you feel you

are today?

2.) How do you talk about yourself to others today?

a.) Could you tell me about a time when you used this language to describe yourself to another person? Where were you? What were you and the other person doing?

3.) Do you feel that you have changed from the way you were prior to having surgery?

If yes, in what ways do you feel you have changed?

a.) In what ways do you think you express who you are today differently than you did prior to having weight-loss surgery? Do you use different language than you used to?

4.) On a scale of 1 to 5, with 1 being “extremely successful” and 5 being “minimally successful”, what rating would you give your overall weight-loss?

Collected List of Demographics:

*Age

*Sex

*Gender

*Time elapsed since
weight-loss surgery

Appendix B

Most Common Types of Weight-Loss Surgeries

Roux en Y Gastric Bypass

The most common type of WLS is the roux-en-Y gastric bypass procedure where the stomach size is reduced to hold approximately two ounces. There is also a shortening of the intestinal tract resulting in some malabsorption (GHP, 2008). Following this surgical procedure the patient is required to maintain a liquid diet for a period of 6 to 8 weeks followed by slow introduction of soft foods and gradual integration of solid foods over a period of about six months (GHP, 2008). Once patients have been reintroduced to solid foods, they are instructed to consume low carbohydrate, low fat diets of only dense, solid foods (GHP, 2008). Protein is very important to maintain muscle mass, continue weight loss and for overall health, and patients are recommended to consume between sixty and ninety grams of protein per day (GHP, 2008).

Laparoscopic Banding

Another common form of WLS is the adjustable gastric band which works to decrease the size of the stomach via constriction of a band, which may be adjusted through the injection or removal of saline solution via a subcutaneous port placed in the patient's side (GHP, 2008). There is no malabsorption aspect to this procedure, but due to limited food intake, daily vitamin supplements are suggested and after an initial healing period on soft foods, patients are instructed to consume a minimum of 60 grams of protein per day and to consume only dense, solid foods that will allow for slower digestion and a full feeling in the stomach (GHP, 2008).

Sleeve Gastrectomy/Duodenal Switch

The final common WLS procedure to be discussed here is the sleeve gastrectomy where approximately eighty-five percent of the stomach is removed to reduce food intake. The ducts that produce enzymes that signal hunger are also removed in this procedure to reduce or eliminate food cravings (GHP, 2008). There is no malabsorption aspect to this procedure and weight-loss is similar to that of the roux-en-Y gastric bypass (GHP, 2008). This procedure can be performed by itself, or as the first portion of a two-part surgery since the sleeve may be converted to a full roux-en-Y gastric bypass or a second procedure called a duodenal switch, which is the most aggressive of WLS procedures and is generally reserved for individuals with very high amounts of weight to

lose (GHP, 2008). With a duodenal switch, patients can expect to lose up to ninety percent of excess weight, but they also must be very aggressive in regard to getting in their required protein of ninety grams per day and multiple vitamin supplements (GHP, 2008).




Appendix C

HSIRB Approval

Date: May 23, 2011

To: Leigh Ford, Principal Investigator
Heather D. Schild, Student Investigator for thesis

From: Amy Naugle, Ph.D., Chair 

Re: HSIRB Project Number 11-04-25

This letter will serve as confirmation that your research project titled "Weight-Loss Surgery and Identity: The Role of Communication in the Renegotiation Process" has been **approved** under the **expedited** category of review by the Human Subjects Institutional Review Board. The conditions and duration of this approval are specified in the Policies of Western Michigan University. You may now begin to implement the research as described in the application.

Please note that you may **only** conduct this research exactly in the form it was approved. You must seek specific board approval for any changes in this project. You must also seek reapproval if the project extends beyond the termination date noted below. In addition if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the HSIRB for consultation.

The Board wishes you success in the pursuit of your research goals.

Approval Termination: May 23, 2012