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Happily-Ever-After: Personal Narratives in WLS Advertising

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Advertising for weight loss surgery is typically not exclusively targeted for women—surgery is portrayed as the most effective way to free oneself from the stigmas and health risks associated with large bodies. WLS clinics routinely feature success stories by former patients that include before and after pictures and personal narratives. Since these testimonials are cherry-picked by the clinics, naturally they do not represent the full spectrum of post-surgical patient experiences, yet they are likely to influence the decision making of prospective patients. Our findings show that these success stories do not offer adequate information to prospective patients about what to expect after the surgery. In particular, the success stories tend to speak of side-effects as self-inflicted, thus reinforcing the healthist cultural/medical message of individual responsibility that is driving the current WLS epidemic.

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My life is totally changed and I have no regrets about choosing this treatment. I really recommend this surgery to all of you out there who struggle with obesity and disease. At my largest my weight was more than 140 kilos and now my weight is 60 kilos and I have now become normal weight.

This is Gina – a Norwegian woman who has lost more than 80 kilos following weight-loss surgery. Her story as a former patient is featured on the website of a private clinic offering this radical treatment; the narrative will thus form part of the total discourse context surrounding potential patients considering weight loss surgery. Gina recommends this treatment to everybody who struggles with obesity. She has “no regrets” and has now become normal weight.

In this article we will further explore stories like Gina’s as part of the marketing strategy of private clinics offering weight-loss surgery. Weight-loss surgery is a drastic intervention with lifelong consequences for anyone who chooses it; thus, it is worth examining closely the frame of discourse within which such decisions are made, including the themes and tropes encountered in advertising narratives. How accurate a picture do they present to prospective patients about what to expect from the surgery?

Background

Obesity rates have increased dramatically since 1980 with recent estimates suggesting that nearly half a billion adults can be considered obese or morbidly obese. Health authorities, obesity experts and the media increasingly worry about this “epidemic” regarding it as one of the greatest public health threats of modern times (Ulseth, et al 2007; Malterud & Tonstad, 2009; Groven, 2014). Given its association with obesity related diseases such as cancer, heart/vascular diseases and diabetes, health promotion campaigns stress individual responsibility for weight

loss or maintaining slenderness. But to assist the many individuals who have tried and failed, there are a wide variety of weight-loss programs offered by health professionals, including combinations of nutritional counseling, exercise, and behavior modification (Ogden et al, 2006; Rugseth, 2011; Groven, 2014; Knutsen, 2013). None of these traditional weight-loss interventions show significant long-term success: whatever weight is lost is usually regained again within a few years, a dilemma that is increasingly debated in the literature (Bacon & Aphramor, 2011; Bacon, 2010; Sumithran & Proietto, 2013; Maclean et al, 2011). With people increasingly recognizing the long-term failure rate of lifestyle modifications, and increasingly fearful of obesity-related diseases, it is not surprising that weight-loss surgery is becoming more and more popular. Indeed, weight loss surgery is commonly regarded as the most effective treatment for morbid obesity (Newhook et al, 2015; Throsby, 2009).

The mass media have given extensive coverage to weight-loss surgery, through television shows, interviews and articles that emphasize its health benefits (Salant & Santry, 2006; Throsby 2011; Lupton, 2013; Glenn et al, 2014). Unsurprisingly, under these cultural conditions for-profit clinics are proliferating which offer private weight-loss operations (Murray, 2009, p. 163).

Women are the primary target of most of this advertising, which makes sense, since women are believed to constitute 80 % of all patients undergoing weight-loss surgery (Martin et al, 2010; Johnsson et al, 2011; Jakobsen et al, 2010; Murray, 2008; Ogden et al, 2006). In their study, “Internet marketing of bariatric surgery” Salant and Santry focused on American private clinics and found that women’s physical and emotional transformation was highlighted in the majority of sites. Moreover, their advertising emphasized women’s bodily changes and the increased social acceptance and self-esteem these changes entailed (Salant & Santry, 2006). In a similar

vein, Glenn and colleagues found that Canadian media texts emphasized a fairy-tale narrative in which women were portrayed as becoming happier and more sexually attractive after undergoing WLS (Glenn et al, 2013).

Even a casual inspection of the websites of Norwegian private clinics offering weight loss surgery shows that women are the subject of most of their patient stories. Given that these narratives are presented as authentic stories written by former patients, it seems likely that women considering weight loss surgery would study them as part of their decision-making process (Groven & Hoffman, 2015).

Bearing this in mind, coupled with private clinics' motivation to attract potential patients (frame and sell their services) it seems pertinent to explore how former patients' experiences are utilized as part of an online marketing strategy. In this article we will take a closer look at such patient stories, currently a gap in the literature. And we will explore how the women's narratives – by focusing on personal experiences of undergoing weight-loss surgery – frame the treatment as necessary, benign, and effective.

A phenomenological-feminist perspective

Our analysis of women who are subject to the stresses and stigmas of obesity is naturally intersectional and thus draws from a variety of theoretical frameworks. Two key concepts in what follows are *dis-appearance* and *dys-appearance*, terms coined by American physician and philosopher Drew Leder. Dis-appearance (or the "absent body") is the tendency of a healthy individual's body not to be the subject of conscious attention; dys-appearance is a state in which an individual's body becomes foregrounded in attention — unignorable — because of some state

of distress, including but not limited to pain, illness, hunger, or dysfunction. In dys-appearance, the body may be felt as an "alien presence" or an obstacle interfering with the individual's projects (Leder 1990, 13-27; 79, 84). Subsequent social theorists such as Shilling have criticized Leder for paying insufficient attention to unequal social privilege that may cause the bodies of some individuals to be "regularly foregrounded" (Gimlin 2006, p.186). However, Leder makes room for a concept of "social dys-appearance" of the body at times when "the gaze of the Other" is perceived as hostile or objectifying (Leder, 1990, p. 96). And, as argued by Leder, in a clinical or diagnostic setting, organic and social dys-appearance may be intertwined (1990a, p. 98).

Leder's concept of dis-appearance may be valuable to sociologists and cultural scholars working in the area which is now sometimes called Privilege Studies (McIntosh, 1988; McIntosh, 2012). In a society where whites of European descent enjoy greater privilege than persons of color, a black person's racial identity will tend to be foregrounded whereas a white person will tend to be seen as just a person, whose racial identity does not register as significant. Similarly, male privilege means, among other things, that maleness is the default and femaleness is marked: the phrase "a woman doctor" may be commonly applied in situations in which a male would simply be referred to as "a doctor." Privilege thus includes the privilege to disappear, not to register as unusual to mainstream perception (Gimlin, 2006). In recent years, some activists and cultural critics have also begun to use the term "thin privilege" by analogy with race- and gender-based privilege.ⁱ

Feminist scholars, including scholars in the newer field of Fat Studies, have written a great deal about the ways in which obese women are explicitly subject to the scrutinizing gaze of others and judged as failing to meet bodily standards of femininity, attractiveness, and even basic

normalcy or acceptability (Bordo, 1993; Mansfield, 2011; Murray, 2008; Throsby, 2008).

Samantha Murray in particular writes of her personal struggles with fat embodiment, the inescapable critical gaze, and the resultant internalized shame and self-contempt (Murray, 2008; Murray, 2009; Murray, 2010). Even while Murray maintained a critical perspective about the operation of social stigma, she also fervently wished to be thinner:

I felt I had little option but to accept her reading of my fatness, drop the clothes I was carrying, and scuttle out of her shop. I was ashamed and hurt, but I was also very angry. I started to seek out ways to renegotiate the system of knowingness” ... about my fat body. The assumptions made about fatness are that the fat person is slothful, lazy, weak-willed, unreliable, unclean, unhealthy, deviant, and defiant. These assumptions are so ingrained in the understanding society believes it has of the fat body that these characteristics have come to signify the fat woman (Murray, 2010, p. 265).

Literally thousands of examples of the public body-policing and shaming of fat women could be cited. To take an example more or less at random, American actress Melissa McCarthy’s performance in “Identity Thief” was reviewed by a male journalist in *New York Observer* who described her as “tractor-sized” “cacophonous,” a “humongous creep” and a “hippo,” as well as “a gimmick comedian who has devoted her short career to being obese and obnoxious with equal success.”ⁱⁱ

Both in popular media and in the discourse of specialists, the obese body almost universally connotes unhealthiness in the sense of being either ill or in the risk zone to become ill in the near future (Throsby, 2011; Lupton, 2010). Deborah Lupton notes that the anti-obesity

messages exert pervasive power in our culture. Weight and health are perceived as necessarily linked. Lupton points to the high level of attention weight loss messages receive in popular forums such as the news media, television documentaries and reality series, books, magazines and websites directed at health/weight issues, and advertising for weight loss-products, as well as statements from governmental officials and in health promotion campaigns (Lupton, 2013, pp. 15-16):

For those researching and writing within this perspective, obesity is a major health risk associated with such significant health problems as cardiovascular heart disease, diabetes and early death (Lupton 2013, p. 15).

Health experts within the area of obesity are strongly influenced by "healthism," – a term introduced by Robert Crawford in the early 1980s to describe the newly emerging health consciousness (Lupton, 2013). Healthism can be explained as a set of neoliberalist attitudes which situate the problem of disease at the level of the individual, assuming that individuals always have it within their power to be disciplined, well informed, and make rational choices about their health (Peterson & Lupton, 1996; Ayo, 2011; Groven et al, 2013). A moral dimension then creeps into health promotion because it is assumed that since individuals *can* be disciplined, informed, etc., they should. So moral pressure is being applied and moral judgments made, but not necessarily through direct repression and coercion. Instead, a set of norms, measurement, and classification are developed by which individuals subject each other and *themselves* to ongoing monitoring and voluntary compliance, with health experts acting merely as guides (Cheek, 2008; Lebesco, 2011; Groven et al, 2013). In line with this argument, Lupton notes that health professionals within the area of obesity are not positioned as domineering or

authoritarian, but as helping individuals to make the right choices (Lupton, 2003). Thus, healthist attitudes are not easy to detect: they have a double aspect, being simultaneously pervasive and almost invisible (Lupton, 2013).

Commercial weight-loss surgical clinics present narratives by former patients as though they are direct expressions of individual experience, not enhanced or repackaged by the clinic itself. Sometimes the patients' full names are provided and sometimes even personal contact information, which increases the sense of authenticity (Groven & Hofmann, 2015; Salant & Santry, 2006). For now we will take these narratives at face value, assuming that the content of each is solely the expression of its putative author and has not been dictated, significantly reshaped, or mediated in any way by the clinics. (This assumption, obviously, might be questioned, and we will revisit the issue in subsequent discussion). Note, however, that even under the most charitable possible assumptions about authenticity, nothing guarantees that these narratives portray statistically typical patient outcomes.

Methods

The material to be analyzed consists of 16 narratives available on the websites of three private clinics offering weight-loss surgery to Norwegians. During the period from March 15 to September 15 2014, we studied each clinic's website and downloaded all of their patient stories. Although the length of these stories varied, they usually consisted of two pages of written text along with two photos. Two of the clinics included stories of both male and female patients, whereas one of the clinics only included stories of female patients. Due to ethical concerns, we have used fictitious names for all the men and the women as well as surgeons being named. As for the clinics, we have used the following terms: clinic 1, clinic 2, clinic 3 throughout the article.

Our analysis proceeded in various stages inspired by Mattingly's narrative-phenomenological approach and Kvale and Brinkman's critical analysis (Mattingly, 1998; Kvale & Brinkman, 2009). This meant that we studied the clinic's patient stories as written texts, searching for themes and sub-themes as well as structure. Studying each text as an individual story we asked ourselves questions such as: Where is the beginning, middle and end? Where are the dramas? Where is the excitement? (Mattingly, 1998, p. 63). Next, we analyzed the stories in terms of "style of presentation". As noted by Mattingly, a narrative is also characterized by "an evocative and seductive prose" directly "related to one of its primary functions – its rhetorical power to persuade" (Mattingly, 1998, p. 8). During this stage we analyzed the texts line-by-line searching for phrases and expressions that seemed particularly illuminating in terms of individuals accounting for their experiences: first choosing and then undergoing surgery. Finally, we conducted a critical interpretation of the patients' stories (Kvale & Brinkman, 2009). This critical interpretation involved contextualizing the stories using previous research. At this stage we went beyond what the men and women explicitly expressed through their stories, uncovering opinions, and motives that were not evident at first glance. We have included verbatim extracts and quotations from the stories to show what our various interpretations are based upon.

Findings

In what follows, we present our findings thematically, highlighting the narrative structure of these stories.

Before and after

The photographs are the most immediately visually striking element in the patient testimonials, and it is likely that a significant number of people browsing these websites will form lasting impressions from the pictures without reading each detail in the written narratives carefully: this is exactly why visual images are so prominent in mass advertisements for all sorts of products and services. These photographs in particular link to a very powerful trope of *before* and *after*, long familiar from the dieting and beauty industries, but stretching back far beyond them in cultural memory to archetypal myths and folktales in which a deserving protagonist in dire circumstances achieves a sudden, complete transformation, like Cinderella.ⁱⁱⁱ

Most of the testimonials feature images of both "before" and "after"; a few provide only an after, and one provides only a before, but in most cases it is possible to fill in the missing pieces by imagination because the before and after weights in kilograms are also provided. The "after" photographs of the women tend to feature stylish clothing, hair and makeup: they look ready for social life whether in formal or casual settings. The men, on the other hand, tend to be shown in sports clothing, exercising or competing. Thus, the emphasis for the men's bodies is action and functionality; for the women it is their appearance. The gender division is not absolute, though: Nina is pictured with her dogs.

The written narratives also adhere very strongly to the before and after archetype. The patients focus on different aspects of their experience, ranging from physical-medical issues to psycho-social ones to lifestyle, but usually casting the decision to have the operation in terms of a dramatic turning point or climax, after which a dire situation resolved into a happy one.

Before:

Something drastic had to be done

Four of the narratives mention diabetes: Nina and Alex had been diagnosed with diabetes type 2, while Oda had been symptomatic "at times" and Knut was told he was in the "danger zone."

These four individuals also mentioned other alarming metabolic indicators such as high blood pressure, high cholesterol, or abnormal blood sugar levels. As Oda describes it:

My blood pressure was too high and at times I was insulin resistant. There was a history of obesity and heart disease in my family. And I envisaged a future of ongoing weight regain, failed diets and more disease. Something drastic had to be done.

Alex writes:

I was diagnosed with diabetes 4 years ago and envisioned a life on blood pressure and cholesterol medication. ... Probably I would not live to old age. My overweight had taken over, and my body was no longer capable of helping itself. I needed help, and I needed it quickly

Three narratives mention problems with knee, hip, or back pain, and three mention physical problems which are less strongly associated with overweight as generally understood: psoriasis (Erica), headaches (Helene), and asthma (Ingrid). A variety of narratives refer directly or indirectly to low levels of fitness, such as having difficulty climbing stairs or getting tired easily.

Inger's narrative is interesting in that she offers no evidence of any *actually existing* negative health indicators — she is only 21 at the time of writing — but nevertheless assumes her health is soon to be at risk in the future:

And you also have all the other problems that were about to come, blood pressure, diabetes, bad heart, yes, the doorstep would soon be crossed over and I would become a very sick girl.

Anna makes a similar assumption:

In the public health system I was told that I had to wait for 5 years because I was “physically and mentally strong.” If I had waited for 5 years I would have risked getting diabetes and comorbidities along the way.

Anna’s health prior to surgery perversely seems to be regarded almost as a disadvantage, because it means she cannot get priority for treatment in the public system.

Two of the women mention severe depression in connection with being overweight, and one of them had even considered suicide because her self-contempt was so inescapable. Almost all the women express the view that obesity is a serious obstacle to happiness or reduces “quality of life.” It is clear that a major source of the suffering connected with obesity is due to shame, feelings of failure, and the perception that one occupies a lower social status than normal-weight individuals. Vilde describes her “miserable feeling” that people looked at her as “the fat woman with all the kids,” and spoke to her condescendingly, assuming she must be “less intelligent” than average. Vilde is sure she is not just imagining the disdain, because she hadn’t been heavy all her life, so she had a baseline to compare her experience to.

Erica writes that she “dreaded social gatherings” and kept in her shell, “hoping that no one would see how unhappy I was.” She also suffered from low self-esteem. Several women

mention the difficulty of buying clothes or physically fitting into public spaces. There is considerable fear about what kind of social figure they project and how they look to other people. Anna says she was “terrified that someone would see me naked.” Both Elisabet and Erica experience disorientation in their self-image when confronted by photographs of their large bodies.

The women voice their social and psychological distress more often and at greater length than the men, but the men are certainly not immune to fears about personal identity and how they look to others. Knut writes that he “could not bear the thought” of dropping off or picking up his young son at kindergarten because he is “terrified that some of the older kids would bully him” for having a fat father. According to Edward, his wife hopes to “get back the man she married” by means of the surgery. And Mattias, a professional soccer coach, appears to have made his decision to have surgery in part on the basis of an intervention by the players on his team: “they gave me a warning— call it a kind of ‘yellow card.’”

No other way

Not every narrative goes into the question of etiology or discusses the individual’s lifetime history of weight loss and gain, but those which do uniformly report repeated and strenuous weight loss attempts, usually over the course of many years, generally with some short-term success. Some of the women initially gained weight after pregnancies. Others speak of having always been heavy. No matter where the weight came from, though, it proves impossible to lose permanently. Anna had “tried most things” but it was like “butting my head against the wall.” She had spent a lot of money and time struggling, but nothing helped. Her dieting and exercise

attempts all “went down the drain.” She regarded her obesity as resulting from a “mixture of genetic factors, poor eating habits,” and problem relationships.

Elisabet had tried to lose weight “countless times” by means of a variety of commercial products and programs; she achieved “normal weight” using Herbalife for several months but then regained: “It seemed as if my body remembered that it had been fat.” Thus, even though she kept a food diary and avoided snack foods, she regained “all 30 kilos plus 10 more.” Alex too had gone on “countless diets” with “new and greater weight gain each time.” Vilde went through “years of yo-yo dieting,” tried and failed with “all the diets and pills,” even though she was physically active. Knut could lose “10, 20, or 30 kg” by his own efforts, but that was “not enough”: he was still obese even at the lowest points in his weight cycling. Inger speaks of “starvation and constant defeat,” Nina of “struggling” her “entire adult life” with diet plans that didn't work long-term, and Oda saw ahead of her “a future with increasing weight gain, failed diets, and more disease.”

No time to lose

Patients who receive serious medical diagnoses naturally feel they need to do something at once. Alex has been told his life will not be long, so “I needed help, and I needed it quickly.” Likewise, Knut doesn't want to wait three years for the public health service:

I could not waste so much time, so I contacted the private clinic [Clinic 1] and we agreed that I should come to see them. I was operated on shortly afterwards.

But interestingly, the rhetoric of urgency is almost as prominent among the patients with no comorbidities. The threat of future illness motivated Inger and Anna, despite their current state of good health. And Erica, shocked by a Facebook photograph of herself, called the private clinic, and had the operation just “one and a half weeks later.”

Happy endings: All of my previous problems are gone

For both the men and the women, the surgery is presented as a life-transforming intervention changing their lives for the better. Not only do they feel healthier and more fit, but they also feel more attractive than previously. Anna gets the full Cinderella-romance happy ending: following the operation she lost weight and now she has “met a wonderful man who I've been with for a year!” Inger already had a boyfriend prior to the operation, but she also uses language appropriate for a story about a princess: “Right now I feel like the luckiest girl!” and “To turn around and smile at each mirror you see is an incredible feeling.” Similar euphoric feelings are emphasized by the other women. Helene for example describes herself as “over the moon” and says that all of the medical problems she had are gone, including back pain, headaches, and psoriasis. Erica’s psoriatic arthritis, knee problems, and eczema are “as good as gone!” Gina’s life “is totally changed.” Vilde says it was “wonderful to watch the kilos” melt away; Elisabet feels that the operation caused her body to “forget that it had been fat.” Oda is proud of her “strong and supple” body and says that at age 50 “I'm fitter and healthier than I ever have been.” Less impressively, Inger, at age 21, also says she has “never felt better.”

Many of the women discuss the new-found pleasure of buying fashionable clothing, reinforcing the message implied by the before and after photographs. Both women and men

frequently express satisfaction with improved stamina and physical performance, but the men dwell on it at greater length, and sports and exercise provide them with experiences of eu-appearance (Zeiler's term for pleasurable awareness of the body (Zeiler 2010)). For Alex and Mattias, the entire narrative focuses on their sports exploits. The women and men who have children or grandchildren mention new satisfaction in activities with them, such as jumping on the trampoline (Elisabet) or skiing (Edward). It is not clear that these changes in enjoyable family activity stem exclusively from improvements in physical ability, however; awareness of social stigma might also play a role, as in Knut's previous reluctance to be seen with his son in public.

Common to both the men and the women was their emphasis on a more or less pleasurable sense of unreality about their current situation. Mattias's 10 km race would have been "an unlikely dream" a few months earlier; Erica "can't believe" she is the same girl; Edward says "The whole thing is unreal." Language like this is quite compatible with dreamy settings and fairy-tale wish fulfillment.

Gratitude (to the rescuer/fairy-godmother)

In these stories, the surgery is always presented as the turning point that leads to the happy denouement, and the majority of the patients express gratitude for the personal qualities or professional skills of their surgeons and/or the clinic staff. There are, however, striking differences in the narrative patterns. The men express gratitude less frequently than the women, and when they do they say at most a sentence or two, in general terms; the women frequently mention doctors by name and devote entire paragraphs to describing interactions with them. In

addition, the patterns differ markedly between clinics, with Clinic 3 patients devoting the largest percentage of their narratives to gratitude and Clinic 1 the least. In fact, among the female Clinic 3 patients, the narratives are often structured around the clinic experience itself, and how pampered and well cared-for the patients felt, almost as though they are describing a spa treatment (being princess for a day?).

Linda's narrative scarcely even touches on any subject other than the clinic itself. When she meets the "very sympathetic and gentle" surgeon Dr. Knutson, she decides at first sight that she can trust him to do the operation. Thereafter the narrative is devoted to attentions she received from Dr. Knutson and others, as well as small luxuries included in the clinic experience, including a remote-control-operated leather chair, and lambskin upholstery in the vehicle that provided her door-to-door service. Yes, it was expensive, she admits, but "how can you put a price on health?" Linda provides no information about her life post-surgery, except that it has gone in "a positive direction."

The surgery is just a tool

Although the patients praise their surgeons for "giving" them a happier and healthier life, many of them equally emphasize that their own efforts have been significant in terms of ensuring good results. We have written elsewhere about the metaphor of weight-loss surgery as a "tool," and a few of these patient narratives refer to their surgery explicitly as a tool (quoting their medical providers) (Groven et al 2013). Many of the other patients, while they may not use the word "tool" in their narratives, nevertheless accept the underlying premise that their own ongoing

lifestyle choices determine their outcomes. However, the women tend to focus on changes they have made in terms of diet, while the men elaborate on their exercise habits. Anna writes:

In the long run, it is important to use this tool in the proper way, through regular meals, normal portions of food, a normal diet. To me, being focused on the surgery as a tool has ensured good results.

Oda notes that it is important to “follow the advice you get in the clinic to the letter,” and if that seems difficult, “think about the alternative: a life in which you would get heavier and heavier with more and more disease.” She goes on to describe her current training regimen.

The tool metaphor modifies the fairy-tale atmosphere created elsewhere in the narratives, adding a dose of non-magical realism. Perhaps it has been very deliberately chosen for exactly that reason: tools are not like magic wands, they do not provide instant or painless transformation. They are not even guaranteed to work at all. The tool metaphor dovetails beautifully with the background healthist assumption that a poor health outcome must be due to poor individual choices.

A bit of pain and difficulty is only to be expected.

Conspicuously absent in these narratives is any elaboration on the unpleasant aspects of life after weight loss surgery. Few narratives mention complications or side effects at all, and those which do minimize them, and do not attribute them to the surgery itself. Elisabet, for example, says “The first year after surgery has been a roller coaster. There have been ups and downs.” But then, in a very unusual use of this figure of speech, she claims that it has been “mostly” up. Though it

is “not always easy” to live with a “mini-stomach,” she feels “lucky” that she has avoided protein deficiency by prioritizing meat and avoiding salad. She hasn’t had “much” dumping during the first year, perhaps because she keeps “many doors closed” with respect to food, being extremely careful to eat only familiar foods and to try new foods only in small amounts. By reading carefully between the lines of Elisabet’s account it is possible to get a sense of how restrictive her current food habits are and how difficult the adjustment may have been, but her own words understate the suffering; she maintains that “weight loss surgery is the best choice I’ve made in my entire life.”

Vilde says that she is “prone to dumping,” but describes only one experience with it, the day after surgery, when the first sip of a juice-protein mix made her feel so “dizzy, sweaty, and weird” that she had to lie down immediately. It would be easy and natural for a reader to conclude that these unpleasant and debilitating physical reactions were connected primarily with the immediate post-operative recovery process and later on it wasn’t so bad. However, Vilde does not actually say anything about how often or how intensely she experiences dumping in everyday life now, just that she “can live with it,” provided she is very careful about what she eats, and in what amount, and how quickly. Anna too hints that she may have experienced dumping without providing any details: “I don’t tolerate unhealthy foods as well.”

Gina says there was “a complication” the day after her surgery but doesn’t say exactly what the problem was, just that the excellent care made her “feel safe all the way anyway,” and that the clinic didn’t charge her extra and even paid her additional travel and lodging expenses.

According to Oda “a bit” of pain and difficulty is only to be expected. She has had three plastic surgeries following the weight-loss operation, “all without complications.” She has no

side effects except those which are “self-inflicted” by eating “too much of the wrong foods.” Edward also says he has no side effects except getting cold more easily. Edward, it should be noted, is only three weeks post-operative and is not yet eating solid food.

DISCUSSION

The narratives in this study present WLS as a means of escaping bodily and social dys-appearance. In particular, the women’s pre-surgical accounts emphasized their motive to escape social dys-appearance. As we recall from the narratives of Anna and Inger, both were convinced that their large bodies made future medical problems almost inevitable, but in fact they had so far experienced only social problems. In a similar vein, Vilde hated to be considered “unintelligent” by reason of her size; she knew the prejudice was unfair but nevertheless fundamentally acquiesced to the idea that she must become thin again to gain respect. By portraying their lives as becoming significantly better after the surgery in terms of bodily appearance as well as social functioning and social status, the argument for surgery as a means of escaping social dys-appearance comes across as trustworthy. Before and after photographs, illuminating the women’s dramatic bodily transformation serve to strengthen this message. Indeed, the “after” photographs featuring the women in stylish clothing, hair and makeup leaves no doubt that their social life has changed significantly for the better: they look ready for social events in formal or casual settings. At the same time, the women’s narratives highlight the interrelatedness between social and bodily dys-appearance (Leder, 1990). Thanks to their dramatic weight loss, they feel more healthy and fit than ever before, enabling them to live a more active and socially rewarding life

compared to previously. As Nina emphasized, all of her pre-surgical problems, (social as well as health problems) were gone after the surgery.

By contrasting problematic pre-surgical lives with happy and fulfilling post-surgical lives these narratives can hardly be said to provide a complete picture of either the risks involved with surgery or the probability of its long-term success. These patients' stories paint a glorified picture of weight loss surgery. From previous studies we are well aware that weight loss surgery is a risky procedure, which can result in severe complications. Some 70-80 percent of all patients report side effects following such procedures, including dumping and nutritional deficiencies (Groven, 2014; Hadam et al, 2011; Mala et al, 2015; Aasheim et al, 2009). Even in the absence of direct, immediate surgical complications, the drastic changes to the digestive system produce long-lasting challenges to post-operative patients' ability to eat normally or without discomfort (Natvik et al, 2014; Singht et al, 2012). Such challenges are, however, not elaborated on in the patient stories under our scrutiny. When they are mentioned at all, they are described from a healthist perspective: side-effects are preventable with self-discipline, or at least readily manageable, if one uses the "tool" of surgery correctly, following the advice of the treatment team (Peterson and Lupton, 1996: p. xiii, p. 12). Any problems are first and foremost to be attributed to the patient's own behavioral lapses, rather than being physiologically-based and iatrogenic. Thus, by emphasizing self-governance, the patient stories we studied leave no doubt about who is to blame if one fails to change lifestyle according to the recommended post-surgical guidelines.

One of the selling points in the private-clinic's narratives is how quickly prospective patients can follow through with their decision to get the operation if they opt out of the public

health system. But the preparation phase before weight-loss surgery is known to be critical to its success (Groven & Hofman, 2015; Glenn et al, 2015). In the public health system, patients usually have to engage in mandatory pre-surgical courses emphasizing intense psychological screening, physical assessments, and lifestyle interventions (Ochner et al, 2012; Glenn et al, 2015; Padwal et al, 2009). In addition to the preparatory aspect, these courses also serve as screening interventions as to which patients are able to adhere to postsurgical dietary restrictions and behavioral changes. Recommending weight loss in the range of 5-10 % is not uncommon in these pre-surgical courses. Indeed, it is often required for surgical approval (Glenn et al, 2015). Finally, there is an ethical aspect to this preparation phase. Too brief a waiting period comes at the expense of an informed decision on the part of both the patient and the treatment team (Hjelmeseth & Sandbu, 2014; Groven & Hofmann, 2015).

Weight-loss surgery – which irreversibly alters the patient’s intestines – is a drastic procedure which can go wrong in a great many ways: volvulus, loose skin, vitamin deficiency, fatigue, stomach/intestinal problems, eating disorders, and dumping (Groven, 2014). The downplaying of complications and side effects in the clinics’ patient narratives can create unrealistic expectations among prospective patients about what their odds are for getting a desirable outcome from surgery, and also how comfortable their lifestyle adjustment is likely to be afterwards (Groven & Hofmann, 2015).

The retrospective narrative format of these individual experiences plays on both the hopes and fears of obese people, making the surgery seem like a foregone conclusion, that there really was no other choice for these individuals, and simultaneously holding out the hope for escaping into a transformed life, like Cinderella, going from misery to nearly unbelievable happiness.

Similar findings were reported by Glenn and colleagues. Focusing on news media coverage of a single publicly founded bariatric clinic in Canada, they found that the fairy-tale narrative fortified the discourse of medicine by positioning obesity as pathology in need of surgical intervention (Glenn et al, 2013). Glenn and colleagues further stress that the transformations and happy endings supplied by the fairy-tale narrative are gender-specific, which is consistent with our findings. In fairy tales, we would like to add, the narrative concludes with “happily ever after,” but in real life the story continues long past the honeymoon stage. As documented in an empirical study drawing on interviews with women suffering from problematic side-effects following weight loss surgery, the honeymoon stage quickly came to an end. Two, three and four years after the surgery, pain, fatigue, and severe complications affected the women’s lives dramatically, so that they regarded themselves as worse off than they had been before. As noted by one of the women in the study,

If I were to compare my life-situation today with my life situation before the surgery, it used to be super. ...Everything has become a hassle, sort of, because my quality of life is worse now than previously. For example, walking to my job is not possible anymore. I do not have the energy to do that. I don’t have enough energy to be with my children. I don’t enough energy to handle my job (Groven et al, 2010).

One is tempted to ask: what will happen after the "after" pictures of these happy patients featured on the private clinics’ websites? The primary requirement of evidence-based medicine has not been met here: to show that the long-term health outcomes of the treatment group are better than those of otherwise similar people who remained untreated. It is notable how little time has

elapsed between the surgery and the writing of most of the narratives, in most cases only a year or less. The longest follow up time is only four years. The narratives frame surgery as the final, permanent success following years of the failure of other methods, but in fact it is known that over time a significant percentage of patients will struggle with ongoing side effects as well as regain some or all of their lost weight (Hadam et al, 2011; Natvik, 2015).

Framing the surgery as a tool allows the clinics both to deflect the blame for any long-term ineffectiveness, and also to some extent to counter possible charges of unrealistic advertising. After all, they never promised an effortless, magical Cinderella transformation, they only implied it, with the pictures and the grateful stories which blissfully dwell on only the positive details. As such, the surgery is held out as a means of escaping bodily and social dys-appearance, enabling the patients to escape the critical gaze of others and prevent severe obesity-related health problems. And beyond mere escape, the surgery promises eu-appearance: positively pleasurable new ways to experience the body (Zeiler, 2010). For the women, the social aspects of bodily eu-appearance are foregrounded. The women expressed great gratitude to the surgeon, their saving prince, for enabling them to become more attractive, and they revel in their new clothing, romance, and social lives. By comparison, the men's eu-appearance experiences are connected to sports performance. In line with previous research, the men's narratives generally confirm hegemonic masculine ideals, which focus on the body's functionality, while the emphasis on bodily appearance for women confirms traditional ideals that value women for how their bodies look rather than what their bodies can do (Glenn et al, 2013; Bottorff et al, 2012; Salant & Santry, 2006).

Gender issues aside, these patient testimonials are quite unlikely to present a representative cross-section of all surgical patients. Instead, they are almost certainly predominantly written by the very luckiest patients, whether they have been self-selected or whether the clinics are engaged in cherry-picking. One need not make any accusations of deliberate deceptiveness. The longer narratives sound like the authentic voices of real individuals with different personalities and a variety of different experiences. Those presented by Clinic 3 include the patients' last names, and those presented by Clinic 2 actually include email addresses so that prospective patients can communicate with former patients. Therefore these accounts are quite unlikely to be fabricated or tampered with to any significant extent. However, editing — or *self*-editing — to fit a preferred narrative framework remains a strong possibility. It is quite striking how many of the women on the Clinic 3 site choose to structure their narratives specifically around the clinic visit. It is possible, of course, that the Clinic 3 experience is simply so superior to the others that it inspires a much higher degree of customer loyalty. It is possible that the women, in writing their stories, tended to imitate previously-published stories they had already seen on the site. But it is also possible that the clinic solicited stories of a certain kind, or only published stories of a certain kind. Even leaving aside the possibility of *quid pro quo* incentives, the writers of any of these narratives may have felt some pressure to write in a positive vein.

Prior to surgery, patients have every incentive to be swayed by a story with a happy ending. But even post-surgical patients may feel considerable pressure to shape their own life stories so that they conform as closely as possible to the happily-ever-after structure that casts them as the deserving protagonist (Glenn et al 2013). The dominant healthist discourse has

provided the context in which obesity is regarded as a matter of personal failure (Lupton 2010). The surgery providers have taken care to frame the surgery as a tool which may be “used” either skillfully or carelessly by individual patients, depending only on their will and discipline (Groven et al, 2013). And the patients themselves have staked their health and wellbeing on a generally irreversible procedure. Those who lose significant amounts of weight following surgery receive considerable social approval (Murray, 2008;Throsby, 2007). Under these circumstances, it would not be surprising if post-surgical WLS patients had a vested interest in packaging their own experience in the most positive possible light, ignoring or minimizing counterevidence.

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Notes

ⁱ It is not clear whom to credit for the term “thin privilege.” Braithwaite used the term in a conference presentation in 2004 but it seems to have been independently invented by several people at around the same time and it is now in wide usage: see for instance thisisthinprivilege.org.

ⁱⁱ <http://www.hollywoodreporter.com/news/rex-reeds-melissa-mccarthy-weight-420052>

ⁱⁱⁱ Glenn and colleagues (2013) have also written about the fairy-tale narrative encouraged by mass-media representations of weight-loss surgery.