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FAT BIAS AND CULTURE  
SHOCK: PSYCHOSOCIAL  
ADJUSTMENTS IN POST-  
OBESITY LIFE

by

Scott T. MacPherson

A thesis submitted to the Graduate College  
in partial fulfillment of the requirements  
for the degree of Master of Arts  
Anthropology  
Western Michigan University  
December 2018

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Scott T. MacPherson

# FAT BIAS AND CULTURE SHOCK: PSYCHOSOCIAL ADJUSTMENTS IN POST-OBESITY LIFE

Scott T. MacPherson, M.A.

Western Michigan University, 2018

Obesity in the United States is unprecedented levels, affecting adults and children as well. As our society has become for sedentary since industrialization, the nation has become fatter. The escalating rate of obesity has had a negative effect on the health of millions of Americans. Health problems such as metabolic disorders and other comorbidities, for instance, hypertension, Type II diabetes, heart disease, weight related cancers etc., (Mozaffarian and Benjamin 2013). The collective cost of obesity to the nation is staggering, weighing in at \$270 billion a year, childhood obesity costs nearly \$15 billion alone (Hammond and Levine 2010). This increase in the obesity in the country also has another less obvious effect, the increase in weight-based discrimination and overt fat-bias. A number of qualitative interviews were conducted in addition an autoethnographic perspective of the authors personal journey growing up as a fat kid in America and the life events that him to choose weight loss surgery. Specific attention was paid to the emergence of identity themes and how they were reclaimed and created by those that identified as early-onset and those that identified as late-onset. The goal of this research study was to answer the questions of how persons who have undergone WLS conceptualize their identities and interpret their experiences with fat-bias both before and after surgery.

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## CHAPTER I

### INTRODUCTION

My earliest experience with being made to feel different was when I was about five or six years old. I was visiting my grandmother's and my aunt was also there with one of my cousins. They were all a lot older than me and everyone was tall and thin as a rail. To this day I can distinctly remember my aunt comment to my grandma, "it's a shame that Scotty is so fat." My grandma must not have been too impressed with her comment because all can recall is my aunt calling my cousin Tommy and saying it was time to go. I didn't know why she said I as fat, I didn't think I was fat. I knew what fat was, and at five years old, I knew I wasn't it. Later when I asked my grandma why aunt Arlene had said I was fat, I remember her explanation, was that my aunt didn't know what fat was, because all of her kids were tall and skinny. Then she asked, if I wanted some more vanilla ice cream and apple pie.

This thesis examines the influence of societal fat-bias, and the power it has to shape the lives and experiences of obese individuals, before and after weight loss surgery. Fat-bias affects the psychological, the emotional, and physical health of all overweight persons in any number of ways, whether they be children or adults. Psychologically, it assaults their self-esteem,

confidence, and their understanding of their own identity. Emotionally, fat-bias is no-less destructive, individuals describe how it causes depression, emotional immaturity and life-long feelings of inadequacy. Physically, fat-bias drives people to restrict the diets of their children, suffer eating disorders, any number of lethal comorbidities, and ultimately choose actions as drastic as weight loss surgery to remedy their condition. As more and more people choose this as a means to alleviate their suffering, some losing hundreds of pounds in the process, they realize that fat-bias still plays a substantial role in their lives. By conducting a series of qualitative interviews with individuals that all chose weight loss surgery as means to relieve their condition, I hope to shed light on the detrimental effects of weight-based bias and discrimination, and whether weight loss surgery improves their lives or not.

First, we need to weigh the current degree of obesity in America. According to the Centers for Disease Control and Prevention (CDC) more than one-third (34.9%) of all U.S. adults are obese, and the rate of adult obesity in the U.S. nearly tripled from 1960-2010. The obesity crisis in America is considered by some to be the single greatest threat to the health of our country. This epidemic has resulted in more and more people deciding to undergo some form of weight loss surgery, a desperate attempt to lose weight, reduce or eliminate the effects of comorbidities, and in some cases, save their lives. The American Society for Metabolic and Bariatric Surgery (ASMBS 2017) estimates that nearly 200,000 people undergo bariatric weight loss surgery each year in the United States. By the end of 2013, the population of the United States of America reached 317 million people, among American adults, 20 and older, 156 million were considered overweight or obese (AACAP, American Academy of Child & Adolescent Psychiatry 2012). Our society is clearly losing the battle with obesity, the rate at which the obesity epidemic has increased since the 1960's is truly alarming, but pales compared

to the CDC's future projections. The CDC expects that by the year 2030, a full 42% of the population will suffer with obesity, that amounts to a 33% increase over the next two decades (ASMBS, American Society for Metabolic and Bariatric Surgery). Healthcare in the United States struggles to provide appropriate medical services that people can afford; this challenge is magnified by the cost of obesity and its related comorbidities. The obesity epidemic weighs on the economy as well. A study by Society of Actuaries showed obesity costs the U.S. economy \$270 billion per year (CDC 2013).

The severity of this problem, combined with the constancy of societal fat-bias, creates an atmosphere that many people find intolerable. Whether their choices are motivated by poor health, or the reality of being fat in America simply unbearable, more people than ever are choosing weight loss surgery as a way change their reality experience. Several cohorts of people today are considered to be overweight, or obese by criterium of the American Medical Association in the United States, and as a result they suffer from a panoply of directly related comorbidities. America's fat problem has gotten so bad in recent years that in 2012, a group of 300 retired admirals and generals and other senior military leaders classified obesity as "a threat to national security," citing soldiers discharged for failing to meet weight standards (Suhay, 2012). Unfortunately, the obesity epidemic isn't simply limited to a bunch of fat soldiers, it also includes our overweight children (Frum, 2010). Obesity most commonly begins between the ages of 5 and 6, or during adolescence (AACAP 2012). Current research indicates that obese children are at a far greater risk of developing severe health issues as they mature, moreover, studies have shown that a child who is obese between the ages of 10 and 13 has an 80 percent chance of becoming an obese adult. (Puhl 2001, Jeffcoate 1998, AACAP 2016). As of 2013, 23.9

million children ages 2 to 19 were overweight or obese, 33% of boys and 30% of girls (AACAP 2012).

As more people have decided that WLS is the only way to improve the quality of their life, a growing body of research data has revealed some unanticipated results. Over the last several years, an increasing number of people have reported experiencing psychological and social phenomena in the weeks, months and years following these surgeries. Only recently, have a number of studies begun to better understand the possible reasons and consequences of these experiences. The psychological effects may be more severe among those adults who had early-onset obesity because of the length of time they were subjected to fat bias. The bias begins to assault the psychological well-being of children before they enter kindergarten (Harrison, Rowlinson and Hill 2016). Even at this early age, average weight children are developing their anti-fat attitudes. These early experiences will inform their opinions for the rest of their lives. Research has clearly shown that fat-bias amongst average weight children begins to develop as early as preschool, and they very quickly begin to project it onto their overweight peers. Clearly, this topic is vast and multifaceted, making it difficult to isolate any one issue with obesity and how its influenced by societal fat-bias. Many consider fat-bias an acceptable form of discrimination, because it is understood by society as a personal responsibility. The stigma of obesity is so powerful, that it can stain how a person is perceived in the eyes of others, even after they have lost weight. (Brewis 2014, Ferrell 2011) By better understanding how culture informs society about what “fat” means to individuals we might then be able learn how to push back against weightism and fat-bias.

What obesity represents in our culture, and how it’s interpreted by society, shapes and influences how we understand beauty, health, socio-economic positioning, and ultimately plays a

role in how overweight individuals experience the reality of obesity. We either experience it from within or from without, as an obese person or someone of average weight. The amount of negative reinforcement and punishment that overweight people endure are troubling, but so are the resulting long-term physical and emotional damage. By examining the level of fat-bias in American culture, and influence it has on the lives of overweight individuals, we gain insight into the forces compelling thousands of individuals to seek weight loss surgery each year. Obese people experience a significantly different reality than those of average weight people. How their realities and subsequent changing concepts of self, are experienced after weight loss surgery highlights the convergence of reality, meaning, and the role fat bias plays.

Chapter two begins with a brief history and development of fat-bias in America, and a short explanation of how reached current levels. Afterwards, we will examine the current degree of obesity in America, social stigma, medicalization of obesity, the detrimental effects to mental and emotional health among children and adults, and lastly, weight loss surgery, early versus late onset obesity and some of the psychological, emotional, and social experiences people have reported following surgery. Chapter three starts with a brief introduction to the project, a description of methodology, and concludes with a discussion about the project's volunteers, their interviews and what has been learned. Chapter four is an analysis of the volunteer data collected and the results. This chapter also discusses the construction and reconstruction of identity post-weight loss, and how age of onset effects this process. Chapter five includes an interpretation of the data, the conclusion, a discussion section, followed by the appendices, and bibliography.

## **CHAPTER II**

### **FAT BIAS AND OBESITY**

Over the last several years there has been an escalation in the rates of obesity, not just in the United States, but throughout the world. In the west, since the Industrial revolution, there has been a steady rise in the adult average weight. The rate and speed that America has experienced this exponential increase in the number of overweight and obese citizens is truly stunning. According to statistics provided by the CDC covering the years 2001-2014, the prevalence of obesity was just over 36% in adults. Among U.S. youth, over the same period, it was 17.0%. This is not simply the percentage of individuals considered overweight, but those that statistically qualify as obese. Two thirds of the American populations are statistically overweight, an increase of 30% since 1970 (Hammond and Levine 2010). Obesity in adults is currently defined as having a body mass index or BMI, of greater than or equal to 30. In children, obesity is defined as a BMI of greater than or equal to the age - and sex-specific, 95<sup>th</sup> percentile of the year 2000 CDC growth charts (CDC, National Center for Health Statistics for 2011-2014). The medical costs of obesity in 2008, in America accounted for almost 10% of all medical spending, equaling \$147 billion (Hammond and Levine 2010). This rise in medical costs due to obesity isn't limited to adults, but to children as well. The yearly costs of childhood obesity in America are currently estimated at nearly 15 billion. What makes that statistic so alarming is that current childhood obesity implies an even greater future cost, given that

overweight children are more likely to become obese adults (Hammond and Levine 2010). The direct and indirect economic costs of obesity are expected to increase over the next few decades (Sobal and Stunkard 1998).

Research suggests any number of causes, ranging from our out of control consumer culture, poverty, lack of education, lack of exercise (Jeffcoate 1998), sugar filled soft drinks/food (Albritton 2013), or a combination of everything (Puhl 2001). Whatever the cause, one thing is clear; the disease of obesity is killing us slowly and in a variety of ways. The disease is directly connected to the development of certain cancers, heart disease, Type II diabetes, sleep apnea, and several other co-morbidities and every one of these can lead to premature death (Jeffcoate 1998). In many cases, death is slow and extremely painful; people often spend years wracked by body pain. Health care professionals differ on the exact causes of the epidemic, or how to treat it, but on this they all agree; obesity is a very serious health issue, considered by many, the greatest health crisis of our time.

## **Culture and Fat**

Despite an overwhelming collection of data, reflecting years of research that seems to make it exceedingly clear that “fat” is bad for one’s long-term health, the American people continue to put on weight, and at the same time, we are collectively more disgusted by it than ever. However, there is push-back against the ever-increasing degree of fat bias in the country. In recent years, a number of groups have tried to turn the tide of weight-hate in America, one such organization is NAAFA, the National Association to Advance Fat Acceptance. NAAFA is a civil rights organization dedicated to protecting the rights and improving the quality of life for fat people. NAAFA works to eliminate discrimination based on body size and provide fat people

with the tools for self-empowerment through advocacy, public education, and support (NAAFA 2016).

However, the vast majority of physicians argue that being thinner is definitely healthier. "The latest science is quite clear that excess weight can carry considerable health risks, including a higher risk for heart attack and stroke, while there is no one-size-fits-all number when it comes to a person's ideal weight, we should not ignore significant weight gain and the implications it has for our future health." says Dr. Jorge Plutzky, director of preventive cardiology at Harvard-affiliated Brigham and Women's Hospital (Harvard Health Publishing 2018). At the same time, others strive to point out that being "fat" doesn't always mean unhealthy. In recent years some studies have shown that "fat" people can be "fit," despite what is often preached about being overweight. Part of the fat acceptance movement is the goal many have, which is, to simply feel good and to be more physically fit. At the same time many people take a closer look at obesity and fat bias and try to understand the position it has in culture and how it maintains hegemony over our cultural discourse. Dr. Linda Bacon, author of *'Health at Every Size'*, points out that being thin is a cultural obsession, and that it is possible to be healthy and technically overweight, even obese. Similar to Kulick's book, *Fat: The Anthropology of an Obsession*, culture determines how a society understands concepts such as obesity (SBS: The Feed 2014, Bacon 2018)

Today western nations, besides the United States are experiencing increasing rates of obesity. A recent study in the International Journal of Obesity examined fat-bias in America, Canada and Iceland and Australia. These countries were selected due to having similar rates of overweight and obese adults (roughly a rate of 60-70%), and comparable per capita income and Westernized democratic government (Clark 2016).



- Believing that people are personally responsible for obesity due to their personal behavior and lack of willpower is a central cause of fat-bias in all four countries (Clark 2016).
- Men in all four countries were more likely than women to be biased against fat people (Clark 2016).
- In Iceland and Canada, fat people are less likely to be biased against other fat people, but in America and Australia, personal weight doesn't predict a level of fat-bias (Clark 2016).
- Having obese family members or friends experience fat-bias makes people less likely to be biased against fat people in Canada, Iceland and Australia, but personally experiencing anti-fat stigma made no difference in how one felt towards other obese people (Clark 2016).

America currently has one of the highest rates of obesity in recorded history, making it the prime location for research on weight bias, or more specifically fat-bias. Such research has found that not only does America have the highest rates of obesity, America is also the most biased against it (Clark 2016). Today the United States finds itself at the center of this maelstrom of cultural attitudes and biologically based health outcomes. Sadly, the overwhelming level in America of fat-bias and weight-based discrimination causes damage to the mental and emotional well-being, manifesting in difficulties interacting with society, stunting of emotional development and psychological disorders. A growing body of research has shown that overweight children, that are classified as “chronically obese,” were associated with a statistically higher risk of psychiatric disorders such as oppositional defiant disorder, attention deficit disorder, and clinical depression (Mustillo et al, 2003).

In the study mentioned earlier, America has more overweight and obese people than anywhere else in the world, one would think this would create a more empathic atmosphere,

creating a lower degree of affective fat bias, but that isn't the case (Marini 2013). On an individual level, fat people, in general, harbor less implicit and explicit fat bias towards other overweight people, than thin people do, but on a national level it's a different story. The fatter a nation becomes, the greater degree of overt fat-bias, and the United States is the fattest first world nation on the planet (Marini 2013). The combination of a weight-hating society with a high-rate of obesity has the potential to create an intolerable environment for overweight people. The resulting degree of fat-bias has the power to cause serious mental and physical damage (Mustillo et al, 2003).

The age at which a person begins to contend with obesity is called "*age of onset*." Age of onset is defined as the earliest age at which person was physically over-weight, either as a child or as an adult. For the purposes of this project, "age of onset" is divided into categories, *early-onset* obesity, defined as, overweight or obese before the age of eighteen, and *late-onset* obesity, weight issues that occur after the age of eighteen. The reason this age was decided upon is because it sits squarely in the middle of how age of onset has been defined in the literature. Some researchers defined it as sixteen and others as late as twenty-one. For this reason, eighteen seemed to be the median choice. Through examining the differences in the way people of each category experienced obesity growing up, personally, and socially, but also, and especially after undergoing weight-loss surgery will allow us to understand how they experienced obesity and what it meant to them, before and after WLS. First, however, it is necessary to look at fat-bias in society and how over the years it has been measured and quantified by researchers.

## The Stigma of Fat

Periodically of the last forty-years, social scientists have taken measurements of the current levels of fat bias in American culture. A variety of studies have been carried out over the years, some examined the bias of marrying age adults, others looks teenagers, and some sought to learn how much bias exists with children fives and younger. In America, obesity carries a severe stigma, it has the power to define a person's understanding of their identity, and this can affect their personal experience of reality (Ferrell 2011, Brewis 2014, Brody 2017). In Goffman's stigma theory, he defines stigma as social perception of "spoiled identity, being disqualified from full social acceptance by others, a personal mark of disgrace and contaminated social identity"(Goffman 1963). The effects of stigma on the stigmatized can be severe and long-lasting in terms of both mental and physical health (Puhl and Brownell 2006). A factor in the stigmatization of fat has to do with obesity being assigned as a personal responsibility. This manifests in two ways. First, the stigmatized person in considered responsible for having acquired the condition. Second, the stigmatized person is charged with the responsibility of ridding themselves of the condition (Anderson and Bresnahan 2013).

Early in my elementary school experience, it became pretty obvious in the eyes of my classmates and even my teachers, that I was something special. It was as if I had magical abilities or something. Everyone was really impressed by how well I could draw. Some of the kids would ask me to draw, just so they could watch me do it. It wasn't long before I realized something even more important than my artistic skills. When I was drawing pictures, the kids weren't making fun of me or calling me names, they were completely mesmerized, as if I were a snake charmer. At the age of nine, I had discovered something, something that would allow me to escape the *fat identity*, I just had to keep drawing.

I can remember it like it was yesterday, as usual we moved again, and I was going to be the new kid for the fourth time, but this time I was going to do something different, I was going to take control. That morning before school, I packed my drawing paper and pencils into my backpack and brought them with me to school. As I expected, I heard the kids whispering to each other about how fat I was that first morning in Mrs. Mackenzie's class. I sat there quietly and waited. At snack time I broke out my drawing pad and pencils and started drawing. It started slow, but as more and more children noticed how well I could draw, a crowd formed around my desk, almost every kid wanted to see my pictures take form on the paper in front of them. I had managed to take control of the narrative, it was a lesson I learned well. Throughout elementary, into middle school, and even into high school, I was the *artist*. The kid who could draw like a god! That isn't to say I wasn't still a fat kid, I assuredly was, it's just that I wasn't only a fat kid, I was now a talented artist that also happened to be fat.

I had wrested control of what other kids thought and said to, and about me. I felt so empowered that my confidence started to grow and over time I felt as if I had almost shed the fat kid identity. I personally identified as an artist, its who I was, what I desperately wanted to be. In school, I wasn't a good student, starting in third grade I was put on Ritalin, a drug to aid with my rampant attention deficit disorder. They didn't call it ADD back then, it was just what the teachers asked the parents to put their child on to make them shut up and be quiet. When mine suggested it to my mother, she did as she was asked. Normally, I was bouncing off the walls as kid, it was impossible for me to pay attention to the teacher for more than a few minutes and besides I needed to be drawing, and draw I did. In fact, it's all I did. I came to hyper-focus on it so much, because I thought if I stopped even for a minute, the other kids would see me again as the *only* fat kid.

Burke's *Identity control theory* states that the way an individual self-identifies will eventually change if it is in conflict with external feedback, i.e. how others see them. If a discrepancy persists long enough between how they see themselves and how everyone else does, their image of themselves will change to conform to that of others (Burke 1991). This discrepancy isn't removed simply by changing the situational meanings to agree with one's identity, but by changing one's identity to agree with the situational meaning, but this generally takes a long time and most people would leave the situation rather than endure such changes to who they are (Burke 1991). This is exactly the case with an overweight individual, their self-image is generally dictated to them by society "the situational meaning," despite any resistance. Those with late-onset obesity, freely exercised their agency before the weight gain, in determining their personal identity, but with the weight comes the newly earned externally granted identity. However, persons that have dealt with weight issues since childhood, early-onset, had their identities determined for them from the beginning, depriving them of any native identity, other than from external determination.

In America, fat-bias is endemic and impossible to avoid. Crossing over into many domains, it influences our behaviors, language, ideas, social and cultural practices and norms, cultural representations in images, media, art, and symbols, as well as social relations, political and legal practices (Morgan 2011). Systemic fat hatred also lurks in education, healthcare, scientific research, and especially in the venomous ideologies that serve to legitimize the hatred of persons regarded by our society as fat. The worst of these exalted ideologies leads us to believe that fat persons are naturally loathsome, animalistic, slothful, weak willed, ugly, asexual, gluttonous, and lazy. The very definition of stigmatized corporeality, and undisciplined desires out of control (Morgan 2011)

The anti-fat ideologies that swirl throughout our culture, constantly assault the psychological and emotional well-being of all overweight people, and influences children before they even begin kindergarten (Holub 2008, 2011). The degree of explicit fat-based discrimination in American culture has increased by 66% over the past decade, and is currently comparable to rates of racial discrimination, especially among women (Puhl and Heur 2009). Weight-based discrimination has been documented in a variety of areas including, but not limited to, work settings, the denial of employment and or promotions; educational settings in which obese students are teased and shamed by peers, viewed negatively by their teachers, and even being dismissed from colleges because of their weight; and healthcare environments, where obese patients are forced to confront bias from health care professionals including doctors, nurses dietitians, and mental health professionals (Puhl and Brownell 2004).

For instance, studies have been done to measure existing levels of fat-bias in health-care. Researchers found that health-care professionals, i.e. physicians, nurses, psychologists, and medical students possess negative attitudes towards obese patients, believing, for example, that obese people are lazy, noncompliant, undisciplined, and have low willpower (Puhl and Heur 2009). In a study of over 620 primary care physicians, >50% viewed obese patients as awkward, unattractive, ugly, and noncompliant. One third of the sample went on to further characterize obese patients as weak-willed, sloppy, and lazy (Schwartz 2003, Puhl and Heur 2009).

Physicians also believed obesity was a behavioral problem caused by lack of physical activity, over-eating, and personality characteristics; considering these to be the most important causes of obesity issues (Puhl and Heur 2009). In fact, as a patient's BMI, (body mass index) increased, physicians reported liking their jobs less, having less patience, and less desire to help the patient (Puhl and Heur 2009). In the last few years two major studies detected a strong implicit fat-bias

among health professionals who specialize in treating obesity. These are troubling statistics. A perfect example of this level of fat-bias amongst physicians is Dr. Kenneth Walker, who said in his nationally syndicated newspaper column that ‘for their own good and the good of the country, fat people should be locked in prison camps’ (Puhl and Brownell 2001).

Overweight and obese people are forced to contend with implicit and explicit discrimination from all areas of life, even in places one would expect a higher level of understanding. Negative stereotypes are developed in people at a very young age, endorsement coming from all directions, but a few inform how we think about weight more than others. Weight bias in the media plays a significant role in warping our perceptions, having incredible power to shape the social acceptability of weight stigma, or lack thereof. Even today in 2018, overweight people remain one of the last acceptable targets of humor and ridicule in North American television and film (Puhl and Heur 2009).

An analysis of adult and children’s entertainment, thin characters are ascribed positive and desirable traits and dominate roles (Latner et al 2007). In contrast, overweight characters are rarely seen, unless in minor, stereotypical roles; and are almost never portrayed in romantic relationships and are most often the objects of humor and ridicule (Puhl and Heur 2009). When cartoons have been analyzed in this context, the prevailing tendency is present positive messages about being thin and negative messages about being overweight. One study surveyed 303 first to third grade children and found that young boys learned from media to denigrate fatness and to idealize thinness. Another illustrated that television watching predicted and increased the tendency of males to stereotype an overweight female target by associating her with negative characteristics, such as greediness. Boys were also more likely to associate thin girls with characteristics such as “nice,” “smart,” “clean,” “tells the truth,” and “has lots of friends” (Puhl

and Brownell 2006, Penny and Haddock 2006). Weight-based discrimination is almost universal within the advertising industry. We are constantly being blitzed with ads pitching weight loss products, programs and pills. Studies that examine fat bias in advertising describe infomercials and how they regularly portray overweight women as unhappy, unhealthy, and especially unattractive.

Television commercials have long promulgated the message that weight loss is simple and straightforward, using before and after pictures to convey the message that weight loss is achievable, and will definitely make a person much happier (Puhl and Heur 2009). The news media is no exception, in fact, it has long functioned to shape society's view of obesity. News media has traditionally portrayed obesity as a personal responsibility, focusing on individual causes of obesity such as, bad food choices, over-eating, and a lack of exercise. Over time this focus on personal responsibility for the condition, eclipses other important causes of the obesity epidemic and often blames individuals and reinforces societal levels of fat-bias (Puhl and Heur 2009, Latner et al 2007). Over the last few decades, researchers have revealed that these biased attitudes begin early in childhood, normally fully developed by the age of eight (Bass and Eneli 2015, Holub 2005).

Negative attitudes towards obese people in the form of stigma and bias result in explicit and implicit discriminatory behaviors against obese persons (Puhl and Brownell 2006). Several studies have been conducted over the years to determine if a relationship exists between culturally endorsed weight-based stigma and psychological well-being. Time and again, these studies identified a greater frequency of stigma positively related to BMI and poorer psychological functioning (Puhl and Brownell 2006). Essentially, the fatter a person is higher the likelihood they were to experience psychological disorders such as depression, psychiatric



symptoms, body image distress, and lower levels of self-esteem. These studies also revealed that obese persons had higher levels of low self-acceptance, which was explained by their experiences with societal discrimination and mistreatment due to their weight (Puhl and Brownell 2006, Schwartz 2006). In general, studies that have been conducted to quantify current levels of societal fat-bias frequently reveal specific patterns.

The most common stigmatizing situation reported by study participants were the negative comments made by others, people staring at them, the low-expectations because of their weight, nasty comments from children, public accommodations that are too small, inappropriate comments from doctors, co-workers, and family members. In fact, generally 50% of obese people participating in these types of surveys report experiencing at least 40% of these and other stigmatizing situations (Puhl and Brownell 2006). Among obese people, the most common and frequently reported source of stigma were family members, followed by doctors and other health professionals, classmates, sales clerks, friends and co-workers. The coping strategy of eating more food and refusing to diet, was reported as the most commonly used when dealing with stigmatization by family members.

Men and women both experience fat-bias, but not in the same way, though there definitely is some overlap. Men reported the most frequent source were classmates, then doctors, family members, and their mothers. Women report feeling weight shamed by doctors more often than in any other situation, followed by their family members, classmates, and sales clerks at clothing stores (Newhook et al 2015). All research indicates that women report being discriminated against because of their weight at a much higher frequency than men, in fact, 16x more likely, and with an increased level of perceived animus (Puhl and Brownell 2006). Past research doesn't reveal any difference in the frequency of depressive symptoms, or self-esteem

issues in the experiences of men and women. Women have reported higher levels of depressive symptoms if they experienced loved ones being embarrassed by their weight, and weight-based ridicule by their friends, while men reported lower levels of self-esteem if they were teased by their sons (Puhl and Brownell 2006). Unlike other forms of bias and discrimination experienced by many other minority groups, negative stereo-types and attitudes towards overweight individuals are generally, still socially accepted and even encouraged in 2018.

The pervasiveness of fat-based stigma can affect the beliefs of overweight individuals themselves (Major et al 2005). Social identity theory states that members of a distinct group are more likely to view group members in a more positive light and members of the outgroup more negatively. However, contrary to this theory, overweight people appear to lack this preference for the ‘ingroup’ and instead actually can and often do, hold negative attitudes towards other obese people. This internalization of fat-bias is quite different from behaviors of other minority groups (Wang 2005). The implications of this apparently absent lack of ‘in-group preference’ among overweight people is a serious problem, as it can serve to perpetuate the stigma of obesity. Indeed, overweight individuals who stereotype others in their group (other overweight people) can be especially persuasive to those outside the overweight community, the ‘out-group.’

Since a stigmatized liaison would be more informing and motivating than a non-stigmatized source in convincing a dominate majority to re-examine a particular issue, such as the detrimental effects of fat-based discrimination, it tends to hinder changing popular opinions regarding fat people. (Wang 2005). The question inevitably arises, why is the current degree of stigma against obesity so pervasive? First, weight, as portrayed in popular culture, television ads, health magazines etc., is seen as a manageable condition, unlike other stigmatized traits such as race, ethnicity and gender. Our society reinforces and recycles stereotypes about fat persons,

recertifying them, as if they were lazy, feeding the assumption they also lack motivation or accept any responsibility for their condition which is explicitly under their control. Studies have found that when a condition or behavior is provided with a medical explanation, it reduces these assumptions about a person's ability to control said condition. The 'medicalization effect' has been recognized in the context of substance abuse, alcoholism and other conditions that have been medicalized, i.e. given a medical explanation, and thereby a certain amount of understanding for the condition. Many of these conditions are now considered by medical science as diseases. (Wang 2005).

In 2013, the American Medical Association officially recognized obesity as a disease. This was done in part to induce physicians to pay more attention to the condition and compel more insurers to cover obesity related treatments. Any positive changes to societal perceptions due to the 'medicalization of obesity' are still currently being measured. Perhaps not surprisingly, initial studies show the trajectory of weight-based discrimination shows little change, in fact, the traditional ameliorating effects the designation of medicalization doesn't seem to apply to obesity in the same way as alcoholism or other previously medicalized conditions. As we have discussed, weight-based stigma is identity threatening for overweight individuals. These experiences trigger a deluge of negative emotions, cognitions, behaviors, and other biological responses. These responses elicit further psychological and physiological reactions, disrupting self-regulatory processes important for self-control. Two major contributors to increased eating and weight gain are known to be inefficient self-regulation and increased stress (Major et al 2012).

Working in combination with social identity theory, is the concept of social identity threat. Social identity threat is the psychological condition that occurs in situations where people feel at

risk of being devalued because of their social identity or judged through the lens of negative stereotypes (Major et al 2012). Recently, researchers have applied this psychological model to the concept of weight stigma. As stated earlier, stigma associated with weight-bias differs in key ways from traditional stigmas such as race, ethnicity, or gender. Since weight is largely considered a manageable condition and the sole responsibility of the individual, it can cause others to hold obese persons responsible for their social identity, feeling they earned it.

This is despite research that clearly shows that efforts to lose weight are usually unsuccessful in the long-term. Individuals that identify as late-onset usually have years to learn the culturally endorsed negative stereotypes associated with obesity, before this identity becomes personally relevant (Major et al 2012). Today, the most serious issues health professionals, and psychologists deal with is the exponential increase in the obesity rates among children. This rapid increase in the childhood obesity rates is exposing more young people to the social identity threat caused by culturally endorsed fat-bias. What researchers are learning is this increased and protracted exposure to weight-based stigma, beginning at a younger and younger age than ever before, can cause serious psychological damage to children and young adults.

Identity is a set of meanings applied to the self in a social role or as a member of a social group that define who one is (Burke 1991). Identity is influenced by both internal determinations, how one self identifies might be based on their career, being a parent, a coach etc., and external reinforcements, or how the world identifies you. Self-identity develops as a response to a stimulus how that response reacts to the stimulus depends on whether it was a positive or negative (Burke 1991). This reinforcement guides the development of one's identity in a social structure (Burke 1991). When the two concepts, how you self-identify and how others identify you are in sync, a healthy concept of self can be achieved (Granberg 2011). Social

feedback or external reinforcement is the most influential in determining self-concept; this is the “angst” part of the teenager experience; negotiating how you see yourself versus how others see you. When there is a conflict between how you self-identify and how others see you, there is a disruption in the development of a healthy identity; this disruption can lead to psychological and emotional disorders.

Overweight or obese children begin responding to negative stimulus as early as pre-school and rapidly they begin to self-identify as fat, and this starts them down road that leads to some form of psychosis (Puhl 2009, Latner 2007, Ferrell 2011, Gumble and Carels 2012). What a child decides to identify with is influenced by many factors these often include their family’s socio-economic status, how they were raised, classmates, pop culture, movies, magazines and TV (Latner 2007); these external influences will exert more power on the shaping of their identity than any other factors (Latner 2007). This embryonic concept of self is extremely vulnerable in these formative years to any external negative stimuli in their environment.

Around the ages of ten and thirteen, normal weight children begin to develop a healthy idea of individual self-identity. In combination with the positive reinforcement of others, these children may begin to see themselves as soccer players, ballerinas, singers, artists, or baseball or football players. A fat child of the same age already has a developed sense self-concept, one that has been shaped by negative reinforcement (Ferrell 2011, Holub 2016). Most of the damage caused by this age only gets worse as the child get older (Puhl and Brownell 2004), because fat bias and discrimination rapidly become part of the everyday life of obese children (Puhl 2009). Their minds become conditioned from a very young age to be sensitive to jokes, off-handed comments, and the stares of strangers. Numerous studies have made it clear, in only a few short years, exposure to fat-bias leaves our children with zero or reduced self-esteem, barely any self-

confidence and self-identifying as a fat kid first, and everything else second (Puhl 2009). By the time children enter middle-school the pressure to be thin, beautiful or at least not fat, has exponentially increased, compelling children of younger and younger ages to conform or risk the terror of fat stigma. This has the effect of causing children to begin dieting at younger and younger ages; often at the suggestion of one or both of their parents. Researchers have discovered the average age children in America today start their first diet is eleven for girls and fourteen for boys (Latner 2007).

America's children are under enormous pressure to conform to a socially acceptable body type; but what is more disturbing, is the fact that a child this young already fully equates beauty and popularity with thinness and the opposite with being overweight. For many decades experts believed obesity was caused by a mental disorder or a general weakness of character, or simply due to sloth and indulgence. There is some ironic truth to the assumption that obese individuals are more emotional and possibly mentally unstable (Mustillo 2003). Here's the ironic part, it's not a mental condition that causes people to become obese (normally) but rather years of mental and emotional abuse, perpetrated by a culture of unfettered, and rampant weight-hate.

Unfortunately, the widespread societal prejudice against obesity is directed at children and adolescents with the same level of vitriol as adults. Researchers have begun to study the vulnerability of children to the negative consequences of fat-bias and stigma (Puhl 2009). Generally, children experience teasing by their peers, such as name calling, nasty remarks, being made fun of, but also physical bullying such as hitting, kicking, pushing, shoving, and social exclusion such as, being ignored or avoided, and exclusion from peer activities (Puhl 2009). Research shows that overweight children experience fat-bias as early as three to five years old.

Average weight preschoolers easily describe heavier children as mean, stupid, ugly, unhappy, lazy and having less friends (Puhl and Brownell 2009).

Children are exposed to fat-bias from a variety of sources, not just other children. Indeed, one of the earliest sources of bias children commonly experience comes from their teachers. One study examined elementary and middle school teachers' attitudes regarding fat children specifically. The researchers discovered that some teachers considered obese children to be generally more unkept, more emotional, less likely to do well in school, and likely have family problems. In fact, nearly half of all teachers surveyed agreed that overweight and obese adults are undesirable marriage partners for non-obese people (Puhl 2009), and another 28% of teachers surveyed believed that becoming obese is the worst thing that can happen to a person.

## **PTSD**

One doesn't need much imagination to think how these attitudes could possibly influence the relationships with their students. Another study examined the relationship between perceived weight-based discrimination and psychiatric disorders. Perceived weight-based discrimination was significantly associated with a current diagnosis of mood and or anxiety disorders. Weight-based discrimination was also positively associated with an increased likelihood of an individual having used mental health services at some point. Post-traumatic stress disorder (PTSD) has frequently been found to influence the development of obesity (Johannessen and Berntsen 2013). Just as obesity and PTSD have been found to be related, so have depression and obesity. The American Psychiatric Association defines PTSD as a relatively chronic disorder if symptoms continue to persist after six months of exposure to a traumatic event (Johannessen and Berntsen 2013).

Although, PTSD can develop over the course of years as well, not requiring a single event or a series of events. Some recent studies support the connection between obesity, depression and PTSD, and have even demonstrated a decrease in reported chronic depression and PTSD symptoms after losing a significant amount of weight due to dieting or especially WLS.

Further research is needed to determine what exactly is causing this recorded decrease in symptoms, what is clear though is a connection between these two specific psychological disorders and obesity exists. Interestingly, late-onset adults demonstrate a lower rate of PTSD associated with obesity, by contrast early-onset adults have a higher rate of PTSD associated with obesity (Johannessen and Berntsen 2013). This could indicate, those exposed to fat-bias in childhood, and continued exposure through adolescence and into adulthood, generally have higher rates of PTSD, than those with late-onset. Currently, there are no standardized, empirically tested recommendations regarding psychological treatment for patients following weight loss surgery (Grimaldi and Van Etten 2010).

A study from 2009 clearly demonstrated a correlation between the manifold psychosocial factors and the physical and emotional results following weightloss surgery (Herpertz 2003). Long term successful weight loss is best achieved and maintained when WLS is followed up by ongoing emotional and psychological support. Post-surgical therapy is especially effective when there is a history of presurgical comorbidities such as clinical depression, anxiety, PTSD from childhood physical and or sexual abuse, binge eating disorder, avoidant personality disorder, and alcohol or substance abuse/dependence (Grimaldi and Van Etten 2010).



## Forms of Weightloss Surgeries

Weightloss surgery is the most effective and durable treatment for individuals suffering from all degrees of obesity, but especially morbid obesity. According to the American Society for Metabolic Bariatric Surgery and the American Medical Association these are but a few of the physiological and metabolic benefits patients gain from bariatric surgery.

- Surgery results in significant weight loss and helps prevent, improve or resolve more than 40 obesity-related diseases or conditions including type 2 diabetes, heart disease, obstructive sleep apnea and certain cancers
- Individuals with morbid obesity or  $BMI \geq 30$  have a 50-100% increased risk of premature death compared to individuals of healthy weight.
- Studies show surgery reduces a person's risk of premature death by 30-40%
- Clinical studies have demonstrated significant improvements in safety, showing that the risk of death is 0.1%, and the overall likelihood of major complications is about 4%.
- Gastric bypass patients may improve life expectancy by 89%.
- Patients may lose as much as 60% of excess weight six months after surgery, and 77% of excess weight as early as 12 months after surgery

(ASMBS 2013)

The most common bariatric surgery procedures are gastric bypass, sleeve gastrectomy, adjustable gastric band, and biliopancreatic diversion with duodenal switch (Mayo Clinic 2018).

In Roux-en-Y gastric bypass, the surgeon creates a small pouch at the top of the stomach. The pouch is now the only part of the stomach that receives food. This severely limits the amount that one can comfortably eat and drink at a meal. The small intestine is then cut a short distance below the main stomach and connected to the new pouch. Food flows directly from the pouch

into this part of the intestine. The main part of the stomach, however, continues to make digestive juices. The portion of the intestine still attached to the main stomach is reattached farther down. This allows the digestive juices to flow to the small intestine. Because food now bypasses a portion of the small intestine, fewer nutrients and calories are absorbed (Mayo Clinic 2018). In the laparoscopic adjustable gastric banding procedure, a band containing an inflatable balloon is placed around the upper part of the stomach and fixed in place. This creates a small stomach pouch above the band with a very narrow opening to the rest of the stomach. A port is then placed under the skin of the abdomen. A tube connects the port to the band. By injecting or removing fluid through the port, the balloon can be inflated or deflated to adjust the size of the band. Gastric banding restricts the amount of food that your stomach can hold, so you feel full sooner, but it doesn't reduce the absorption of calories and nutrients (Mayo Clinic 2018).

In a sleeve gastrectomy, part of the stomach is separated and removed from the body. The remaining section of the stomach is formed into a tube-like structure. This smaller stomach cannot hold as much food. It also produces less of the appetite-regulating hormone ghrelin, which may lessen your desire to eat. However, sleeve gastrectomy does not affect the absorption of calories and nutrients in the intestines (Mayo Clinic 2018). As with sleeve gastrectomy, the biliopancreatic diversion with duodenal switch procedure begins with the surgeon removing a large part of the stomach. The valve that releases food to the small intestine is left, along with the first part of the small intestine, called the duodenum. The surgeon then closes off the middle section of the intestine and attaches the last part directly to the duodenum. The separated section of the intestine isn't removed from the body. Instead, it's reattached to the end of the intestine, allowing bile and pancreatic digestive juices to flow into this part of the intestine, called the biliopancreatic diversion. Because of these changes, food bypasses most of the small intestine,

limiting the absorption of calories and nutrients. This, together with the smaller size of the stomach, leads to weight loss (Mayo Clinic 2018). Weight-loss surgery helps you lose weight and lowers your risk of medical problems associated with obesity. Bariatric surgery contributes to weight loss in two main ways:

- Restriction. Surgery is used to physically limit the amount of food the stomach can hold, which limits the number of calories you can eat (Mayo Clinic 2018).
- Malabsorption. Surgery is used to shorten or bypass part of the small intestine, which reduces the number of calories and nutrients the body absorbs (Mayo Clinic 2018).

Of the different methods, Roux-en-Y gastric bypass is generally the most successful, resulting in the fastest and greatest degree of weight loss. Gastric by-pass is also the only type of WLS that isn't reversible. An analysis of WLS data revealed that the average percentage of excess weight loss was 47.5% for patients who underwent gastric banding and 61.6% for those who underwent gastric bypass (Kubik et al 2013). Over the last several years there has been an exponential increase in the number of annual procedures. This increase has provided millions of people a second chance at life, free of the many comorbidities that often accompany obesity. This increase has also provided an incredible increase to the body of data regarding the physical results of rapid weight loss, and they are significant, the Roux-en-Y gastric bypass has been shown to seriously reduce, or in many cases eliminate the effects of Type II diabetes. In many people it also relieves the symptoms of numerous other comorbidities, including heart disease, diabetes, hypertension, dyslipidemia, stroke, atherosclerosis, and specific types of cancer (Kubik et al 2013). The physical benefits have been studied intensely over the last two decades, however, the resulting psychological effects are only recently being appreciated (Herpertz 2003).

As we have already discussed, obese persons also have an increased risk of psychological distress, disordered eating, and impaired health-related quality of life issues, but what has not been examined closely until only recently is the psychological effects of significant and rapid weight loss on an individual's mental health (Kubik et al 2013). A higher rate of psychological disorders exists in obese people, particularly mood disorders, anxiety, and low self-esteem etc.

Those considered morbidly obese are five times more likely than average weight people to have suffered a major depressive episode in the last five years (Kubik et al 2013). In fact, 25–30% of all weightloss surgery patients report depressive symptoms at the time of surgery and up to 50% report a lifetime history of depression (Major et al 2012). Another recent study showed that obese individuals that actively sought out WLS had a significantly higher frequency of psychological distress compared to other obese patients that do not seek surgery (Kubik et al 2013). In fact, 38% of all weight loss surgery candidates actually met the diagnostic requirements of at least one 'axis I disorder' in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, (DSM-V) an additional 29% met the requirements for one or more 'axis II disorders' at the time of preoperative evaluation.

Research data clearly indicates that individuals that previously, or currently contend with issues concerning their weight, have a higher likelihood to also suffer from a number of physical and psychological comorbidities (Kubik et al 2013).

## **CHAPTER III**

### **METHODOLOGY AND PROFILES**

During this project a qualitative strategy was used for the collection of data (Bernard 2011). Six women and two men interviewed, as well as two bariatric health professionals. A total of eight interviews might be viewed by some as too small a sample size to elicit any valuable data from. I agree that perhaps a larger sample would have provided more information, but I would argue that any additional information, would likely not contradict the results gained from the comparatively few interviews conducted. The reason for this I would submit is the degree to which the results across these interviews, were consistent with my own experiences and the many informal conversations I had with individuals that all expressed very similar psychosocial, emotional and physical experiences. I agree that if a similar study was conducted in the future, one with a larger sample size, perhaps the authors of that study would reveal even more consistent patterns in the same issues I examined and perhaps, others in areas of experiences that

were not included in this present study. That could be a valuable contribution to this important subject area.

Another important point that needs to be made is in regard to how the volunteers were recruited for this study. I had attempted to recruit participants from online support groups, and word of mouth. As it happened this method didn't work out as well as I would have liked. It limited the number of participants, and severely limited the amount of control I was able to exert over the recruitment process. It also created an unintended bias in the recruitment process from the beginning. Those that were interested and likely had something to share sought me out and signed up to participate. I can't know what other individuals might have had another story to convey but were perhaps reticent to share in their experiences. Also, I only was able to interview white, middle-class individuals that had quality enough health insurance to provide them with a means to get weight loss surgery. This excluded many other socioeconomic groups that would have perhaps had an entirely different experience than what was conveyed to me by the volunteers that I was able to enlist. These are issues that need to be considered in the present study.

## **Recruitment**

The volunteers had all previously undergone some form of weight loss surgery. Volunteers were allowed to participate in the project if at least nine had passed since their surgery. Nine months was chosen as appropriate, because it provided them with enough time to completely heal after their surgery, and to allow for significant amount of weight loss. Another reason why nine months of time was chosen is because in the weight loss surgery community, the first nine or twelve months following WLS is generally called the "honeymoon" period. This

is when most of the reality of the experience becomes personally apparent. A minimum age of eighteen was chosen so that a participant could legally fill out a consent form.

After confirming their interest in participating, we arranged to meet at a location of their choice and further discuss the study, at that point I gave them the consent form to sign. The volunteers then participated in open-ended interviews, each lasting approximately an hour (Bernard 2011). They were asked to describe their personal experiences with fat bias or weight-based discrimination prior to WLS, and any post-surgical psychosocial and/or emotional issues experienced in the months or years following weight loss. After the interviews were complete, their profiles were divided according to how volunteers self-identified, in their history with obesity, whether they were early or late onset. In addition, two bariatric professionals, both currently working in the bariatric field, and both very interested and willing to participate, also joined the study. The same method was used to record these interviews, i.e. a digital voice recorder. These were also conducted in person. Before the interview process began, they read and signed the consent form, discussed any and all concerns they had with the study to their satisfaction. During these two interviews, the questions concerned issues that revolved around their personal experiences treating and caring for WLS patients before and after surgery; what types of issues do their patients contend with if any, are there any patterns to post-surgical behaviors, do they think age of obesity onset plays a role or not, what are some the reasons patients have given for choosing something as drastic as WLS, how do they address the psychosocial and emotional issues that patients might raise.

All of the interviews were designed to be casual conversations about the participant's personal struggles with obesity and fat-bias in their lives, whether early or late-onset. These conversations revolved around topics such as, age of onset, fat bias, personal identity, WLS

issues, obesity and gender etc. As I mentioned earlier, one of the issues this study was looking at was whether those that self-identified as early onset, reported more intense and disconcerting experiences following WLS, and if they did, could these experiences be the result of having been exposed to fat bias and discrimination longer, i.e. since childhood. I placed significant emphasis on these *semi-structured* interviews, using the same set of questions, however, some questions were specific to the volunteer's experiences. For instance, topics like experiences of fat bias as a child or as an adult, if and how they felt differently after WLS, and after the weight-loss, if and how friends, family and strangers treated them differently, have they experienced any physical and or social benefits and or problems after WLS, etc. The goal for this project was to interview a number of past weight loss surgery patients, listen to their personal experiences with obesity and from their stories try to learn the answers to these questions.

- **Did WLS patients experience reality before and after surgery in different ways that can be explained *only* by age of onset?**
- **How did they transition from one reality to another and did losing weight change their lives?**
- **What did obesity symbolize to them before weight loss surgery and has its meaning changed since, and if so, how?**
- **How did they contend with identity reclamation, and creation?**

## **Methodology**

The names and personal data were protected by keeping the consent forms in a locked cabinet in the office of the principal investigator throughout the project and after the study was concluded. Volunteers were assigned Participants Identification Numbers, their real names were never written down, except on the consent forms. These precautions were taken because of the real possibility that a one or more of the volunteers would feel uncomfortable with the personal



nature of the questions; obesity is a very emotional issue, in several cases the discussion revealed long suppressed anger, sadness, and in one instance, severe emotional distress.

### **Volunteer Profiles**

**Alias:** Wilma

**Age:** 59/female

**Age of onset:** early onset

**WLS type:** Roux-en-Y Gastric by-pass 25-years ago

**Psychological disorders:** clinical depression

**Alias:** Brian

**Age:** 37/male

**Age of onset:** late onset

**WLS type:** Roux-en-Y Gastric by-pass 2-years ago

**Psychological disorders:** ADHD

**Alias:** Judy

**Age:** 38/female

**Age of onset:** late onset

**WLS type:** Roux-en-Y Gastric by-pass 6-years ago

**Psychological disorders:** clinical depression

**Alias:** Amy

**Age:** 44/female

**Age of onset:** late onset

**WLS type:** gastric sleeve 3-years ago

**Psychological disorders:** clinical depression

**Alias:** Gina

**Age:** 52/female

**Age of onset:** early onset

**WLS type:** Roux-en-Y Gastric by-pass 15 years ago

**Psychological disorders:** none

**Alias:** John

**Age:** 56/male

**Age of onset:** early onset

**WLS type:** Roux-en-Y Gastric by-pass (5 years ago)

**Psychological disorders:** clinical depression

**Alias:** Barbara

**Age:** 35/female

**Age of onset:** early onset

**WLS type:** gastric sleeve (2 years ago)

**Psychological disorders:** clinical depression and alcoholism

**Alias:** Joan

**Age:** 68

**Age of onset:** late onset

**WLS type:** Roux-en-Y Gastric by-pass (8 years ago)

**Psychological disorders:** clinical depression

### **Bariatric Professionals**

Darci, Bariatric Dietician

Melissa Bariatric Nurse

## CHAPTER IV

### TO BE, OR NOT TO BE FAT

Over the course of this research, eight people were interviewed, six women and two men, all of whom had some form of weight-loss surgery. The number of people that self-identified as early onset, and late onset of was numbered at four each. Two healthcare professionals were also interviewed, specializing in both pre and post weight-loss surgery care, a bariatric dietician, and a bariatric nurse. Today in the United States of America, one can experience two different realities growing up, one as an overweight child or one that is not. The differences in these two realities are marked by how one experiences fat-bias, either from the perspective of an average weight child or one that grew up obese.

Factors such as the socio-economic status of one's family, community, gender, and even race, all yield to the power of fat-bias in society. It isn't much a stretch to say that an overweight child from a wealthy family will experience nearly the same degree of fat bias growing up, as a child from a poor family (Amsterdam 2013, Ferguson 2009). Perhaps even more, due to the fact that obesity is often associated with poverty today. Whether or not a person was heavy when growing up effects a person in deep and meaningful ways, that last a lifetime. The stories that were told to me during the interviews are very real and personal, and at times extremally emotional. Vividly describing their earliest childhoods memories sprinkled with some happy and sad times. They share a few things in common, at some point in their lives, they were seriously

overweight and, in a few cases, morbidly so; they all had personal experiences contending with fat-bias and weight-based discrimination, and eventually each made the decision that weight loss surgery was their only option.

### **Early-onset: Growing up fat**

Wilma, Gina, John, and Barbara all identified as early onset. All four, claimed remembering how different they felt from their families and friends. Starting at about the age of five, all four claimed that they distinctly remember, not knowing what it was, or why, but each recall feeling different from their siblings and other family members. Each them recalls the feelings of inadequacy and somehow unacceptable to the other kids. Three of the four, had the good fortune of being parented by loving and supportive families, that shielded them from fat-bias in the home.

In my house, my mother did all the cooking. She made old school meals, meat and potatoes, and there were plenty of cakes and pies around the house just in case company should stop by. My mother was constantly on a diet. She had always been thin and pretty. When she struggled in high school with her grades, her mother told her not to worry too much about school, just don't let yourself get fat, and stay pretty and everything will be fine. As a result, my mother was always standing on the bathroom scale, fretting over every tenth of a pound. She deprived herself of eating much of anything, never publicly, enjoying any of the cakes or pies she was constantly baking. My mother enjoyed eating vicariously, she enjoyed watching those she cooked for scarf down her gigantically portioned meals and desserts. If anyone tried to evacuate the dinner table without having a healthy second or third helping, she would accuse them of causing her to waste food, and besides, we couldn't waste food, because there were

millions of children starving to death in China. I remember wondering what the fancy dishes had to do with starving kids.

When I was six, my mom and dad split-up, it was 1977, we were the last family on the cul-de-sac to succumb to divorce. My mother was an emotional wreck, she seemed to cry non-stop, I remember that very clearly. Some people eat when they are stressed, some go jogging etc., my mother cooked, and cooked, and also baked. Without my dad at home, you would think that she would have scaled back the amount of food she cooked since it was just my sister Becky and I now; but no, it was up to me to replace his absent consumption. My mom didn't expect my sister to eat as much as me. In fact, she restricted my sister's diet and made her aware of her need to be thin, even at the age of five. My sister was a skinny little thing when we were young, she was very active and never was even remotely close to being chubby. Though years later my sister developed a severe eating disorder in high school, Becky and I both knew, without a doubt, from where this psychological disorder came.

As I got older, my weight slowly started to creep up. My mother started having me stand on the scale too. She would chastise me for gaining weight, telling me that she couldn't afford to keep buying me new clothes every time I outgrew the clothes I had. I remember pointing out that I was growing up, and of course I would need bigger clothes, and she told me that wasn't the issue, I was growing out faster than I was growing up. My mother would take me shopping for new jeans, I recall being excited because I wanted a pair of Levi's 501 button-fly. Instead, my mother bought me jeans called "Huskies." They weren't even close to being as cool as Levi's, she told me they were made for husky kids, "you mean fat kids mom?" I'd ask, "no just husky." I might have been twelve when I found out there actually was a dog breed called a Husky, and it wasn't because it was a fat dog.

When I was in elementary school, it was made clear to me that I was indeed fat. Unfortunately, it was nearly impossible for me to forget, indeed if somehow, I'd successfully achieved that, other children were more than happy to endlessly remind me. On one such occasion, I remember being in gym class, it must have been in second or third grade, we were testing our seven or eight-year-old, athletic ability for the ever-anticipated Presidential Youth Fitness Program. The gym teacher had the boys all gather around, while we took turns doing as many sit-ups, and push-ups etc., as we possibly could while he and the other boys watched and counted. Needless to say, I was humiliated, unable to do many of the President's favorite exercises.

I distinctly remember looking at the teacher's facial expressions between my grunts and groans and watching them flip between looks of disgusted exasperation and a contrived affectation of encouragement. But I especially remember the other boys pointing to and laughing at my fish belly white bouncing belly rolls and commenting on my obvious fatness. The gym teacher made it very clear to me and all the other boys, in a volume and tone meant to elicit an example, that Scott was an embarrassment to not just President Carter, but to all of America. As result of situations such this, school was a place I felt the most vulnerable as a child, I had no one to stand up for me and stop the teasing and bullying that I dealt with every day.

After my folks split up, we moved around quite a bit, so I found myself being the new kid a total of seven unbearable times. It might not have been so awkward or torturous, if all I had to endure, was being the "new kid" and understandably devoid of friends, but I was the "*new fat kid*." I remember one day in the lunch room, sitting by myself, I noticed a freckle-faced girl apparently walking up to me carrying her food tray, I actually allowed myself to think, that just maybe, she might sit down next at me. Nope, that wasn't the reason, not even close. Instead this

girl pointed to a chubby boy, sitting alone, smiling ear to ear, from across the cafeteria, was overjoyed that I was the new kid at school; because it meant he was no longer the fattest kid at Ramona Lane elementary.

### **Wilma**

At the age of four, Wilma remembers being aware of how she was different from her siblings. Wilma was never made to feel ashamed about her weight, at home or even after she started school. She believes this was because of her very close group of very close friends and the overt love and support her parents provided her in the home.

### **Gina**

Gina was made aware of her weight at five years old in a very negative way. Her father ridiculed all the children, but he reserved a special kind of harassment for young Gina. She was the only child that had a weight problem, and her father was relentless in his attacks. Her mother didn't say anything to protect her. Gina thinks this was because her parents believed that if they harassed her enough, she would lose the weight. She never did. When Gina tried to diet, she was teased about dieting and exercising, because her family thought it was ridiculous to watch a fat person eat small portions and try to exercise.

### **John**

John was obese as far back as he could remember. His parents and siblings teased him about his weight in his earliest memories, but it didn't reach the level of constantly unbearable until he started school. Beginning with elementary, until he graduated high school, John was mercilessly teased about his weight. John told me when he realized that being the fat kid in school, is what shaped him into the man he is today. He came to that realization when he was not

yet twenty-years old. He said that it saddens him to think that at age he already understood the power a fat-identity had had over him. Not only does he believe that being fat made him who he is today, but he's also convinced that the endless harassment and bullying, took a toll on his mental and emotional health. He shared with me that at times he actually considered suicide, he was so tired of it. As a teenager in high school, John had zero self-esteem, zero self-confidence, it was all teased out of him on a daily basis. He never gave up trying to discover who he was and who he wanted to be, this quiet desperation kept him going. John was tired of being the funny fat kid. He was over it, he was tired of being defined by others, what they would expect, and that was a source of entertainment, and nothing else.

## **Barbara**

Barbara believes she started gaining weight by at least age six. She remembers being treated different by the kids at school, and she says that she knew it was because of her weight. It was also probably due to the fact that her family was very poor. Barbara never had fashionable clothing and her mother cut her hair with bowl and a pair of scissors. She remembers other children calling her dirty and saying she smelled. The fact that she was chubby just added to the over-all humiliation.

Her parents did the best they could to protect her from social fat-bias, but it was something they really could do little to stop. When both of her parents starting working, she began spending a lot of time at her grandmother's home. From the minute she would arrive, her grandmother would constantly harass her about her weight. She called Barbara names and even accused her of being stupid and lazy, because she was fat. Over time this had a negative effect on her self-esteem.



## **Late-onset: Growing up thin**

Brian, Judy, Amy, and Joan all identified as late-onset. They generally experienced what they described ‘normal’ childhoods. Their parents supported them in sports and other activities. Aside from being accused of being too skinny they didn’t experience bias or discrimination of any sort. These individuals grew up through their developmental years as average weight children, and generally harbored the normal level of fat-bias towards overweight people.

### **Brian**

Brian was the only child in a happy middle-class home, that provided him with all the love and support a child deserves and more. Brian was a rather short and skinny child, and for him it was quite the opposite of being overweight, he desperately yearned to be a big man, a strong man, like his father. In elementary Brian was relentlessly picked on and bullied because of his small size. He was teased so much, that his self-esteem was in tatters. To remedy this, parents enrolled him in karate classes, eventually Brian earned a black belt. This did wonders for his self-confidence. At about the age of twelve Brian finally felt closer to becoming the person he wanted to be.

### **Judy**

Judy was a below average weight child, she was always being called “too skinny,” and told she needed to eat more. She grew up on a farm, and spent her days helping her mother around the home, cleaning, cooking and doing other domestic duties by her side. Sadly, for Judy, from approximately the age of two, until she was eleven, she was sexually abused by a family friend. This experience has had an understandably damaging effect on Judy’s ability and willingness to recall many of the events of her childhood. Judy was the youngest of two girls and

the thin one of the two. Her older sister struggled with her weight since early childhood. Obesity was very common in the family and it was never demonized by her parents, though she was aware of the physical and emotional challenges her sister went through as she grew up. In school, Judy experienced a very normal childhood, with more than her share of drama, demanding a disproportionate amount of her parent's attention. It was constantly the Judy show.

### **Amy**

Amy was the athlete, from her earliest memories, she was always involved in sports. As a result, she was always in great shape, very thin and petite. Amy enjoyed popularity and plenty of attention growing up. School was a good experience for Amy, she was popular, played several sports, and her family loved and supported her too. As Amy made her way through her young life, she admits that she despised the fat kids. Like the other kids, she considered them lazy, dumb and socially awkward, she was one of the mean girls. Amy teased the fat kids just like everyone else. After high school she went off to college to chase her dreams.

### **Joan**

Joan's earliest memories from her childhood were of a very skinny little girl growing up on a farm, working hard with her siblings and parents almost every day. Everyone worked hard, ate a lot, and nobody was ever fat. Her parents were thin, so was the rest of the family, including herself. In elementary she doesn't remember there being any overweight children, like her, they all lived on farms too. Fat-bias or weight-hate wasn't something she remembers being an issue when she was young. The only people in Joan's life that were heavy were her grandparents, and that was normal, everyone loves a chubby grandma. Her family life was filled with love, and her parents were always supportive in everything she chose to do. School was also a happy time in

young Joan's life, from elementary through high school, she had several very close friends. Like all of her friends, she looked forward to the next chapter in her life, getting married and having babies. That was still expected of a young woman after graduating from high school in the early seventies, especially in her small farm town community.

### **Early-onset: From high school graduation to weightloss surgery**

As the years went by, and got older, and the confidence and respect I got from drawing, helped me in other ways too. I soon realized that I could make kids laugh. Like the drawing it came be used as a means by which to distract kids from laughing at me, instead I was able to take control of the moment and cause them to laugh with me, instead of at me. By the time I was in high school, I was officially the class-clown that could also draw, and also happened to be fat.

No matter how much I made the other kids laugh I was still alone. No girlfriends for artists, that also fat. There wasn't a big demand for that combination in a guy. Whenever I looked in the mirror, I still saw a fat kid, not an artist, or a comedian, but a fat kid, trying to be other than what I was, and had always been. The teenage years are normally filled with angst and overt emotion while trying to discover who we are. Problem was, I already knew, and I didn't like it. I was the fat kid, with bad grades, ADHD, socially awkward and emotionally immature. I tried to be a football player in high school, because it was acceptable to be a "big guy" if you were a football player. I failed, because I was too awkward and didn't have an athletic bone in my body.

Eventually I gave up and stuck to drawing, reading books history books and playing Dungeons & Dragons with the other social misfits. When I graduated high school, I weighed about 230 pounds. I didn't go to college like my friends, I worked crap jobs and drank too much and smoked ample amounts of dope. Now I drew pictures for myself, because there wasn't

anyone to impress now that I wasn't in school anymore. When I was 26 years old my first daughter was born, I was over 300 pounds at the time. Her mother was someone I had met at a bar, and three months later she was pregnant. She wasn't even close to what I had dreamt of in a partner, but I didn't think there were too many women out there that would want a fat ass like me, so I married her. Within four years, another daughter was born, and not long after that I was divorced. The stress of divorce and the unbelievable sadness I felt whenever I thought about not seeing my little girls every night led me down the dark path of depression.

As a result, I gained even more weight, making depression worse, which made me eat more. I was trapped in circle of death. Eventually, we were divorced. it was official in 2001. By that time, I was deep in depression and drinking too much. My confidence was extinct, to feel better I would draw, like I had always done, but it wasn't quite the catharsis it had once been. I was a very sad and unhappy person. I owned my fatness from a very early age, but I never gave up on the possibility that other people would see me as something other than a fat dumb kid.

Though that is who I long believed myself to be. That little boy is still in the recesses of my mind laying the fetal position, just waiting for a moment of weakness to remind me of who I really am, and who I'll always be. 2001 was also the year I started college for the first time in my life. I desperately needed to be doing something positive. I cannot describe how beneficial my experience in college was for me. I realized a great deal about myself. One day it dawned on me that I hadn't draw a single picture in years. I was floored by the realization. Something that had such a big part of who I was, was gone. But why? Turns out I didn't need to draw anymore, I was for the first time in my life comfortable in my own skin. The college and university experience helped me realize that I wasn't stupid after all. I was finally free, confident in myself, more so than at any time in my life.

In 2005, I met my current wife and within a year my third daughter was born, life was getting a whole lot better. However, in 2006 I was diagnosed with type II diabetes and I was in bad shape. My overall health of a bad, hypertension, high cholesterol, and my knees were bad. I was at the doctors one day and when they weighed me, I was up to 365 pounds. My doctor mentioned weight loss surgery and said that I was a perfect candidate for Roux-en-Y gastric bypass. He told me that it might eliminate my diabetes, hypertension and cholesterol, but definitely make my knees feel better. I agreed and was scheduled for weight loss surgery. When I first started college, I decided that I would first get ahold of my mind and learn discipline from school, and then afterwards I would do the same with my body. Now it seemed to be happening.

## **Wilma**

Wilma doesn't ever remember being happy with her body. Her earliest memories were filled with thoughts of fat, and as she matured, she grew taller and taller. In Wilma's mind this only magnified her body image issues, now she was big and fat! Wilma had a very close group of friends, but she was still lonely. She worried that she would never find a boyfriend, especially now that she wasn't just fat, but a giant too. After college Wilma finally met the man that she would marry, a man that she admittedly wishes she had never met. It was a difficult marriage, he was an abusive alcoholic, yet it lasted ten years and resulted in her children. Wilma attributes the length of the marriage and the marriage itself, as a direct result of her low self-esteem and a fear of being alone. Finally, in 1991, she decided she was ready to make a change in her life. That year Wilma underwent have the Roux-en-Y gastric bypass procedure. At the time of her, surgery Wilma weighed 315 pounds, and she was in a very bad place psychologically and emotionally. She looked at the surgery as a last-ditch effort to save herself.

## **Gina**

Gina didn't appreciate the fact her family moved a few four times between elementary and high school. As a result, she always felt like an outsider. It's never easy being the new kid, and it's near intolerable being the "fat" new kid. Her siblings were all very popular, athletic, and extremally sociable, her school experiences were riddled with situations that made her feel inadequate, damaged her self-esteem. Everything in her teen years was shaped or destroyed by her weight. Gina never had any boyfriends, boys had no interest in dating a fat girl, she was just invisible.

When Gina graduated high school, she weighed 250 pounds and was 5'3" tall. As a teenager, Gina always felt like an outsider, her family moved a few times between elementary and high school. It's never easy being the new kid, and it's near intolerable being the "fat" new kid. Her siblings were all very popular, athletic, and extremally sociable, her school experiences were riddled with situations that made her feel inadequate and damaged her self-esteem. Everything in her teen years was shaped or destroyed by her weight. Gina never had any boyfriends, they had no interest in dating fat girls, she was just invisible. When Gina graduated high school, she weighed 250 pounds and was 5'3" tall. After graduation she took a job as a nanny, and right away she could tell that her weight was still an issue.

The mother of the house was constantly demeaning to Gina about her weight, regularly accusing her of eating things that weren't hers. She tolerated it as long as she could but ended up quitting because of the constant mental abuse. Gina decided she had had enough of her fat body, she started to diet, and she finally lost a significant amount of weight. For the first time in her life, men were noticing her, finally she was normal. It didn't take long for Gina to meet a guy. Almost immediately she got pregnant. During her pregnancy, Gina gained back all the weight

she had lost and even more. The worst experiences with fat-bias in Gina's life came from the medical community while she was pregnant. Gina described how from the minute she walked into the doctor's office, she was humiliated by the office staff and nurses because of her weight. Gina's was immediately considered a high-risk pregnancy the whole nine months, because her weight, co-morbidities were considered a danger to baby. The child's father didn't remain in their lives, he wasn't interested in being a father or being with a fat woman. It's not easy for a single mother to meet men and date, it was especially difficult when she's grossly obese. Eventually, she did meet a man that seemed to be just right. Gina was terrified that he would leave her if she didn't lose weight. This is what ultimately convinced Gina to seriously consider weightloss surgery.

## **John**

Over time, John came to truly believe he was a sub-par, broken person, and he would always be fat. John had been teased, harassed and bullied because of his weight since his earliest memories. It had completely eroded any remnant of a self-esteem, positive self-image etc., and despite all of this he has survived by becoming the class clown. John always said, 'it's better for them to laugh with him than laugh at him.' This strategy became his primary social-survival method, throughout high school and after. Despite all of John's challenges and self-esteem issues, he met the woman that he would one day marry.

She was also overweight, but not nearly as heavy as he. John described how he felt closer to her because she was also fat, because they had the experiences of obesity and fat-bias in common. A rare mutual understanding of life's challenges. After a several years of marriage and

four children, his health had deteriorated rapidly as a result of his morbid obesity. Comorbidities, such as diabetes and sleep apnea were out of control, and his knees and hips were also in bad shape. John says he was a psychological and physical wreck. One morning he woke up, looked in the mirror and decided he was going to get weight-loss surgery. John hoped the procedure could save his life. Within six months, he was going in to the hospital for the Roux-en-Y, a surgery that would save his life, but also finally let him feel better about himself. The morning of his surgery, John weighed 375 pounds.

## **Barbara**

As Barbara grew older, she continued to gain weight. Barbara has no memories of her parents ever making her feel inadequate because of her weight. They never shamed her or required her to lose weight. They tried hard to build up Barbara's self-image in a positive way. In school, Barbara didn't ever get invited to parties or other social engagements much. She only had one or two good friends. At the same time, Barbara doesn't remember being really teased by the kids at school about her weight, she said that most the kids just thought of her as the "funny kid," but now she thinks that she was funny because she was fat insomuch as it was a defense mechanism, to deflect the teasing and laughing at her, to something else.

Even to this day she uses humor to defuse situations, she learned this when she was young. As Barbara was about to start high school she started to think more like a typical girl, she started to experiment with make-up and hair products. In high school, she started engaging in bulimic behavior to lose weight, and she did. Finally, Barbara was getting noticed by the boys, and she liked it. She had her first boyfriend in 9th grade, but they broke-up because he lived in another town and Barbara was getting attention from other guys and was eager to test the waters. Barbara immediately found another, cuter guy. Life was great! The more weight she lost by



forcing herself to throw up, the more attention she received. Even from the popular guys at school. All of this attention was a new experience for Barbara. This caused her to ramp up the non-healthy behavior, such as bulimia, drinking, and drugs. She admits to having felt deprived of attention and felt that she deserved it. At seventeen-years old, Barbara met a guy at work, he wasn't from around there. He invited her to a party at his house. When she arrived it as clear it wasn't really a party, but an excuse to get Barbara to come over, not long after she arrived, he raped. Barbara had always dreamed of being a skinny girl, for all sorts of reasons, but for the purpose of attracting men, was never a reason.

Looking back Barbara believes that having been raped caused her to put on weight, as a means of protection. Gaining weight, made her invisible to the boys again. When Barbara graduated high school, she weighed 160 pounds. In 2005, Barbara graduated college, she was close to 250 pounds. Five years later she was married, and sixteen months after that, she was divorced, it was an unhealthy relationship. During and after her divorce the constant stress caused her to put on even more weight.

Barbara had never been this fat. She tried to go bicycling and hiking for exercise, but her size made it all but impossible. She was also in pain from other co-morbidities and taking a variety of meds. Finally, she spoke to her doctor, the doctor gave her a referral to see the weight loss surgeon. Everyone that Barbara spoke to about the idea of WLS told her one of the same two things, you're not fat enough and it's the easy way out, however, Barbara was in daily pain, and had already decided to do it.

## **Late-onset: From high school graduation to weightloss surgery**

### **Brian**

Brian still felt less than his image of the ideal strong man. So, Brian decided to make a change, began lifting weights on a regular basis, and by the end of his second year he had packed on 100 pounds of muscle, he had also grown several inches in height. Brian was finally the man he wanted to be in size and strength. He engaged in all the activities college could offer, namely excessive drinking, experimentation with drugs, and consuming vast quantities of pizza. While he was spending so much energy working out, and exercising, he stayed fit and trim. Brian truly enjoyed being the “big guy,” an identity that he had chased since early childhood.

Within a couple years of college, Brian had long quit working out and exercising, however, he didn’t quit the drinking and over eating, and soon he began put on weight. Within a couple more years he had developed diabetes, hypertension and his asthma had gotten worse, and the weight just kept piling on. For first time in his life, Brian noticed that people were looking at and treating him differently, he soon realized it was because he was so fat. He doesn’t remember the people he had known for years treating him any different, it was the people that he encountered on a daily basis in public or at work.

Brian described how it became very clear that people seemed to have reduced expectations of him, professionally, and in his social relationships. This infuriated him. Brian is a nurse, and he had spent time as a hospice in particular, he had personally witnessed a great deal of death. Being a father, husband, his deteriorating health, had forced him to consider his own mortality. His personal physician recommended to Brian that WLS would be the best solution for his various metabolic issues. Brian agreed and after a decade of being obese he decided to

undergo weight-loss surgery at the age of thirty-five. At the time of his surgery Brian weighed 350 pounds.

## **Judy**

As soon as Judy was out of school she moved in with a man and soon was married, and pregnant, eight months she delivered a still-birth baby. Six weeks later, her husband was nearly killed in a terrible motorcycle accident. Judy was twenty-one years old. Due to a toxic combination of boredom, severe depression and sadness Judy spent most of her time eating while her husband was slowly recovering from his injuries. Within a couple years Judy went from 140 to 315 pounds.

For the first time in her life Judy was undeniably fat, and she was ashamed of how she looked. She was embarrassed that she had become so fat, she couldn't believe it, but what bothered her the most, was the fear that her daughter would be teased by other children because she had such a fat mom. Motivated by fear and shame more than anything else, Judy chose to undergo WLS. She also desperately wanted to be happy like her sister and being thin again was an obvious way to achieve that goal.

## **Amy**

After college Amy got a good job, she was dating and having fun, she was living the best life she could. At the age of twenty-five, Amy was involved in a life-altering car accident. She nearly was killed and caused her to be bedridden for almost a year as she recovered. Over the next two years she fought depression and was constantly filled with melancholy, so she sat around and ate. At the end of the two years, the athletic social butterfly was no more, she had gained over 100 pounds. All that additional weight on her 5'3" petite frame nearly crippled her

with fat. When she eventually returned to work, after hardly leaving her house for almost a year, the reactions she received from co-workers ranged drastically. There were many comments about her weight, but they were couched in such a way as to be overtly ambiguous, “Wow Amy, you must not have been able to get out and do much, you sure can tell!”. As she navigated the public world after she returned to work, she noticed the comments and facial expressions of people all the time.

As a result, she became increasingly self-conscious about her weight. Amy was a medical assistant, she took patients vitals etc. at the doctor’s office. Patients increasingly asked when she was due. For the first time in her life, Amy experienced shame and embarrassment and she undeniably knew it was because of her weight. Amy refused to admit that she was one of them, continually telling herself, “I’m not one of them, I’m not a fat bitch”. She had always thought of fat people as lazy slobs, with less than average hygiene habits at best. The last thing she could stomach was accepting the fact, that she was one.

This admission upsets her, because she now feels extreme guilt and regret. Amy now believes she was a bad person, and it saddens her to think about it. Amy describes how her attitude towards fat people began to shift. As she gained more and more weight, she also gained a perspective that she never had before. It allowed her to relate to other fatties, an empathy for the challenges they contend with every day. As she continued to gain weight, it was other overweight people that treated her with respect and humanity. Amy didn’t feel she deserved to be treated so nice, they didn’t know she used to tease and humiliate fat people for years. As time went by Amy pretended not to hear the hurtful comments from adults and children, but she did. With each increase in her weight, she had no choice but to shop in places that she had never been in before. Amy described to me how “humiliating” it was to buy clothes in those stores. A good

friend of hers underwent WLS and suggested Amy look into it, because she felt it would help her. Amy was slow to seriously consider the idea, according to Amy, she considered WLS, the easy way out. When she discussed the idea with her family, they also derided the idea of surgery, considering it a dodge. Her husband didn't support the idea either because he also considered it the easy and expensive way out. He was convinced that all she needed to do was, *"get off her fat ass and go to the gym and stop eating like a pig."*

### **Joan**

Joan was married right after graduating high school. Her husband took over his family's farm and they became farmers, like their parents before them. Within three years she had two babies and had gained about eighty pounds during the pregnancies, and now weighed nearly 250 pounds. Joan was convinced that given enough time she would lose the 'baby fat' and everything would be fine. Fortunately, for Joan, she was a tall woman, at 5'10" she carried the weight well, but it was slowly eroding her self-esteem. Joan describes the first time she remembers contending with fat-bias; she was shopping for a dress for her niece, a petite woman.

The sales lady walked up to Joan and literally took the dress out of her hand and told her that wasn't going to fit her and walked towards the section of the store reserved for the "plus sizes" clothing. Joan didn't know what to say, she was totally stunned, not just by the rudeness of the saleswomen, but especially, because it was the first time, she had been treated like a fat woman in public that she could recall. She was embarrassed and felt ashamed that she couldn't lose the weight. Over the course of the next several years, Joan gained more weight eventually reaching 340 pounds, this was possibly driven by the stress and depression that resulted from her husband's early death from a heart-attack. The instances of fat-bias, that occurred over those years became too many to remember according to Joan. She was raising two daughters and

dealing with clinical depression, trying desperately to hold on to the family farm. In Joan's mind, she didn't have time to worry about other people thought about the size of her ass. Being an older woman, Joan reacted like many women do that elect to undergo the surgery later in life, they aren't worried about how they will look in a bathing suit they just want to feel better physically, emotionally and psychologically. However, she never truly thought of herself as a fat person, she tried desperately to push her weight to the back of her mind, but it got increasingly harder as she got older and the comorbidities became more serious. Overtime, Joan came to except the fact that she was a fat, her size made it impossible to deny.

Her physical and emotional health were visibly suffering as she dealt with her husband's death, she found herself fighting depression, making it even more difficult, she was a wreck. Joan had always been stoic, nobody ever knew what troubles she was dealing with because she was such a strong woman. However, her daughters knew their mother more than anyone else and confronted her about her health and depression. Joan realized they were right, and she needed to do something drastic, she wasn't happy with her physical condition and she had grown weary of her mental and emotional health as well. She desperately needed a change.

### **Early-onset: Life after surgery**

My surgery was performed on May 30, 2013. At the time of the procedure, I weighed 365 pounds. Fortunately for me, the surgery was totally free of any complications, or side effects, it went perfectly. I was back to work in six days. Within six months, I had lost sixty pounds, I felt fantastic. All of my metabolic disorders were in check, technically I wasn't diabetic anymore. I felt the best I had in decades. I didn't really engage in social outings for several months, because of the constant vomiting and sudden needs to use the bathroom.

In the fall of 2013, I decided to go out and see a friend of mine play with his band at a local bar. At the time I had lost about 85 pounds and was feeling like a god. I walked in a made my way towards the back of the bar where the stage was, so I could find a place to sit. As I was making my way through the crowd of people, I remember suddenly and strangely feeling self-conscious, really self-conscious. By the time I got to the back of the bar, I was convinced that people were staring at me for some unknown reason. Was there food on my face, was my fly open, I had no idea. All I knew was that people, both men and women, were looking at me as we passed longer then I was accustomed to, and it had unnerved me. I looked in a mirror near my table and there wasn't anything out of place.

I decided to sit and just watch people. I realized, possibly for the first time in my life that they hadn't looked at me any longer than they looked at each other. What I was finding strange was the additional seconds that people spent looking at me, when I was fat, I didn't get even that much recognition from a stranger. So stark was the difference from my expectation that it was noticeable and shocking to me. I never thought of myself as invisible like some fat people describe feeling. I remember sitting and thinking to myself, "so this is what it is to be normal."

Eventually, lost 120 pounds, I never felt as good. Fitting into clothing sizes I hadn't been able to wear since middle school. I was on top of the world. It's called the "Honeymoon" period for a good reason, because no matter what you do, what you eat, or what you drink, you still lose weight, and people are still noticing. I enjoyed it when people I known for years didn't recognize me because of the weight loss. It wasn't long before I noticed other things too. Some of them not so good. When walking past a reflective surface I would catch a glimpse of myself out of the corner of my eye, and it was the fat me. I remember commenting that I felt as if I was being stalked by my "old fat self." In fact, it started happening more frequently, eventually I was

looking in the mirror constantly. Not because I was shamelessly vain, because what I was seeing in the mirror wasn't what I looked like. My reflection staring back at me was my old fat self.

It was like a ghost of my formerly fat body. I eventually, learned about this psychological phenomenon, it's called body image dysmorphic syndrome, or body dysmorphia, BIDS for short. Its described as a condition that many with severe eating disorders contend, and it's detailed in the DSM-V. Women that have had mastectomies and people that have suffered amputations at times can experience these phenomena (Wenxin He 2018). After several months these strange episodes slowed and eventually completely stopped, but then something else began to afflict me.

Depression began to creep into my mind. Slowly at first, then more frequently. I would hear a voice in the back of my mind, whispering to me. Telling me, that I was a total fraud, that I wasn't fooling anyone. I was a still a fat ass, and I would always be fat ass, no matter what I did. I came to realize that I was still that little boy, that came to know who he was so long ago. It was truly disturbing at first.

Today, nearly five years later. Most days I'm fine, I feel great, but on occasion my brain works against me, and tries to convince me yet again that I am a fat man in a skinny suit. The fact is, that's the truth, I am, a fat man in a skinny suit. Most days I feel like the only one in the room that knows I'm fat, at least, fat in the head. During the interviews I conducted for this project, every one of the early-onset volunteers mentioned this very same experience, more than any other post-surgery. Some still fight it, some embraced these feelings as reminders of having been fat.



## **Wilma**

After her surgery, Wilma discovered a self-confidence in herself that had been missing all her life. Now she was in control of her life in way that she had never truly felt before. Wilma felt like a Phoenix, she excitedly wondered who this new person was going to be. Interestingly, Linda expressed how determined she was, to be the one to choose who she was going to be. Looking back, Wilma believes it was this conscious goal that caused her to work as hard as she did in her professional career. Following her surgery, the next 9-10 months resulted in a loss of a 110 pounds.

She was 200 pounds when the weightloss eventually stopped. At the time of her interview, 200 pounds is the least she would ever weigh. Linda related that she was unhappy that she never was able to be the 150-pound girl she had always dreamed of being since she young, but at the same time she eventually realized she would never be that thin, “it just wasn’t in the cards for me.” Her friends and family gave nothing but positive feedback and didn’t treat her differently in any real way than before. When she was amongst the public, things were different, she could she the change very early in her weight loss journey, from co-workers and others. Suddenly, people were smiling at her more, and men held open doors.

For the first time in Wilma’s life she didn’t feel quite so invisible. The fact wasn’t lost on her that this change in the way she was being treated in public was only because she lost weight. This caused her to decide that she wasn’t going tell anyone other than her closest friends and family. Wilma believes that because her family life when she was young was so supportive and positive, it provided a good foundation, allowing her to maintain her self-confidence and self-esteem. Giving her the tools necessary her to succeed in life, despite the mental demons that were always there in her head telling her she wasn’t worthy and would always be fat. Today,

Wilma feels that she has earned the right to feel better about herself and is more comfortable in her own skin than at any other time in her life. As of this interview, Wilma is actively considering a second revisional surgery to shrink her capacity to eat again. The journey continues.

## **Gina**

When Gina was in her mid-thirties, she had the Roux-en-Y gastric bypass. At the time of the surgery she was over 300 pounds. Her surgery went very well, and she recovered quickly, and within eighteen months she had lost 170 pounds. However, Gina did suffer from anemia requiring her to take additional supplements, and she currently still takes iron pills, and B-12 vitamins. She would have to be 100% focused on herself if she hoped to be successful. However, nobody supported her plans, not her family or the man in her life.

Getting rid of her family wasn't an option, so she decided the guy had to go. Looking back, she is so glad that she didn't stay with that man, she needed someone that could provide her some emotional support. Gina explained that she firmly believes that everything about who she was in the past, is today, and ever will be in the future, has and will revolve around her weight. Her weight, like it or not, has defined her. Gina's family wasn't supportive when she broached the idea of WLS, and they continued to chide her decision afterwards.

Most of her recovery period was spent with her family accusing her of taking the easy and lazy way out. They made it clear that it didn't surprise them at all. Gina struggled emotionally after the surgery, knowing, despite what people thought, inside, she was still the same fat girl. Surprising herself, Gina declared she would never forget that fat girl. Her journey was long and difficult, physically, emotionally, psychologically and spiritually. Describing what

she calls her “fat odyssey,” began when she still a little girl, and after so many years, the long road she had been travelling eventually led her to seek weightloss surgery.

Gina considers WLS as an opening door, leading to a world of new and exciting first-time experiences, granting her the chance to be the person she would have been, if she had never been fat. Today when comparing her psychological, emotional and spiritual health, to before the weightloss, it’s no less remarkable than the metamorphosis of a butterfly.

## **John**

John was nervous the day of his surgery. Turns out he reason to be, it didn’t go as smoothly as he had hoped, he experienced a great deal of pain and several post-surgical complications, these issues effected the amount of weight he would lose. As he lost weight, his comorbidities started to fade from his medical charts. John’s Type 2 diabetes was finally under control, the sleep apnea was silenced, and his knees felt better than they had in thirty years. John was starting to actually believe that he was going to finally be happy with who he is, and excited about who he could be.

That was a choice he never had. John claims his post-surgical complications caused his weight loss to plateau rather early in his particular experience. After losing about 100 pounds, his weightloss abruptly ceased, he slowly started to regain weight. John admits that he never fully adopted the new eating habits, and behaviors so important to WLS success, but he adamantly claims he still doesn’t eat anything like he did before the surgery. However, John thoroughly believes that he long ago bought into the notion that he was meant to be a fat guy.

He claims that low expectations have shaped his life for many years, that he now psychologically acts accordingly. In fact, it’s possibly the reason he failed to lose the weight, he

wanted to after surgery, because he really didn't think he could, should or deserved to. John is now only fifty pounds from his maximum weight again. Today John is wracked by guilt, he considers himself a total failure. He believes that he still experiences the same amount of fat-bias he did prior to surgery. John still sees people looking at him and hears the comments about his size.

## **Barbara**

Barbara was young and strong at the time of her surgery. The procedure went perfectly with no complications, or post-surgical issues. Barbara lost her excess weight very smart very quickly and also healed fast too. She decided to keep the fact that she had WLS limited to her circle of closest friends and family. The first chance to go out and show off her new physique was the Fourth of July. As her first time out in public, she was excited to experience all the surprise and wonderful comments from the people she used to work with at her old job. They had never known Barbara as anything other than overweight Barbara.

Since she had the surgery, Barbara describes experiencing a significant increase in her self-confidence, and body-image, but she admits, at times she still feels like the little fat girl. At those moments, it's difficult, because she starts to doubt herself, and then she's suddenly overwhelmed by a deluge of ancient insecurities. Barbara still wrestles with depression at times. Frankly, she is surprised by this fact, because she expected her depression to disappear after the weight came off.

Today, Barbara is trying to reconstruct her life, sanitize it of negativity, be the person she wants to be. She is very happy in a long-term relationship with man that loves her for who she is.

The only negative that she reports in her post-obesity life is the amount of alcohol consumption she now engages in. Her drinking concerns her family, friends, and Barbara herself.

### **Late-onset: Life after surgery**

#### **Brian**

Brian wasn't worried at all and his surgery went very smooth, with no complication, however Brian was in a tremendous amount of pain, far more than he anticipated. Immediately, he started losing weight, and fast. He had decided that he wasn't going to tell many people about the surgery. He explained that he felt embarrassed, that he had to have surgery to lose the weight. Later that year, Brian started medical school to become a nurse practitioner. In medical school he would be working constantly, and very closely with the same group of fellow students.

For this reason, he was reluctant to share the fact that he had WLS, because of the shame and concern that they would think he took the easy way out. Brian admits he kind of thought that way too, he worried people would think less of him if they knew the truth. However, he let it slip in conversation one day, and he was pleasantly surprised by how positive his fellow students took the news. This was a huge relief. As the weight came off and he shrank from 350 to 220 pounds, he was surprised by a strange realization. Brian was startled to realize that he was "mourning" the loss of the "big guy". He had not realized how tightly he had held onto that identity.

Brian's desired self-image had always been so elusive as a kid. He had worked very hard to become the "big strong guy," and he had finally achieved that level of manliness. But now he was thin again and felt small and weak again, compared to when he was heavy. The juxtaposition of these differing identities caused Brian confusion. He was happy to be healthy again, yet

deeply disappointed that he felt again small and weak, a negative association with his body size from his youth. Brian talked a great deal about this being a very personal journey of self-awareness. He truly believes that becoming obese was a personal failing that he somehow had to experience, and now that he has, he is a better, more understanding person.

## **Judy**

Judy was desperately worried that her weight would keep her from being the active and involved mother she wanted to be, and she needed to be for her little girl. Judy knew she needed to lose weight. However, that wasn't Judy's only motivation and fear. She also worried about what other children might say to her daughter about her fat mom. Judy was also worried what other mothers might think of her and judge her to be. Being a fat mom and all. Around the same time, Judy's older sister had WLS.

Her sister lost a great deal of weight, Judy described feeling that her sister had blossomed and felt beautiful for the first time in her life. She was so happy to see her sister enjoy life. Judy described witnessing her sister go from fat, and depressed, to feeling great about herself and feeling like she was a new woman. After seeing how well her sister's surgery went, Judy decided it was time for her to make the same change. She eventually decided to undergo WLS and chose the Roux-en-Y.

Judy's surgery went perfect and she began to rapidly lose weight. She decided not to tell many people about her choice to have WLS. She didn't go out into public for about 8 months, and when she did, everyone noticed her weight loss. Judy started noticing a significant change in the way people treated her in public. Men began holding doors and looking at her longer. She enjoyed being noticed. Being late-onset, she very easily slipped back into her old body image.

Before long she was commenting to her friends and family, how she felt like she was seventeen again.

However, Judy described how she felt, she discovered, there was very little difference in how men looked at woman between sizes 21 and 28, and since she never lost a ton of weight, she never experienced a huge difference in the reaction of people. She also described how she was disappointed that she didn't experience the euphoric sensation of experiencing so many firsts, like her sister. Today, Judy considers herself less biased than most other late-onset people due to the fact that she grew up in a home full of bigger people, and especially because she was never truly a skinny girl.

To this day, she's still disappointed that she simply went from really fat, to not as fat as she was. Judy had always thought of her size as something far smaller than it was in reality. She never could shake the old self-image of herself, what she actually weighed versus what she thought. Judy finally found true love and got married again and is living the best life she can, satisfied with the woman she is today.

## **Amy**

Amy was at a routine doctor's appointment, when she was weighed, the scale read 280 pounds, this was her clear-eyed moment of self-awareness. Unable to handle it physically or mentally another day, she decided it was time for her to make a change. Amy had the Roux-en-Y procedure, and it went very well, she was back to work in three weeks. Amy explained to me that looking back, she still had a bias against fat people, after she was fat herself. She told me that this is when she first realized the power cultural fat-bias has over our lives.

It was a difficult emotional journey to forgive herself for how she had treated overweight people, for most of her life. Amy believes being fat, taught her how to be a better person. After Amy had lost about seventy-pounds, she noticed her husband was acting differently around her.

Suddenly, he was all hands, and more flirtatious. He was looking at her in ways he hadn't in a very long time. It surprised her how this made her feel. She was mad as hell, and she confronted him. At first, he denied that he was more attracted to her now since she had lost weight, but eventually he admitted it. She told him how hurtful she found it. Co-workers, Amy had worked with for twenty-years suddenly spoke to her. Sales clerks suddenly wanted to assist her. Changes in how she was being treated, such as these made her angry. She was totally overwhelmed by the way society rushed back at her, like a tide, of smiles, and pleasant greetings, all the while Amy knew it was only because she was thinner. Amy eventually weened herself off the anti-depressants, today she feels much better. Her life is filled with much more positive energy today, in all aspects of her life. Amy went from thin, to very fat and then to thin again.

## **Joan**

Joan was in her early sixties, it was time to make a change. She elected to undergo Roux-en-Y gastric by-pass. Her surgery went flawlessly, and she began to lose weight very quickly. Ultimately, Joan lost a total of 170 pounds, and has been much healthier, in all ways, since the surgery. Having been obese for several years, Joan had begun to think and act like a person that had been fat their whole life. Although Joan never fully accepted the fat identity, she realized that she needed to do something about the fat she had developed during and since her two pregnancies. Joan considered this was a rather weak and old rationalization. After the weight came off, she felt as if she had found her old self again, and people would tell her how good and young she looked again. This made her feel great, she has never regretted getting the surgery.



## **Bariatric Professionals**

### **Darci, *Bariatric Dietician***

Darci has worked for nine years at Bronson Methodist hospital. She organizes support groups for those considering WLS and those who have already had and seek further support with nutrition. Darci attempts to establish good eating practices with pre and post-operative patients in order to better ensure success. She leads these meeting at times with the hospital bariatric psychologist, to better answer the questions that patients might have concerning the psychological issues they are contending.

Darci says that one of the issues she deals with the most is educating WLS patients in what to expect after the surgery, both physically and mentally. Most people expect to get certain things out of the surgery and subsequent weight loss - that everything will be better, including their marriages, job, relationships, and health. For years Darci has witnessed a different recovery pattern that exists between early onset and late patients. Early onset patients have no idea what it feels like to be thin, whereas late onset remember it mentally, and after the weight is gone, they remember it physically. She has also noticed that not all experience the post-weight loss issues the same. Some are bitter and angry, some become very worried when eventually the, “wow you look so good” stops, some don’t want to be noticed, and some love the attention.

Plus, a whole self-esteem issue exists that can result in all sorts of changes in people’s lives. Darci expresses frustration that in the healthcare industry, specifically in bariatric healthcare there is a serious disconnect when it comes to the relationship between the physical and psychological health of fat people. Today bias exists in the ideology that obesity is a personal failing, the worst possible fate one can suffer and as soon as one loses the weight, all

will be better, and there isn't any connection to the mental health of a patient. This is clearly not the case.

**Melissa, *Bariatric Nurse***

Having worked as a bariatric nurse for 15 years Melissa has wide-ranging insights, and an invaluable perspective. Back then WLS wasn't covered by insurance, and she was working as a nurse in the emergency room. Regularly obese individuals came in because of the various comorbidities that accompany obesity. These patients were commonly lower income individuals. The ER was their only source of healthcare. She has personally witnessed the increase in childhood obesity, the number of children coming into the hospital that are overweight has grown rapidly over the last fifteen years.

Melissa stated that her hospital has been progressive in its approach to helping obese patients with a two-prong approach, addressing both body and mind. Treating the physical issues related to obesity, but also the psychological consequences of obesity as well. The increase of obesity in the United States is largely due to the shift from an agrarian society to industrial one, resulting in a more sedentary way of life. This less active lifestyle begins now at a younger age than ever before. Currently, the medical industry is witnessing a dramatic increase in the number of people that identify as early-onset. However, late-onset obesity is also experiencing a dynamic shift from how it traditionally begins to affect one's health. In the past, it wasn't uncommon for people to gain weight as they age.

According to Melissa what the industry is now witnessing is how the late-onset obesity is now occurring at a younger and younger age. Instead of gaining weight in their fifties, they are gaining weight in their twenties and thirties. This is causing a significant change in how obesity

affects the population. With people becoming obese earlier in life than ever before, there is now a proportional increase in the number of people being affected by the usual comorbidities that go along with being overweight, hypertension, type 2 diabetes, cancer etc.

As the population is getting older, their quality of life is going down at an earlier age than ever before due to these associated metabolic disorders. Melissa explains that bariatric surgery is giving hope back to these people, alleviating so many comorbidities associated with obesity, granting them a second chance for a healthier life. It is precisely for this reason that weight loss surgeries are increasingly prescribed by doctors today more than ever before. Melissa makes a very interesting point concerning the increase in the number of weight loss surgeries performed every year, and that's dramatic rise in the number of surgeries performed on people in their twenties. In fact, most of her patients are in her late twenties.

Nowadays, a majority of physician referrals to bariatrics come out of obstetrics, because of the hormonal and fertility issues caused by a woman's weight. Obesity can cause a dramatic decrease in female fertility. Fatter pregnant mothers are almost always considered high-risk during their pregnancies and will likely develop gestational diabetes as well. Today people are becoming obese sooner in life than at any time in American history, this is also causing them to be exposed to fat bias longer sooner and for longer. Melissa makes another very important point regarding people with late-onset obesity. It is far more likely that those suffering from late-onset obesity will be slower to notice the gradual creep of comorbidities.

Simply put they are not used to being fat, and in their minds, they are still average weight. This results in these people not seeking treatment soon enough, due to ignorance or denial, and when they do, their health issues are often worse than someone that identifies as early-onset. Melissa explains that this issue occurs more often with the male population than the

female. This is because women have a variety of issues that can potentially raise red flags. In general women will see a doctor more often than men and are more willing to seek treatment as soon as they realize there is a problem. According to her experience, men average ten years later than women in seeking treatment for health issues. Melissa points out a couple of additional issues challenging bariatrics today. First, physicians just don't have the time to fully listen to their patients. It takes a while for people to feel comfortable enough to openly discuss their obesity, and possible related issues, whether physical, emotional or psychological.

Secondly, physicians would rather not treat obese patients, the bias amongst a good number of physicians is ridiculous according to Melissa. Obese patients are getting the short end of stick when it comes to health care, specifically because of fat-bias. Physicians are less likely to discuss a patient's weight, for fear of offending them, they might not even want to discuss it with them in the first place. These patients need more time with their physicians than they are currently getting across the board. The fact that obesity has recently been medicalized, is a great first step in addressing the issue of bias. It is going to take time to permeate the healthcare industry to a point where doctors and nurses understand that obesity isn't a matter of personal choice.

Physicians desperately need to be educated in how to better interact with obese patients, how to discuss their weight issues without immediately pointing out their patient's weight. Melissa points out another interesting fact regarding our collective cultural responsibility. Fat adds to the cost of nearly everything in society, whether it's the size of chairs in waiting rooms, or in restaurants, obesity is causing everything to cost more. But at the same time, our food portions are getting bigger, plates are bigger, and foods are continually more fattening and less

nutritious. Yet everyone screams that the cost of healthcare is going up! We want it both ways, and it's not working.

Dining out in America remains a sign of affluence, and yet eating at a restaurant is not a healthy practice. Good bariatric healthcare looks at the whole patient. Melissa explained how they look at a patient's overall nutrition, mental and emotional health, and any other issues that might be lurking. In her opinion, proper patient care is only achieved through a concerted effort by all bariatric professionals on staff, including nurses, physicians, dieticians, and psychologists. The care a bariatric patient receives should not end with weight loss surgery, it needs to continue afterwards as well. After about a year, the physical challenges, like constant nausea and rapid weight loss have slowed or completely stopped, this is typically when the emotional and psychological issues become more apparent.

After all the physical health is in check, the head remains in bad shape. Melissa suggests that all professionals in the bariatric arena, need to be educated substantially more concerning the psychological issues confronting post-surgical bariatric patients. As a bariatric nurse with fifteen years' experience, Melissa has seen it all. Without fail, she can very quickly guess whether a patient is early or late-onset. There are clear indicators, if you know what to look for. For example, what kind of clothing are they wearing? Does their choice of clothing hide their body, or are they wearing an outfit two sizes too small and at the same time, they are comfortable with the way that looks?

Melissa described how those that identify as early-onset dress the part, because they owned it a long-time ago, and they tend to be softer spoken. Whereas, late-onset individuals tend to be more vocal, not as reserved or shy. They are usually the patient that complains about the chairs being too small, and they can't believe that the chairs aren't big enough. An early-onset

person is like, welcome to the club. Late-onset people tend not to return to support groups after one or two visits, because in their minds, they don't belong there with all those fatties.

This because they never excepted the fact that they are obese. Melissa told me that in her experience, it's the late-onset patients that tend to regain the weight most often. This is because they don't always grasp the fact, they have a problem. They tend to view weight loss surgery as if they got face-lift, a quick fix, nothing more. She relayed her experiences with late-onset patients, they tend to carelessly demonstrate more fat-bias than average weight people. This is because of an inclination to be the loudest voice of condemnation, because it serves to distract from oneself.

This phenomenon is especially the case after late-onset patients have the surgery, and those that still attend support groups generally demonstrate a predictable set of behaviors. They tend to deny having any of the negative experiences after surgery, especially any emotional or psychological issues. Whereas, early-onset patients are desperately seeking advice, because they are experiencing a myriad of social, emotional and psychological phenomena.

## CHAPTER V

### CONCLUSIONS

The differences between the four early and four late-onset testimonials are remarkable. The group of early-onset volunteers reported without hesitation that their earliest memories were dominated by feelings of inadequacy, and feeling different from their average weight siblings, and classmates. Uncomfortable memories of teasing and bullying on an almost daily basis, staining what would have otherwise been normal childhood. They reported avoiding sports, school dances and other social circumstances that could have very easily turned into some form of fat related humiliation.

While other children were engaging in a variety of coming of age activities, Wilma, Gina, John, and Barbara made a choice. They chose to avoid them, thereby stunting a degree social and emotional maturation. By contrast, Brian, Amy, and Joan all reported basically normal childhoods, with loving homes and supportive families. Even Judy, despite having been sexually abused for eight years as child, understandably causing her severe emotional and psychological trauma, still reported, a rather normal, boring home life and school experience. Amy reported her overt fat-bias, and how she regularly teased fat kids about their weight. Joan was obese longer than she was an average weight person, over forty years, experiencing more exposure to fat bias than the other three. Yet how she reacted to her rapid weightloss was very similar to how other late-onset people do.

These testimonials reveal patterns in the experiences of the volunteers. Individuals that self-identified as early onset, almost without fail experienced a degree of fat-bias that resulted in some form of long-term trauma. Whatever form that bias took, it left an indelible mark on their memory. Each of the volunteers claimed they could remember their earliest experience with bias being around the age of five. Having a recollection from that young an age is completely in line with research concerning the effects of fat-bias on small children (Puhl 2009, Schupp and Renner 2011). When Gina was a little girl, her first exposure to fat-bias wasn't from peers but from her own family, her father in particular.

This is normally the first experience, followed by events that take place in school (AACAP 2011). She was put on a controlled diet at about the age of seven, by her parents and was specifically chided about her weight with the idea that it would cause her to alter her behavior. A seven-year-old child. Studies show that putting children on diets or other forms of controlled eating causes more damage than anything else (Brody 2017). In fact, forcing children to diet or controlling their food, can lead to future psychological problems such as a wide variety of eating disorders such as anorexia nervosa or bulimia (Darcy, Doyle et al 2012).

When John was a child, he experienced the same type of treatment because of his weight. His earliest memory of teasing was at home. His parents and siblings bullied him relentlessly, destroying his young and developing self-image before it had a chance to fully form (Burke 1991, Cramer and Steinwert 1998). John tells how he has carried these very early experiences throughout his whole adult life. John believes that being fat made him who he is today. He explained that he's convinced that the harassment and bullying he experienced as a young boy, caused long-term damage to his mental and emotional health. As a young teen John even had suicidal thoughts (Puhl and Brownell 2001).



At the age of six, Barbara remembers gaining weight, but only because it was pointed out to her. Otherwise, a child that young would never recognize it as negative (Cramer and Steinwert 1998). She was made fun of in school, called names by the other children. They said that Barbara was dirty, that she smelled and was dumb. Even at this young age these children already demonstrated the power of fat-bias to influence their opinions of weight. Studies have shown that society has assigned several cliché expectations of obese individuals such as bad hygiene, lower IQ, lack of friends etc. (Brody 2017, Ferrell 2011).

According to Barbara the worst experience with fat-bias, with the longest and most damaging effects was the treatment she experienced at the hands of her own grandmother. Every day after school she went to her grandmother's house and was browbeat because of her size constantly. Wilma was the only person that didn't have any conscious memory of experiencing bias as a child. However, she claims to have been aware of the fact that she was different from her brother and sisters as early as four years old. Again, I would submit that she might remember it, but the fact that she remembers being different, seems to indicate that she was made to realize it for some reason.

Standing in stark contrast to the experiences of the early-onset, are those of the late-onset. All four described their childhoods as basically normal. They engaged in sports and a variety of other activities as normal children do with the support of their parents and other family members. Brian did tell how he was picked on for being too skinny and small as a child. He believes that this was similar to what fat kids had to contend with but just in reverse. This teasing took its toll on his self-esteem and ruined his confidence. To help him contend with this his parents enrolled him into martial arts, eventually he earned a black belt and self-respect. Little Judy grew up on a

farm and worked hard every day as did everyone in her family. They worked hard and ate hearty meals.

Obesity wasn't something she even remembers as a child. She was the youngest of two girls. Judy was always a skinny little girl, she loved her parents and idolized her older sister. She occupied herself playing with her dolls and helping her mother around the house. Sadly, for Judy her life took a dark turn around two years old. About that time, a friend of the family started to sexually abuse young Judy. This would go on for another nine years to the detriment of Judy's mental and emotional health. Causing her years of behavior problems, trust issues, and anxiety and depression. However, despite the near constant sexual abuse, Judy described her childhood as relatively normal, and her experiences in school growing up as basically ordinary.

Amy experiences as child revolved around playing sports. She was constantly involved in some outdoor activities. Her family enjoyed the outdoors, camping, biking and all manner of sports. It wasn't difficult to stay fit in her home. In fact, there were no fat people in her family. Amy was a naturally pretty girl and received an above average amount of attention because of it. She was a popular girl in school growing up. In school she was always in some sport and doing well at it. Amy was a good athlete. As one of the popular kids, she engaged in teasing of the less popular kids. One of her favorite targets were the fat kids.

According to her own admission Amy was ruthless. She couldn't stand how they almost without exception were bad sports or didn't participate in them at all. It used to make her so mad when a fat kid was put on her team. Amy shamelessly considered fat kids, lazy slobs. She also thought of them as dirtier than normal people. Amy didn't feel guilty about bullying fat kids, because the gym coach and teachers did the same thing. They deserved it in her mind, for being fat.

Joan was also a skinny girl when she was young. Like Judy, she grew up on a farm, and was expected to work hard every day. She lived in a community of farmers, all of her friends had similar childhoods growing up. There were no fat kids. As a result, there really wasn't a reason to have negative feeling towards or about fat people. The only fat people she knew she loved, her grandparents. Joan's young life was one of happiness. She loved living on a farm and being around the animals. Her parents supported her in everything she chose to do, and that was to ride horses. When she was nine her parents got her a young horse for her birthday. The contrast between these two groups is clear.

Fat children were exposed to discrimination, bias and experiences that today would be considered mental abuse on an almost daily basis. The only ameliorating factor being that of a loving caring and supportive family. As with Wilma, she believes that factor alone prepared her to better weather the challenges of being an obese person in this culture. She wasn't beaten down every day because of her weight, in fact she never was. Her issues with inadequacy and shame were developed from within. Those ideals of beauty and size surrounded her and assaulted her self-image and esteem every minute of every day. The late-onset individuals were free to develop their own self-identities in healthiest way possible, on their own, with support from loving parents. By contrast fat children are not afforded that right, their identities are assigned to them by others (Burke 1991)

Today I embrace the person I am and the body I have. My only regret is that I didn't have the surgery sooner, but it's really not something I think about much. Another issue that all of the early-onset individuals mentioned, was at one point or another, wondering, who they really were. Were they the person they are today, as a result of having been fat, or was there someone else they were originally supposed to be and is that identity still waiting to be fulfilled? Most

believed, they are who they are today, because they grew up fat. I wondered the same thing many, many times, and since have come up with an answer that I'm comfortable with, I am who I am, because I was fat. Where I'm at in life and how I feel about things owes a great deal to the fact that I was fat kid, not a fat man, but a fat kid. Those experiences that I lived through and were forced to confront made me the man I am today. I consider myself very lucky, that I had a talent I was able to exploit when I was young and that I was smart enough to realize it. The early-onset individuals that I interviewed didn't have that option, they had to fully contend with being assigned an identity and having to fight to exert their own personal agency in the formation of one, but only after reaching adulthood.

The power and influence fat-bias has over American society is seemingly unstoppable. It manipulates and molds our conception of body-shape in ways that compel us to take drastic measures to avoid it. Obesity hijacks one's native agency in the development of their identity and self-image, supplanting it with the "fat identity." The fat identity is a very powerful social-construction, pushing aside everything else that you represent, and this begs the question, is fat something one *experiences*, or is it something one *is*? The goal of the qualitative analysis strategy was to better understand the social constructions of fat. Unpack some of the social meaning and symbolism society attaches to *fat*, what does it mean *to be fat*?

- Did WLS patients experience reality before and after surgery in different ways that can be explained *only* by age of onset?
- How did they transition from one reality to another and did losing weight change their lives?
- What did obesity symbolize to them before weight loss surgery and has its meaning changed since, and if so, how?
- How did they contend with identity reclamation, and creation?

## **What Did We Learn?**

From the conversations I had with the volunteers and from the considerable amount of research data available, the answer is clearly yes. Those that identified as early-onset, had experiences and missed out on a number of others as a direct result of being fat as children. The data reflects the fact that without exception they were aware of their weight from a very early age and knew it wasn't desirable, compared to other average weight children. They had diminished self-esteems and low-self-confidence, often a poor self-image as well.

Even those that grew up in loving supportive homes still felt different, with parents that didn't make them feel bad about their weight, they still reported feeling ashamed of their bodies. 75% of the early-onset cohort reported years long issues with depression, and even suggested that it was as result their history with obesity. John firmly believes that the relentless teasing and bullying that he was exposed to did permanent damage to his mental health. The late-onset crowd, suffered as well from their bout with obesity, but in different ways. In the case of Amy, she experienced a perspective that she had never known, that of a fat person. She learned what it was to be teased and made to feel inferior and dirty.

Judy got to understand some of the challenges her sister confronted but was saddened by the fact that she didn't get to experience the same kind or degree of the post-surgery euphoria as her sister, because her mind and body remembered how it felt to be thin. None of her experiences were new. Late-onset people have to endure a physical and mental transition twice, from thin to fat and to thin again, whereas early-onset transition only once. I believe they are able to do this because of the strength of their mental resolve, having developed their sense of self organically, without having it assigned to them. In that, they had a wonderful advantage over the early-onset individuals.

The early-onset people made the transition from a fat reality to one of *not* fat, despite what they may have anticipated, losing the weight did little for their mental health or any other issues in their lives. However, aside from John, they all felt a huge surge of new-found confidence and surprisingly an appreciation for who they are and have always been. Quite often, people have all sorts of inflated expectations about what life will be like after they lose weight, and the truth is all the same problems remain, except it's easier to find clothes. That is not to say that losing weight didn't affect their lives in significant ways, sometimes losing the weight allowed them to realize how to love themselves for the first time in their lives. Realizing they are who they are.

For the late-onset people, prior to surgery and losing the weight, obesity was largely a very negative social stigma, an issue of the other. Those that grew up in homes that actively sought to be unbiased against fat people, and were not fat themselves, didn't learn their biased attitudes until starting school. Even though their attitudes were delayed, they eventually learned the culturally mandated opinion of fat people. The stigma of obesity carried all the typical baggage. They believed as they had been instructed by society. Obesity symbolized slothfulness, weakness of will, low-ambition, dull-wittedness, and an array of other negative stereotypes, but the most terrifying aspect that fat symbolized was the threat of social exclusion, not being popular or having many friends. Interestingly, after the late-onset folks lost their excess fat, their interpretations of what obesity represented to them personally were of mixed results.

In the case of Amy, she dedicated herself to making it up to overweight people whenever possible. The guilt she felt for having been so abusive to the fat kids in school was visceral and made her very emotional just telling me about it. But in the case of Joan, she was much older than the others when she had her surgery, she had been fat longer than any other late-onset

participant. Joan fully believed the experience of being obese had changed her and given her a perspective that she would have for the rest of her life. She was surprised by how fast she returned to her original biased mindset from forty-years before.

The early-onset individuals understood full well what obesity symbolized. Obesity was a bane in their life, a form of universal disdain and source of embarrassment and shame. Social exclusion eventually became a self-imposed condition to a couple of them, why bother putting one's self into potentially humiliating situations. In turn they became less socially adjusted causing them to seem awkward in social settings, because they were. John was constantly abused and bullied by his brothers and schoolmates, after the surgery he lost some weight, but not much by comparison to the others or even the average generally.

What obesity symbolized to John before the surgery didn't change afterwards, his experiences with fat-bias continue in his life today. John wishes he had lost more weight, and "done it right" and still believes he can, but the reality is he won't. Research is clear that the mental health of individuals prior to surgery is indicative of future post-surgical success. John is a classic example of somebody that needed substantial therapy before and after surgery (Grimaldi and Van Etten 2010). The repossession of a prior identity is exclusively the purview of late-onset individuals. As we discussed earlier, these individuals were permitted to develop their identity naturally, through exertion of personal agency.

Growing up in a loving supportive home that provides a child with the means to pursue his or her desires, builds self-confidence and a degree of self-respect and independent thinking. When these individuals gained weight later in life, it never impugned on their self-estimation or identity, both were built long ago with a strong enough foundation to weather the storm of fat, and all that society attached to it. Amy, Judy and Joan, all knew who they were, in fact, what

upset them the most about being fat, was how their daily lives were filled with people that only knew them as obese women. They felt compelled to tell them that they weren't always so fat, but would stop themselves short, because in their minds, it was more shameful to have once been thin and then became fat, than to have always been fat. Brian had always been frustrated by his diminutive sized body, when he later gained weight and became obese, he gained solace that at least he was still a "big guy."

The surgery was something he did strictly for health purposes and when he lost all of his excess weight, he told me, that he actually "mourned" the loss of the big guy identity. When Judy reclaimed her identity as a "not-fat" woman, she realized there wasn't anything new about experience of being thinner. She was the exact same Judy, just a smaller, less fat version, she was disappointed, eventually Judy found her way a better emotional place and is happier and more content now than at any other time in her life.

Generally speaking, early-onset individuals don't have a previous identity to reclaim, this is one of the reasons so many continue to believe they are still fat, just in their head. As we discussed in chapter 2, identity is best developed by the individual, but in the case of a young child that is estimated by his peers to be fat, they are not allowed that privilege. They are given the fat identity, and all the stigma that goes with. They carry it like an albatross their whole lives. Their fat identity becomes the determining factor in who they are, and who they will forever be as Goffman called it, "a spoiled identity."

However, WLS affords one a chance to escape that label and stigma. Allowing them to create a new identity, or simply maintain the one they have always had. Some make a point not to forget that they were once fat too, other change everything about themselves, cut and dye their hair, change the way they dress etc., and everything in between.



Fat bias is still considered the last socially acceptable form of discrimination in America. It's time for us to take a closer look at why this is the case and who it benefits. Michigan is the only state with a law on the books that specifically protects fat people from weight-based discrimination. It is my hope that eventually the bariatric industry will soon recognize that not WLS patients are the same, before or after surgery, because that's definitely not the case. Losing the weight, doesn't changed what might have caused the weight gain in the first place. Perhaps, future studies will convince the industry that early-onset individuals might require additional psychological care following surgery.

In regard to the potential pitfalls of including so large a portion of my own experiences into this project, this was an issue that I kept in mind. However, I believe that my own experienced offered more to enrich the narrative than my bias risked poisoning it. I understand that its risky any time we include so much of own story, but there are times that our own stories serve to lend credence and tangibility to the work. It is my hope that this is how my personal contribution will be regarded.

## DISCUSSION

The subject of obesity is obviously a very personal and emotional issue. It is nearly impossible to parse it apart, and separate so many different factors. Obesity is something that people carry around for many, the whole time, degrading their health. What is interesting is that in numerous surveys, and conversations with this project's volunteers and other post-weight loss surgery recipients, health is rarely the reason why they chose to get the surgery. It definitely was a consideration, but it just wasn't the main reason. Most people say they felt the surgery and the subsequent weight loss would give them a chance to start over or give them a chance to feel what its like to be normal. During the course of my research for this project, I continually came across issues related to my thesis that would make for fantastic future thesis subjects. One thing that I found very interesting was the different understanding and meaning the African-American culture assigns to fat and obesity, and how it differs from white culture. As we discussed, its typically more trying for a woman to be fat in American that it is for a man. In the African-American, it is almost the opposite. There are many factors that play into this. Among them, a rejection of the white definition of beauty, and expected norms of the long dominant commercial control by white culture. But there are many more reasons too.

Another would be to examine the specific ways in which the ideas and meanings of obesity are transferred from one generation to the next, from mother to daughter, father to son, mother to son, and father to daughter, and how that transmission changes, if it does at all.

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# WESTERN MICHIGAN UNIVERSITY

Human Subjects Institutional Review Board



Date: May 6, 2015

To: Jon Holtzman, Principal Investigator  
Scott MacPherson, Student Investigator thesis

From: Amy Naugle, Ph.D., Chair

Re: HSIRB Project Number 15-03-34

This letter will serve as confirmation that your research project titled "Fat Bias & Culture Shock: Psychosocial Adjustments of Post-Obesity Life" 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: This research may **only** be conducted exactly in the form it was approved. You must seek specific board approval for any changes in this project (e.g., ***you must request a post approval change to enroll subjects beyond the number stated in your application under "Number of subjects you want to complete the study."*** Failure to obtain approval for changes will result in a protocol deviation. 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.

**Reapproval of the project is required if it extends beyond the termination date stated below.**

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

**Approval Termination: May 5, 2016**

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