Bariatric Biosociality: Pushed Together, Pulled Apart

Zoë C. Meleo-Erwin

Abstract

This article explores the postoperative experiences of weight loss surgery patients. More specifically, it investigates why bariatric patients seek out and form connection to similarly situated others in online and in-person support forums. Based on a thematic analysis of 30 semi-structured interviews with individuals who have had bariatric surgery, it is argued that the experience of having been medically classified as obese or severely obese, a long history of failed dieting attempts, fears of future morbidity and mortality, and then undergoing bariatric surgery serve as an axis around which some individuals interact, create identity, and form community. The perceived lack of postoperative support from home bariatric clinics, inadequate provider knowledge about the particularities of bariatric bodies, and the fact that patients must “work with” their surgeries to avoid postoperative adverse events are additional drivers for the formation of such bariatric kinship. It is argued that Paul Rabinow’s concept of “biosociality” provides a helpful theoretical frame for understanding these processes. However, just as the aforementioned factors push bariatric patients together, tensions around the type of bariatric procedure undergone, the amount of weight loss, and economic access to reconstructive plastic surgery cause conflict, leading to the formation of subgroups within bariatric communities. It is argued that, ultimately, bariatric biosocialities are spaces in which bariatric patients collectively work to achieve normative health and aesthetic standards. However, these spaces also reflect highly complex, sometimes divergent and conflictual, and often ambivalent frameworks of understanding and experience.

Keywords

bariatric surgery, weight loss surgery, stigma, responsibility, healthism, biosociality

Introduction

During the end of the 20th and the beginning of the 21st centuries as population-level body mass index (BMI) climbed and obesity became referred to as an epidemic (Boero, 2012), the United States witnessed a tremendous increase in the number of bariatric surgeries (also known as weight loss surgery [WLS]) performed. In 1996, there were fewer than 10,000 bariatric procedures undertaken in the United States (Hutter, 2006). Yet, between 1998 and 2004, this number increased by 726% for individuals between the ages of 18 and 54, and nearly 2,000% for those between the ages of 55 and 64 (Agency for Healthcare Research and Quality, 2007). Currently, approximately a quarter of a million Americans undergo bariatric surgery each year (American Society for Metabolic and Bariatric Surgery [ASMBS], 2018). A 2015 meta-analysis of bariatric patient characteristics suggests that individuals who undergo bariatric procedures are more likely to be female, White, middle aged, or younger, and hold private insurance (Bhogal et al., 2015).

The advent and refinement of laparoscopic techniques in bariatric procedures, which were associated with fewer complications than the open methods that had been utilized previously, clearly contributed to the increase in WLSs performed (Sundbom, 2014). However, it is reasonable to assert that rising anxieties related to the now “epidemic” nature of obesity also drove this increase. For example, during this time, obesity was increasingly described in media coverage in terms of crisis, urgency, and alarm with a significant proportion of news articles using war metaphors to describe the vital need to take action (Saguy & Almeling, 2008; Saguy & Riley, 2005). In December of 2001, then Surgeon General David Satcher announced America’s “War on Obesity” to the press. In encouraging Americans to take action, Satcher and former Health and Human Services Secretary Tommy G. Thompson suggested that, as their patriotic duty, all Americans should lose 10 pounds (Herndon, 2005). And in 2006, former Surgeon General Richard Carmona referred to obesity as “the terror within” that would destroy the United
States. He stated, “Unless we do something about it, the magnitude of the dilemma will dwarf 9-11 or any other terrorist attempt” (Biltekkoff, 2007, p. 29).

WLSs were then held, as they are to this day, by the medical community to be the most efficacious and durable interventional available for both obesity and weight-related metabolic diseases (ASMB, 2007; Maciejewski et al., 2016). Although the amount of weight loss varies by procedure, in general bariatric patients lose up to 70% of what is deemed their “excess weight” within 2 years following surgery.2 Bariatric procedures work by reducing the volume of the stomach. Although the vertical sleeve gastrectomy (VSG) and laparoscopic adjustable gastric banding (LGB) procedure (known popularly by the trade name LAP-BAND) are solely restrictive in nature, some bariatric surgeries, such Roux-en-Y gastric bypass (RYGB) and biliopancreatic diversion with duodenal switch (BPD/DS), additionally reroute the small intestine to limit the degree to which the body can absorb fat and calories. Given the rapid pace of weight loss as well as the strict, lifelong postoperative dietary and nutritional supplementation protocols that patients must follow to avoid or minimize surgical complications, side effects, and regained weight, bariatric patients contend with substantive physical, physiological, and psychosocial adjustments. As a population, they thus require specialized follow-up medical care and support services (Koball et al., 2017; Sharman et al., 2015).

There is a substantive literature on the relationship between more favorable outcomes and postoperative support services for bariatric patients (Beck et al., 2012; Bradley et al., 2016; Compher et al., 2012; Livhits et al., 2011; Spaniolas et al., 2015). And yet, there are no standardized guidelines for how such services should be set up (Livhits et al., 2011; Obeid et al., 2016). Moreover, although the joint accreditation standards (2016) from the ASMBs and the American College of Surgeons (ACS), known as the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP), require accredited bariatric centers to hold organized support groups supervised by a health care professional, bariatric centers do not need this accreditation to perform WLS procedures.3 As a result, some bariatric surgical centers may not offer support services. Perhaps, to fill this gap, bariatric patients have often turned to one another. A number of studies have documented the fact that the bariatric patients use the internet for information and support, both before and after a WLS procedure (Ferry & Richards, 2015; Koball et al., 2017; Martins et al., 2015; Paolino et al., 2015).

It is suggested here that Paul Rabinow’s (1996) concept of “biosociality”—or the ways in which advances in biomedicine and clinical treatments have shaped new forms of identity and collectivity—provides a useful lens for understanding the formation and utilization of peer-led bariatric groups. Rabinow coined the term “biosociality” as a challenge to what he saw as the crude biological determinism of sociobiology. By contrast, he was interested in how sociality and identity might emerge, shift, and change during a period of time in which understandings of and treatments for disease were undergoing tremendous change (Gibbon & Novas, 2008). Since Rabinow first introduced the term, a number of researchers have explored these new areas of identity and sociality, looking specifically at how they intersect with other categories of classification (Rapp & Ginsburg, 2001). Some have examined how the internet has facilitated the growth of new biosocial communities, allowing geographically dispersed individuals who share medical diagnoses (as well as parents whose children have been given the same diagnosis) to connect with one another, particularly in online forums (Parr, 2002; Rapp & Ginsburg, 2001; Schaffer et al., 2008).

Using both biosocial and health social movements frameworks, other scholars have traced how certain biomedical communities have become powerful advocacy forces (Brown et al., 2004; Novas, 2006; Parr, 2002). Brown et al. (2004) do not frame their work in terms of biosociality but “embodied health activism” and “health social movements.” Although there are important differences, both frameworks examine collectivities formed around a shared disease category. As well, both examine how such collectivities politicize their experiences, challenge dominant conceptualizations of disease categories, advocate for greater treatment and care, and often work in conjunction with medical and scientific professionals. One of the main differences seems to be that work on biosociality typically frames discussions of these phenomena within a Foucaultian analysis of biopolitics and governmentality, whereas the health social movements work does not explicitly do so. Health social movements contest, expand, and even fund and coordinate medical knowledge, research and development for particular disease categories. As Gibbon and Novas (2008) note, the organization of layperson groups around particular disease categories is not new. However, in the past such groups largely focused on providing social and economic support to affected individuals and families, whereas today such groups are organized around lobbying for as well as financing and directing scientific research efforts toward developing better tests, treatments, and cures.

Work on “biological citizenship” and “biomedical citizenship” has taken up these questions at a different register. Herein, researchers have examined how developments in the life sciences and global capitalism are shifting notions of citizenship (Biehl, 2005; Petryna, 2004; Rose & Novas, 2005). As well, authors such as Scheper-Hughes (2004) have looked specifically at the ways in which larger macroeconomic conditions create biosocial benefits for some but do so based upon the exploitation of others. On the whole, research on biosociality thus examines contemporary shifts in how humans understand themselves, their bodies, health, and illness, and do so in relation to institutions of power (Gibbon & Novas, 2008) and within a sociopolitical context of neoliberalism. There has been relatively little research on the formation of identity and community around having had bariatric surgery. Of that which exists, Throsby’s (2008a) and Boero’s...
(2012) research comes closest to exploring the biosociality of weight loss. Throsby (2008a) explores the work required by former WLS patients to support the identity of a postsurgical “new me.” Throsby’s (2008a) interview-based research demonstrated that, given the stigma sometimes associated with having had a WLS procedure to lose weight, patients often experience a great deal of anxiety in attempting to hide the fact of their surgeries from others. Furthermore, the disciplinary work necessary to “pass” was often based on information and tips collectively shared in support group meetings. Throsby (2008a) concludes that the communal declaration of a “rebirth” through WLS “signals a new form of belonging (to the bariatric community) that stands in stark contrast to the exclusion and denigration that many of those who are visibly larger experience routinely” (p. 130).

In tracing the contradictions between public health framings of obesity as epidemic and individual lived experiences, Boero (2012) interviewed individuals who pursued weight loss through commercial diet programs as well as bariatric surgery. Looking specifically at WLS patients, Boero argued that the bariatric community is built on the common experience of having experienced stigma for being a very fat person, the desire for or experience of having had WLS, and the process of learning to live in a thinner and externally more normal body that is also highly surgically altered. In addition, Boero (2012) suggests that WLS communities are places in which women in particular learn to “negotiate a world of normative gender and sexual expectations that they had previously been outside of by virtue of their fatness” (p. 104). Aside from these notable works, there is a dearth of scholarship on the biosociality of weight loss. This article seeks to address that gap and is guided by the following research questions: Why do individuals seek out others around the experience of having had WLS? As well, why do some who have had WLS form ongoing kinship around what would seem to be a transitional bodily state?

**Methods**

This article is based on doctoral research conducted between 2011 and 2013. As part of that investigation, upon approval from the institutional review board of the researcher’s university, 30 semi-structured interviews were conducted with bariatric patients either in person (19 interviews) or by telephone (11 interviews). All participants resided in the United States at the time of the interview. The purpose of that larger study was to examine the experience of having been medically classified as obese or severely obese, having a bariatric procedure, and then losing a substantial amount of weight (up to 70% of excess body weight) in a relatively short period of time (approximately 2 years). In the interviews, an attempt was made by the researcher to assess the embodied lived experience of both pre- and postoperative life. This larger study additionally focused on the role support groups (both online and in person) play in both the pre- and the postoperative experience of bariatric patients. The interview guide utilized was developed based on the researcher’s knowledge of the relevant literature.

With an average age of 40 (range: 19–71 years), 90% of the participants were female (n = 27), nearly three quarters identified as Caucasian (n = 22), and 87.7% identified as heterosexual (n = 26). Data were not collected on income. However, a question was asked about the highest level of education achieved as an approximate measure of socioeconomic status. Slightly more than half the participants had earned a college degree (n = 9) or a postgraduate degree (n = 7). The majority of the participants resided in the Greater New York City Metropolitan Area (n = 19). Finally, the most common length of time out of surgery (n = 12) was 1 to 2 years, and the most common procedures that the participants had undergone were the RYGB (n = 9) and BPD/DS (n = 9).

To begin recruiting participants, the investigator posted a call for research participants on several online WLS forums after being granted permission to do so by site moderators. A URL for a study-specific website was provided in the call for research participants. Upon visiting the study website, potential participants filled out a short screening questionnaire and provided contact information (email address and phone number). Further recruitment proceeded by means of a nonprobability, snowball sample design wherein candidates referred by a past participant contacted the researcher by email. All candidates were contacted by phone to complete an additional screening questionnaire. Inclusion criteria for participation were (a) having had bariatric surgery of any type, (b) being a resident of the United States, and (c) being more than 18 years of age. There was no length of time out of surgery that was required to participate in the study. Eligible candidates were then scheduled for either in-person or telephone interviews. All participants gave express written consent to be both interviewed and digitally recorded. Interviews averaged 60 min in length (interview length ranged from 45 min to 2 hr) and were professionally transcribed verbatim. This investigation was approved by the institutional review board of the researcher’s university. Pseudonyms are used in this article to protect the confidentiality of the participants.

Using the cloud-based software program Dedoose (n.d.), the data were examined with an inductive coding scheme to discern emergent themes (Charmaz, 2006; Gill, 2000; Glaser & Strauss, 1967/2009) and proceeded by means of a discourse analysis. Here, the investigator followed Gill’s (2000) definition of discourse analysis as a “careful, close reading that moves between text and context to examine the content, organization and functions of discourse” (p. 188). More specifically, the analysis focused on both patterns and variability, paying particular attention to exceptions and differences, what was said, and what was not (Gill, 2000). Finally, in an attempt to understand the fullness of participants’ experience, the author was mindful of the complexity, contradiction, multiplicity, and unexpected emergences in the data (Walkerdine, 2009).
Results

The analysis suggests that bariatric communities become spaces in which individuals who have had WLS collectively negotiate the physical, physiological, psychological, and social changes that are typical of postoperative life. As will be discussed, bariatric patients seek one another out around the following common experiences: having been medically classified as obese or severely obese; having felt profound hopelessness over a lifelong history of unsuccessful dieting and escalating body weights; being highly concerned over current and future weight-related health risks; undergoing WLS; contending with the adjustments required of bariatric surgery; fears and realities of weight regain; and a perceived lack of postoperative support from home bariatric clinics as well as inadequate provider knowledge about the particularities of bariatric bodies. However, the analysis also reveals that, just as these experiences bring individuals together, other factors drive them apart, creating divisions and factions within bariatric communities. Specifically, these tensions arise over bariatric surgery subtypes, the amount of weight lost and weight regain, and, finally, access to (or lack thereof) reconstructive plastic surgery.

Shared Experiences: “They’ve Been Where You’ve Been”

During the interviews, participants were asked whether or not there is a bariatric patient “community” and each and every individual answered with a resounding “yes.” Nearly all articulated that it was a vital one. As the participants discussed, having bariatric surgery involves a whirlwind of not only physical and physiological shifts but psychosocial ones. Collectively, these changes drive the need to connect with others who have been through a similar set of experiences. Describing what it was like to be considered severely obese and then become thin within a year’s time, one participant stated,

It’s [having been obese] just an enormous part of your life, and to have that kind of severed off so abruptly, there really is no adjustment for it . . . You’ve just kind of got to surround yourself with people who do understand what you’re going through. (Hanifah)

This experience is so particular, argued another participant that he felt an instant connection to others who had had surgery:

I think you have like a kinship with people, instantly, if you know they’ve gone through the same thing as you. (Chris)

In discussing the need for bariatric-specific communities and forums, participants distinguished themselves from both thin people and from dieters alike. Skinny people, they argued, just could not understand what it was like to be fat. Although many of the individuals interviewed for this study were now thin themselves, they were still highly connected to the experience of having been very fat. Kaia suggested that the experience of having shifted from being very fat to being thin was more significant than the experience of being thin itself. Dieters who sought to lose 10 to 20 pounds were also not kin, other participants argued. As an individual stated, most people can relate to a desire and struggle to lose some weight, but few knew what it was like to lose more than 100 pounds. Yet another participant argued that it was not merely the amount of weight lost or the reasons one had been fat that distinguished bariatric patients from dieters. Rather, it was a long history of unsuccessful dieting and the hope that bariatric surgery would provide a way out. She said,

The bariatric community, they’ve been where you’ve been. They know what you’re thinking; they know what you’re feeling. They know you’re up against the wall and you have nowhere to go. Most of us we have spent years and years dieting, trying this one, trying that one, knowing it’s not going to work. Every next diet is your last diet. You finally get to a point where you just don’t know what to do; you don’t know what else is next, and hopefully you stumble upon someone who’s talking about surgery, or who’s had it, or you hear about it on TV or something, and you see a light at the end of the tunnel. (Yvonne)

All of the individuals interviewed for this study described a long history of yo-yo dieting and cited health concerns as the main motivating factor in pursuing WLS. In choosing surgery, they sought to address current health issues as well as act preemptively to ward off what they believed to be impending (further) morbidity and (early) mortality.

As well, all of the participants discussed experiencing substantial improvements in health and quality of life following surgery. However, they also described in stark detail the realities of living with a bariatric procedure. These embodied particularities also drove participants’ desire to connect with one another. Many spoke specifically of the gastrointestinal distress that came having had surgery and stated that they could only discuss such sensitive topics with other patients. For example, one individual remarked that, when dining with other bariatric patients, she did not have to explain a sudden need to get up and go to the bathroom to regurgitate food stuck in her esophagus—a common side effect of having the LAGB procedure. Participants also felt as if their nonbariatric patient friends had tired of hearing about the ups and downs of their procedures, which were nevertheless ongoing. For example, Chris stated that talking to nonbariatric friends about his constant vomiting would be experienced as “bitching.” These friends did not have the first clue what he was going through, he continued, whereas other bariatric patients could relate.
**Shepherding One Another Through the Process: “It’s Going to Be With Them for the Rest of Their Lives”**

Nearly all of the participants did extensive research and talked at length with other patients before undergoing surgery. From the moment they decided to have surgery, other seasoned patients began to guide them on what to expect and what to do. In effect, given the realities of living with a bariatric procedure, not only does WLS demand a new form of embodied subjectivity, it is one that is collectively negotiated and, moreover, taught.

Interestingly, this phenomenon has a name within the bariatric community and is known as “Angeling”—or the process by which an experienced patient takes on the primary support and sometimes advocacy role for a new patient undergoing the same procedure. One participant, who was more than a decade out of surgery, served as an angel to many other BPD/DS patients. Even those participants who did not use the term “angel” described a desire to “pay it forward.” For example, although Kristen was less than a year out of surgery, she stated that now she primarily went to online bariatric forums to help new patients. And Kaia, who was 19 at the time of the interview and had surgery at 16, took responsibility for shepherding new teenagers that were interested in the BPD/DS procedure. She advised them of the maturity required to have bariatric surgery and the necessity of doing their homework. She stated,

That’s the most important thing to me, that they know the hard, straight facts about all of their options and that they understand that it’s going to be with them for the rest of their lives. (Kaia)

Angeling and paying it forward, then, not only provide key information and advice, but also underscore notions of responsibility for “working with” the surgeries by making proper choices and sticking with postoperative surgical protocols.

In the interviews, participants stated that, without question, the preoperative information sessions that they had attended at their home surgical clinics had not remotely prepared them for what life after surgery would truly entail. And within the first few days and months following surgery, regardless of how well they had been prepared, these individuals sought out others online and in person to ask some variation of the question, “Is this normal?” Patients thus turned to one another to learn how to adjust to and live with bariatric surgery—information they felt they had not sufficiently received from their home surgical clinics. Online forums, in particular, as Danielle noted, were available 24/7 when there was no one else to ask. However, she continued, sometimes the amount of advice and information was both overwhelming and contradictory. She asked,

How can I do everything right if there are so many different answers? (Danielle)

She concluded that although patients should seek advice, they should also weigh it against their own embodied experience to make the choices that they felt were right to them. They needed, she stated, to “learn their way through it.”

**Sharing Vital Information: “You’ve Got to Be Able to Speak Up Because This Isn’t Well-Known”**

Getting advice and tips from others was also necessary, participants suggested, because their primary care providers were woefully unprepared for how to deal with the particularities of bariatric bodies. This meant that patients often had to take what they had learned in bariatric forums and educate their physicians:

I tell my doctor at [redacted], “Once a year I need a whole battery of tests.” I’ve told him what I’m at danger for. He doesn’t necessarily know that, nor do I know if he’s incented at all to go look it up himself. He’s always been very agreeable to me with what I’ve told him. And, he’ll interpret the blood test results, or whatever test I say I need, and everything has been fine so far. But I do know that this surgery only works if you’re the kind of person who’s really going to take charge of your own medical needs. You’ve got to be able to speak up because this isn’t well-known. (Hannah)

Similarly, another participant said that having bariatric surgery meant that she had to advocate for herself more, something that she seemed to somewhat resent:

It’s frustrating because I feel like there are surgeons out there, they do their job very well, but as far as the follow up stuff with nutrition, there’s not enough research being done that needs to be. So, again, that goes back to that need for a sense of community with everybody. (Irene)

As these individuals made clear, to avoid regain, side effects, and complications, patients must proactively “take charge” of their own medical needs because they perceive there to be a lack of adequate structured postoperative support, care, and medical knowledge about bariatric bodies.

The ability to navigate side effects and complications collectively was vital to these individuals. Several participants stated that they might have suffered dire consequences, including death, without the support of other bariatric patients. For example, Katrina made an appointment with the surgeon who performed her LAGB surgery because she wanted to revise to a BPD/DS procedure to lose additional weight. Her surgeon, however, told her that her inadequate weight loss and the complications she was experiencing were caused by her own noncompliance, not the device. Instead of scheduling her for a conversion surgery, her surgeon tightened the band by adding more saline to increase restriction and speed up her weight loss. Afterward, she left with a band so tight that she was unable to swallow any liquids, including saliva. She later told others in a bariatric
Because of the advice and support from other patients in this forum, she avoided what might have been a serious complication associated with her LAGB procedure.

Similarly, Kaia described blacking out, being taken to the emergency room, and trying, in vain, to talk to the medical staff about how her surgery might be related to her having passed out:

I was trying to tell them what surgery I had, because I’m pretty sure I had some low vitamin levels that caused me to black out. And, I was trying to explain to them that I had the Duodenal Switch. And they just said, “Oh, Gastric Bypass!” And, I kept telling them, “No, it’s not Gastric Bypass!” And, they didn’t understand what my surgery was . . . and they didn’t test my vitamin levels, which is very important. (Kaia)

Because of the lack of understanding about her procedure, having a community of people who could provide information and support was key for this participant. When asked if she thought she would continue to need this community in the years to come, after her surgery had become more normalized for her, she replied with an emphatic “yes”: She continued,

[The] DS is always going to be with me. There’s not a day that I forget that I have it. I will always know. (Kaia)

Her response suggests that patients perceive bariatric surgery as not only a lifelong embodied transformation, but also a lifelong intersubjective one.

Helping One Another Stay on Track: “It Just Gives You Motivation”

As the participants interviewed for this project made clear, and as is well documented in the bariatric literature, some degree of regain is common with all bariatric procedures. Although many patients initially believed that having a surgical procedure would free them from dieting, they learned, often from others in bariatric forums, that continued weight loss and weight maintenance required ongoing vigilance and “hard work.” Bariatric forums, as these individuals described, provided a degree of accountability, nonjudgmental understanding about

“bad days,” near-evil support for getting “back on track” (i.e., following the dietary protocols given by their clinicians), and promoted notions of personal responsibility. Thus, a collective fight against what can be seen as the stubborn ontology of fat itself also drives the formation of bariatric support groups.

When asked what it was about the groups that motivated them to change their behavior, the individuals interviewed for this study overwhelmingly stated that the patient forums provided information, advice, support, tips, and encouragement from other patients. Being able to hear from those who were bariatric “successes” seemed to be particularly helpful. As one individual put it,

You’ll always find someone there who has the same issue as you. The fact that you have people who have done so well attending the support groups makes me feel that I could be like that person . . . It just gives you motivation. (Denisa)

For these individuals, the accountability such spaces provided was a key factor in continuing to participate in online forums. For example, one participant stated that her weekday routine involved going to work and then going to the gym. When she got home, however, she was not sure how to occupy herself:

You start wandering. You know? There is nothing in my house that I can’t nosh on and be OK with because I only have healthy things to nosh on, at this point. But it was bothering me that I was doing that. So, if I whip out the computer and I go onto the website, and I get involved in that. It’s something to do. And, it reminds me where I am and what I’m doing, and you almost like kind of recommit to it. (Barbara)

As with this participant, knowing that they could connect with others online, day or night, provided motivation to continue working “with” their surgeries by choosing the right behaviors and avoiding temptation.

Contending With Regain: “It Will Contradict Everything that They’re Out There Touting”

Despite the ways in which patients motivated one another to “stay on track,” individuals who had found their weight creeping up over the years felt that there was sometimes a lack of true acknowledgment of the realities of regain after WLS. This lack of acknowledgment, they continued, prevented them from continuing to participate in both online and in-person patient forums. For example, in discussing her regain, one individual stated that her group was more effective in its support when she was doing well, but less so when she began to struggle. When asked how she felt about this, she said,

I’ll be honest with you, it angers me. It really does. Sometimes—I can’t believe I’m even going to tell you this, but sometimes—I think to myself, “You just wait, you just wait two years.” You
know, “When you start gaining it back, you’re going to need help.” I hate to admit that, but I get angry and I get upset. (Tania)

Naomi also experienced regain with her RYGB procedure and dropped out of the online group she founded because she no longer felt like a good example. When queried about whether or not the bariatric community adequately addressed the realities of regain, she stated that it did not. In explaining why this was the case, she stated,

Because it will contradict everything that they’re out there touting. That, “This is the way to lose weight if you are morbidly obese.” That “this is the way to lose weight.” That “this is a permanent fix.” And it’s not. (Naomi)

When asked what could be done to help remedy this problem, she stated that bariatric surgeons just needed to be “more honest” about the realities of weight maintenance and regain.

For some patients, regain led to redoubled efforts to work with the surgeries they had, often described as “going back to basics.” For others, it meant undergoing a surgical revision. For instance, Naomi had her surgery revised to the BPD/DS procedure and, despite having spent 18 months in the hospital because of revision-related complications, she was thrilled with the procedure. Another individual connected with a small number of patients in her area who had also regained weight and they hired a trainer to help them work out together. When asked if she would consider a revision, Naomi remarked that she preferred not to have one but would if she had to:

I went and spoke to the doctor that was doing my fills and he suggested that I have a revision. I don’t want to do that. I truly believe that it is a tool and you have to learn how to use it. And, if I didn’t learn how to use the LAP-BAND, then I don’t know that I’m going to learn how to use any of the other surgeries either. (Tania)

Thus, although some participants felt that both the bariatric profession and bariatric patient communities were silent about regain, they nevertheless fervently emphasized the importance of both support and individual responsibility for achieving bariatric success, particularly at moments when the achievement of such “success” was in question.

Factures in Bariatric Communities: “Forums a Lot of Times Bring Out the Worst in People”

In asking participants about the process of deciding to have surgery, many cited Google in their answers. Candice reported searching “what to do when you are obese” and came upon a bariatric website. Although participants varied in terms of how much they utilized these online spaces after surgery, all of them had heavily utilized online spaces while considering and researching surgery.

Unsurprisingly then, beyond general bariatric patient sites, there are a large number of surgery-specific forums and groups. As well, on some of the larger bariatric forums such as Obesity Help (OH), one can find highly specific sections, such those that are region specific and age group specific, forums aimed at initial starting BMIs, as well as those geared toward identity groups. Finally, there are topical forums on relationship issues like dating, marriage, and divorce after surgery. All of the participants interviewed for this study reported eventually gravitating toward those sites and forums that best suited their specific needs and identities. Irene sought out an online BPD/DS community because she was the only “DSer” at the in-person support groups in her area. Tired of having to explain her surgery to people, she found her community online.

Each and every individual who participated in this study currently visited and participated in the OH website or had done so in the past. As well, all participants cited OH as the first site or among the first sites visited when considering and researching bariatric surgery. Those individuals that still visited the site tended to gravitate toward procedure-specific subforums because many felt that the larger forums were now overrun with strife and conflict. Interestingly, both individuals who had had surgery nearly a decade ago and those who had had their surgeries more recently echoed the sentiment that the site was not what it used to be. Kaia referred to some of the subforums as “war zones” and said she felt bad for new preoperative patients that were now coming to these spaces looking for information. Another stated,

Those people on the forums—they’re crazy. Forums a lot of times bring out the worst in people. I really try to stay out and just, you know, cherry pick the good stuff. (Hanifah)

The general consensus among the participants was that the conflict centered around arguments about which surgeries were the best as well as how one should best “work with” a particular bariatric surgery postoperatively, in terms of what to do and what to avoid. As Kaia put it,

You can’t just go in there and ask a simple without getting some person that had the surgery eight years ago and thinks that they know everything just jumping in. (Kaia)

Despite the feeling that the tenor had changed, all of the participants that had utilized the OH site stated it had been invaluable to them, even if it was not a space that they currently participated in.

Divisions by Surgery Subtype: “Even in the Weight Loss Surgery Community, We Are Outsiders”

A number of participants indicated that online strife spilled over into the in-person conferences that OH held as well.
Often, these debates and conflict centered around surgery subtype. Nearly all of the participants who had had the BPD/DS procedure spoke readily and without prompting during the interviews about the discrimination they felt from other bariatric patients. One individual, who was interviewed approximately 6 weeks after she attended her first OH in-person event, stated that while being there she felt like an outsider:

I thought it was very oriented towards other surgeries than mine specifically. (Nina)

She, like many of the other participants who had had the BPD/DS procedure in this study, felt that because RYGB patients were the most numerous at the conference, workshops, information, and even the food served tended to cater to their interests and needs. But it was not just that BPD/DS patients felt ignored, rather they felt actively resented. Some BPD/DS participants even said that they felt actively hated by other bariatric patients. Upon inquiring why this might be the case, individuals who had the BPD/DS procedure stated again and again that other bariatric patients were “jealous.”

The BPD/DS procedure is both the most extreme and the riskiest of the bariatric procedures but is also associated with the most durable weight loss over time (Khan et al., 2015). As well, because of the malabsorption fat, BPD/DS patients can consume foods that other bariatric patients must heavily limit or avoid:

DSers understand where I’m coming from when I’m stuffing cheese in my face. RnYers think I’m crazy for eating the amount of calories I eat per day or eating the amount of fat that I eat per day. (Candice)

Although most BPD/DS patients speculated that jealousy over both the ability to eat fatty foods and maintain weight loss was at the heart of other bariatric patients’ jealousy, Katrina’s friend confided in her that this was in fact the case:

My friend, who’s a gastric bypass patient says, “. . . I’ll be honest, do you know why they don’t like you guys? . . . Because you can eat all of these things and as unhealthy as they are for us, they’re not for you because you don’t absorb it. So, yes, we’re pissed at you.” (Katrina)

Her friend also confessed that, had she known about the BPD/DS at the time she had undergone surgery, she would have chosen that procedure instead of the RYGB.

Feelings of resentment, envy, and hatred from other bariatric patients represented one of the primary reasons that individuals who had had the BPD/DS procedure formed surgery-specific subgroups, both online and in person. Katrina said that she had been told by other bariatric patients that BPD/DSers had uncontrollable diarrhea and emitted a foul odor:

I was like, “No, we have poop that smells. But, then again the last time I checked nobody pooped roses.” There’s so much ignorance! (Katrina)

Nina had been told that BPD/DS patients chose their surgeries because they were unwilling to change their eating habits. She described the effect of this in the following manner:

So even in the weight loss surgery community we are outsiders ourselves. I think that’s why we stick together so much. (Nina)

And although most BPD/DS patients felt angry that they were outcasts in the larger bariatric communities, some expressed sadness:

We’re all in this together. We’re all people who used to be heavy. There should be some kind of like brother and sisterhood. (Irene)

Although LAGB patients interviewed for this project did not report feelings of being isolated or having experienced discrimination, it was clear from this investigation that this procedure is very much maligned by patients who have had other surgeries. In fact, almost all of the participants interviewed for this project that had had other forms of bariatric surgery, particularly those who had revised from the LAGB to another procedure, stated how “awful” the adjustable gastric band surgery was—in terms of both side effects and regain. Although they did not discuss coming together around feeling isolated by other patients, LAGB patients did discuss the fact that the particularities of living with a medical device drove their desire to congregate with one another. More specifically, it was particular experience of living with adjustments that fueled a desire to connect with other band patients:

Unless you have a band, you cannot possibly understand that you cannot get food down, or the tightness you feel in your chest. You only get that in the support group. I can’t really talk about that with other people in my life. My boyfriend will say, “Well, just get loosened.” That’s not the answer. It’s not just to get loosened because then, I’ll always be loose. I have to figure out a way to work around my restriction. Only another band patient will know what that means, will know what that feels like. (Denisa)

Similarly, Talia stated that LAGB adjustments were not an “exact science” and so there was a day-by-day relearning of what worked, what did not, and what to do about it. Connecting with other gastric banding patients was especially helpful because they could help each other figure out what was going on.

**Rifts Over Reconstructive Plastic Surgery: “They Cross Into the Skinny Girl Category”**

Rapidly losing a large amount of weight typically results in substantial, residual loose skin. Some tightening of this
excess skin can occur over time and through exercise, particularly for younger patients whose skin is more elastic. However, older patients and those individuals who lose a very large amount of weight are typically left with significant excess skin, something that makes them appear larger than they actually are.

The issue of loose skin was a topic of much angst and upset for many of the women interviewed for this study, particularly when it came to sex and dating. Sarah spoke of the difficulties that she felt her loose skin presented in dating now that she was separated from her husband:

The sex thing is difficult because I now have all this hanging skin. Before, everything was firm. Now it’s a little nerve-racking, especially the first time. (Sarah)

Another participant remarked that her husband had not seen her naked since shortly after she had her procedure nearly a year ago. And Talia was cognizant of the fact that her partner preferred the way her body looked and felt before surgery, even though she was also thrilled that Talia’s health had improved. Although the dramatic transformation that WLS entails does provide patients with increased confidence about their overall appearance, substantive ambivalence neverthe-less surrounds bariatric patients’ experience with weight loss and body image.

Unlike bariatric surgery itself, reconstructive surgeries are rarely covered by private insurance in the United States with the exception of the panniculectomy, which removes excess skin from the abdomen. However, even this procedure is only approved by private insurance carriers after a patient has provided substantial documentation from medical professionals, such as dermatologists, of medical need (e.g., rashes being caused by hanging skin). None of the participants interviewed for this study had undergone reconstruc-tive plastic surgery, though many hoped to have it at some point in the future. For most of them, reconstructive plastic surgeries either were completely out of their reach financially or would take a long time to save up for. Based on the data collected for this project, economic access to recon-structive plastic surgery (or lack thereof) seemed to be another dividing point within bariatric communities.

One individual stated that there were two types of women who attended her bariatric support group:

The women who have plastic surgery now have these great bodies that were reconstructed and now can wear bikinis and can wear mini-skirts and can wear tight dresses. Then there’s the women who lose weight and still have all of this excess skin and they still need to be conservative with their dressing. (Nina)

When asked how this affected the dynamics between community members, she stated that those with access to plastic surgery crossed over into the “skinny girl category” and became the source of intimidation and envy for others. Discussing how this made her feel, she continued,

[E]ven though you had surgery, you still feel out of place . . . you feel like you don’t fit in. (Nina)

One participant stated that envy that other women felt toward those who better “pass” because either they had had reconstructive surgery or they did not have much loose skin to contend with after weight loss was palpable. In discussing her first OH event, she recalled the great hostility she felt from others:

It was just so odd, because I felt like I was being discriminated [against] . . . I heard a woman saying, “What is that girl doing here? This is not the event for her, you know, looking like a model like that. She probably doesn’t even know what being fat a day in her life is like.” (Katrina)

She stated that she was shocked by this remark and decided to confront the woman behind her:

I turned around and I said, “Actually I lost 212 pounds. Now [it’s] 190, because I have gained weight back.” And she looked at me and she was like, “Yeah, you probably had major plastic surgery.” It was almost bickering and I’m like, “Actually I haven’t, and I had a baby three months ago.” I mean it was almost like I had to defend myself! (Katrina)

She surmised that women who chastised her had “failed” WLS (i.e., had regained a substantial amount of weight due to noncompliance) and were thus miserable and envious of her success. She described their feelings of envy as “Why me and not you?” Although she could understand this, as she was once an LAGB patient who had not lost a significant amount of weight before converting to the BPD/DS, she believed the women who were jealous had a responsibility to take action like she did and have a revision.

**Discussion**

This study finds that a number of factors push bariatric patients together and work to create bariatric biosocial communities. First, bariatric patients shared a set of highly salient experiences: having been medically classified as obese or severely-obese, having a long history of unsuccessful dieting, being significantly concerned over current and future health risks, undergoing bariatric surgery, losing a significant amount of weight in a relatively short period of time, and making substantial life adjustments required to live with a WLS procedure. Second, echoing Throsby’s (2008a) findings, online and in-person bariatric patient-led forums arise as spaces in which individuals help one another navigate the realities of postoperative life, including side
effects, complications, and regain. Because the work of living with a bariatric procedure is ongoing, for many patients the need to connect with others who have been there, particularly long-time patients, becomes necessary. As Schaffer et al. (2008) suggest, the advice participants in health-based forums provide one another is “viewed as reliable because it [is] based on extensive biomedical research and real-life experiences” (p. 151) Third, bariatric patients are drawn together around the lack of (or perceived lack of) adequate postoperative support at home surgical clinics as well as inadequate medical knowledge about the particularities of bariatric bodies from providers. Participants in health-based forums must learn how to understand, evaluate, and communicate medical and scientific information to medical providers so that they are taken seriously (Schaffer et al., 2008). And finally, unquestionably the rise of biosocial community and kinship has been fueled by the digital era. As many scholars have documented (Advocat, 2009; Novas, 2006; Parr, 2002; Rapp & Ginsburg, 2001; Rose & Novas, 2005; Schaffer et al., 2008), the internet facilitates points of contact, the exchange of support and information, and the formation of kinship across geographical boundaries as well as within specific locales. The results of this study thus confirm but also expand Boero’s (2012) findings regarding the shared experiences that help create bariatric communities.

Moreover, this study also finds that as biosocial community comes together around these commonalities, other differences emerge and create lines of conflict. First, fueled by tremendous fear and anxiety over regain, tensions exist around surgery type. Although bariatric surgery is a far more durable method of weight loss than is dieting, regain is nevertheless common within the bariatric patient population (Christou et al., 2006; Magro et al., 2008; Shah et al., 2006; Sjöström et al., 2004), though the amount does vary by procedure (Sjöström et al., 2004). Concerns over regain are shaped not only by the likely possibility of this outcome, but also by a larger sociopolitical context of neoliberal healthism. Here, neoliberal healthism (Crawford, 1977, 2006; Metzl, 2010) refers to a set of societal discourses which assert that individuals are rational, self-determining actors who can and should make their own best choices in the marketplace. They are therefore responsible for their own life chances and health outcomes. Even more particularly, fears and anxieties over regain are informed by a climate of substantial and increasing weight-based stigma and discrimination (Puhl & Brownell, 2001; Puhl & Heuer, 2009, 2010). Notably, weight-based stigma and discrimination are topics that each and every participant discussed as characterizing their preoperative lives. Throsby (2008b) argues that the internalization of neoliberal discourse by patients contributes to the withdrawal of those who regain weight from support forums. This was evident in this investigation as well. Yet, this study also found that regain, or fear thereof, seemed to result in patients’ (at least expressed) recommitment to bariatric surgery in general and the lauding of their particular procedures in specific. A final area of rupture in bariatric communities is reconstructive plastic surgery. Those who have had the economic access to reconstructive surgery—or are perceived to have had such access—become objects of envy for those who lack the same economic privilege.

Lemke (2015) has offered a number of useful critiques on work taking up Rabinow’s concept of biosociality. A few are of particular note. First, according to Lemke, the literature on biosociality has tended to promote a form of “political optimism” by focusing on the ways in which patient advocacy and self-help groups produce “new forms of participation and democratic action subverting the dividing line between lay and expert knowledge” (p. 191). Second, this literature focuses on alliances made by individuals fighting for medical solutions to health problems but has tended to ignore oppositional groups. Finally, Lemke argues that Rabinow was careful to stress that new forms of biodisciplinarity did not supersede older cultural classifications, but rather they would coexist, in a “reciprocal interaction.” The findings of this study speak to many of Lemke’s (2015) critiques. Specifically, this study has shown that emotions of envy, anxiety, ambivalence, and hate thus work alongside mainstream and sexist beauty norms, class-based inequalities, neoliberal rhetorics of responsibility for health, the physiology of the body, bariatric surgeries themselves, and digital technologies to both push bariatric patients together and to pull them apart.

There are a number of limitations to this investigation. First, the data were collected between 2011 and 2013, which may restrict the findings. Second and relatedly, as some authors have noted (Koball et al., 2017; Martins et al., 2015), bariatric patients may now be connecting via social media sites such as Facebook rather than websites such as OH. Nevertheless, sites like OH continue to have high traffic use and thus the conclusions drawn in this study about online WLS patient communities may still be relevant (Mele Erwin, 2019). Third, the sample was overwhelmingly female and based in the New York City Greater Metropolitan Area of the United States. The bariatric patient population, however, is itself largely female (Bhogal et al., 2015; Pratt et al., 2009) and Poulose et al. (2005) found that, within the United States, rates of bariatric procedures per 100,000 are highest among women in the Northeast. Future research is nevertheless necessary to explore how popular forms of social media such as Facebook and Instagram may be impacting the ways in which bariatric patients connect and interact online. As well, future studies should include a more diverse group of participants to better explore how patients’ backgrounds may shape their experiences with online and in-person bariatric support forums. Finally, the author takes note of Whyte’s (2009) critique that the focus on emergent health identities runs the risk of overemphasizing the importance of biosocial connections in the lives of those who participate in diagnosis-specific forums. In line with Whyte’s critique, participants interviewed for this study did vary greatly in terms of
how frequently and how deeply they participated in bariatric communities (online, in person, or both) after having surgery. With that said, although some of the individuals interviewed for this study did not participate in bariatric communities frequently, the connections they made were nevertheless important precisely because they did not extend into the other areas of their lives. In this sense, although relationships with other bariatric patients were not central to the lives of some participants, they were nonetheless very significant to them. And they were significant because the particular set of physiological, psychological, physical, and social experiences bariatric patients undergo and continue to live with may not be shared with the key individuals in their lives. Ironically, then, this distance allows patients to share highly personal and sensitive information about their lives and get support—something they cannot get from or do with those with whom they are otherwise most close. Despite these limitations, this investigation provides insight into the experiences of bariatric patients and the reasons why they seek similarly situated others out in online and in-person support forums.

**Conclusion**

This study has found that the desire to transform the fat body through surgical means and the experience of doing so is an axis around which bariatric patients interact, create identity and community, and collectively negotiate the ongoing requirements—and responsibilities—of living with a bariatric procedure. However, just as a number of forces cohere to push bariatric patients together, other conditions pull them apart, creating tensions and divisions, and driving the formation of very specific subgroups. Biosocial community around bariatric surgery should not, in this sense, be thought of as a coherent and harmonious whole. Rather, this form of biosociality can be seen as centered around both commonality and alliance as well as conflict and division. These ruptures are, in turn, shaped by a larger sociopolitical context of neoliberal healthism, discrimination, and inequality. Overall, this investigation finds that bariatric biosocialities are spaces in which bariatric patients work toward the achievement of normative standards of health and appearance, but always in ways that reflect highly complex, sometimes divergent and conflictual, and often ambivalent frameworks of understanding and experience.

**Acknowledgment**

The author is grateful to the anonymous reviewers who provided helpful comments on earlier versions of this paper. The paper is much improved thanks to their feedback.

**Declaration of Conflicting Interests**

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

**Funding**

The author(s) received no financial support for the research, authorship, and/or publication of this article.

**ORCID iD**

Zoë C. Meleo-Erwin https://orcid.org/0000-0003-3099-1266

**Notes**

1. This increase in the 55+ age range is partially explained by the decision of The Center for Medicare and Medicaid Services (CMS) development of guidelines, accreditation, and coverage standards for bariatric surgery in 2006.

2. For example, O’Brien et al. (2006) report that patients who have had the Roux-en-Y gastric bypass (RYGB) procedure have a mean excess weight loss (EWL) of 67% in Year 1 and 67% in Year 2. For laparoscopic adjustable gastric banding (LAGB) patients, the mean EWL in Year 1 is 42% and 53% in Year 2. The general consensus in the literature is that the vertical sleeve gastrectomy (VSG) results in less long-term EWL than the RYGB but more than the adjustable gastric banding procedure (Ali et al., 2017). The biliopancreatic diversion with duodenal switch (BPD/DS) is associated with the greatest weight loss but is also the most complicated procedure to perform and can result in long-term nutritional deficiencies (Kim, 2016). Excess body weight is calculated with reference to a body mass index (BMI) of 25.

3. According to a (August 2019) search on the American College of Surgeons (ACS) website, currently there are 832 Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP)-Accredited Bariatric Surgery Centers in the United States (ACS, n.d.).

4. Following the tradition of Fat Studies and Critical Obesity Studies, the term “obesity” is used to refer the medical and public health framing of higher body weights as an indicating state of chronic disease, whereas “fat” is used as a neutral descriptor of body size, similarly to how “tall” might be used as a neutral descriptor of height.

5. The Centers for Disease Control (2016) define obesity as a BMI of 30 < 35. A BMI of 40 or higher is sometimes known as “extreme” or “severe” obesity.

6. Perhaps because the majority of the participants were recruited by other participants, none of the individuals who contacted me were deemed ineligible for participation based on the screening questionnaire. However, one individual was preoperative at the time the screener was first conducted. Given that her surgery was scheduled (and did in fact occur) within 3 months of the original screening, a decision was made to interview her briefly before her surgery and then again, a few months afterward.

7. In total, 87% of the participants had conducted online research prior to surgery and 83% had visited online support groups prior to surgery. Postoperatively, 76% visited online support forums and 66% had attended in-person support groups and/or bariatric conferences. Of those who participated in support groups online postoperatively, there was a substantial variation in terms of frequency, with some individuals signing on daily after work and others signing on only occasionally, particularly when encountering challenges or needing information.
8. Getting food stuck in the esophagus, known as “plugging,” after the LAGB procedure is often due to patient behavior, such as eating beyond satiety. However, the procedure itself, particularly when the LAGB is tightly filled with saline, can also cause this phenomenon. In such instances, patients can often consume “slider foods,” such as smoothies or processed white bread products, but not items such as a baked chicken breast or broccoli. In that regard, both patient behavior and the mechanism of the device itself can lead to regurgitation.

9. Revision bariatric surgery (either fixing a previous bariatric surgery or converting from one surgery to another) following regain and/or complications has become commonplace and reoperative procedures are associated with higher rates of adverse events than are the original surgeries (Brethauer et al., 2014). Among the participants in this study, 10% had had revisions and at least two others were considering it. With the exception of one individual (who revised from an RYGB to a BPD/DS), all of the participants who had had or were considering revision were LAGB patients who were frustrated with insufficient weight loss, regain, and/or complications from the device.

10. The Roux-en-Y has been considered the gold standard of bariatric procedures and is much older than the LAGB or VSG, although versions of gastric banding had been performed previously (Batchelder et al., 2013). As well, the duodenal switch is not commonly performed because of the complicated and potentially high-risk nature of the surgery (Khan et al., 2015). For all of these reasons, RYGB patients tend to be the most populous in general bariatric forums, both online and in person, thought they are now likely being outpaced by vertical gastric sleeve patients, as this has become the most commonly performed surgery in the United States (Nguyen et al., 2011, 2013).

11. Although the cost of out-of-pocket procedures varies by the experience, prestige, and geographic location of a plastic surgeon (American Society of Plastic Surgeons, n.d.), it is safe to say that a postoperative bariatric patient who was looking to have multiple skin removal surgeries done would face tens of thousands of dollars in out-of-pocket costs. Furthermore, in addition to surgeon’s fees, a self-pay patient would also be responsible for hospital/surgical facility costs, anesthesia fees, and specialty garments to reduce postoperative swelling and might also be responsible for costs associated with pre- and postoperative medical tests and prescription drugs, such as pain medication and/or antibiotics (American Society of Plastic Surgeons, n.d.). In this sense, both socioeconomic inequality and insurance carrier practices limit access to reconstructive plastic surgery for bariatric patients, leaving them to contend with the physical and psychological challenges of excess skin.

References

Advocat, J. (2009). Internet clinical trials: Examining new disciplinary experiments in health care. *Anthropology Matters*, 7(1), 1–8.

Agency for Healthcare Research and Quality. (2007, January 10). *Obesity surgeries have jumped dramatically since 1998* [Press release]. https://archive.ahrq.gov/news/press/pr2007/obesjump.htm

Ali, M., Chaar, M. E., Ghiassi, S., & Rogers, A. M. (2017). American Society for Metabolic and Bariatric Surgery updated position statement on sleeve gastrectomy as a bariatric procedure. *Surgery for Obesity and Related Diseases*, 13(10), 1652–1657.

American College of Surgeons. (n.d.). https://www.facs.org/search/bariatric-surgery-centers?allresults=

American Society for Metabolic and Bariatric Surgery. (2007). *Benefits of bariatric surgery*. http://asmb.org/benefits-of-bariatric-surgery

American Society for Metabolic and Bariatric Surgery. (2018). *Estimate of bariatric surgery numbers, 2011-2017*. https://asmb.org/resources/estimate-of-bariatric-surgery-numbers

American Society of Plastic Surgeons. (n.d.). https://www.plastic-surgery.org/reconstructive-procedures/panniculectomy/cost

Batchelder, A. J., Williams, R., Sutton, C., & Khanna, A. (2013). The evolution of minimally invasive bariatric surgery. *Journal of Surgical Research*, 183, 559–566.

Beck, N. N., Johannsen, M., Stoving, R. K., Mehlsen, M., & Zachariae, R. (2012). Do postoperative psychotherapeutic interventions and support groups influence weight loss following bariatric surgery? A systematic review and meta-analysis of randomized and non-randomized trials. *Obesity Surgery*, 22(11), 1790–1797.

Bhogal, S. K., Reddigan, J. I., Rotstein, O. D., Cohen, A., Glockler, D., Tricco, A. C., . . . Jackson, T. D. (2015). Inequity to the utilization of bariatric surgery: A systematic review and meta-analysis. *Obesity Surgery*, 25(5), 888–899.

Biehl, J. G. (2005). *Vita: Life in a zone of social abandonment*. University of California Press.

Biltekoff, C. (2007). The terror within: Obesity in post 9/11 U.S. life. *American Studies*, 48(3), 29–48.

Boero, N. (2012). *Killer fat: Media, medicine, and morals in the American “obesity epidemic.”* Rutgers University Press.

Bradley, L. E., Sarwer, D. B., Forman, E. M., Kerrigan, S. G., Butryn, M. L., & Herbert, J. D. (2016). A survey of bariatric surgery patients’ interest in postoperative interventions. *Obesity Surgery*, 26(2), 332–338.

Brethauer, S. A., Kothari, S., Sudan, R., Williams, B., English, W. J., Brengman, M., . . . Morton, J. M. (2014). Systematic review on reoperative bariatric surgery, American Society for Metabolic and Bariatric Surgery Revision Task Force. *Surgery for Obesity and Related Diseases*, 10, 952–972.

Brown, P., Zavestoski, S., McCormick, S., Mayer, B., Morello-Frosch, R., & Gasior Altman, R. (2004). Embodied health movements: New approaches to social movements in health. *SocioLOGY of Health & Illness*, 26(1), 50–80.

Centers for Disease Control. (2016). *Defining adult overweight and obesity*. https://www.cdc.gov/obesity/adult/defining.html

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. SAGE.

Christou, N. V., Look, D., & MacLean, L. D. (2006). Weight gain after short-and long-limb gastric bypass in patients followed for longer than 10 years. *Annals of Surgery*, 244(5), 734–740.

Compher, C. W., Hanlon, A., Kang, Y., Elkin, L., & Williams, N. N. (2012). Attendance at clinical visits predicts weight loss after gastric bypass surgery. *Obesity Surgery*, 22(6), 927–934.

Crawford, R. (1977). *You are dangerous to your health: The ideology and politics of victim blaming*. *International Journal of Health Services*, 7(4), 663–680.

Crawford, R. (2006). *Health as a meaningful social practice*. *Health, 10*(4), 401–420.
Meleo-Erwin, Z. (2019). “No one is as invested in your continued good health as you should be”: An exploration of the post-surgical relationships between weight-loss surgery patients and their home bariatric clinics. *Sociology of Health and Illness*, 41(2), 285–302.

Nguyễn, N. T., Masoomi, H., Magno, C. P., Nguyễn, X. M., Lauenou, K., & Lane, J. (2011). Trends in the use of bariatric surgery, 2003-2008. *Journal of the American College of Surgeons*, 213(2), 261–266.

Nguyễn, N. T., Nguyễn, B., Gebhart, A., & Hohmann, S. (2013). Changes in the makeup of bariatric surgery: A national increase in use of laparoscopic sleeve gastrectomy. *Journal of the American College of Surgeons*, 216(2), 252–257.

Novas, C. (2006). The political economy of hope: Patients’ organizations, science and biovalue. *Biosocieties*, 1(3), 289–305.

Obeid, N. R., Malick, W., Baxter, A., Molina, B., Schwack, B. F., & Fielding, G. A. (2016). Weight loss outcomes among patients referred after primary bariatric procedure. *Journal of the American College of Surgeons*, 212(1), 69–75.

O’Brien, P. E., McPhail, T., Chaston, T. B., & Dixon, D. B. (2006). Systematic review of medium-term weight loss after bariatric operations. *Obesity Surgery*, 16(8), 1032–1040.

Paolino, L., Genser, L., Fritsch, S., de’ Angelis, N., Azoulay, D., & Lazzati, A. (2015). The web-surfing bariatric patient: The role of the internet in the decision-making process. *Obesity Surgery*, 25, 738–743.

Parr, H. (2002). New body-geographies: The embodied spaces of health and medical information on the internet. *Environment and Planning*, 20(1), 73–96.

Petryna, A. (2004). Biological citizenship: The science and politics of Chernobyl-exposed populations. *Osiris*, 19, 250–265.

Poulose, B. K., Holzman, M. D., Zhu, Y., Smalley, W., Richards, W. O., Wright, J. K., . . . Griffin, M. R. (2005). National variations in morbid obesity and bariatric surgery use. *Journal of the American College of Surgeons*, 201(1), 77–84.

Pratt, G. M., Learn, C. A., Hughes, G. D., Clark, B. L., Warthen, M., & Pories, W. (2009). Demographics and outcomes at American Society for Metabolic and Bariatric Surgery Centers of Excellence. *Surgical Endoscopy*, 23(4), 795–799.

Puhl, R. M., & Brownell, K. D. (2001). Bias, discrimination, and obesity. *Obesity Research*, 9(12), 788–805.

Puhl, R. M., & Heuer, C. A. (2009). The stigma of obesity: A review and update. *Obesity*, 17(5), 941–964.

Puhl, R. M., & Heuer, C. A. (2010). Obesity stigma: Important considerations for public health. *American Journal of Public Health*, 100(6), 1019–1028.

Rabinow, P. (1996). *Essays in anthropology of reason* (pp. 91–111). Princeton University Press.

Rapp, R., & Ginsburg, F. D. (2001). Enabling disability: Rewriting kinship, reimagining citizenship. *Public Culture*, 13(3), 533–556.

Rose, N., & Novas, C. (2005). Biological citizenship. In A. Ong & S. J. Collier (Eds.), *Global assemblages: Technology, politics, and ethics as anthropological problems* (pp. 439–463). Blackwell Publishing.

Saguy, A. C., & Almeling, R. (2008). Fat in the fire? Science, the news media, and the obesity epidemic. *Sociological Forum*, 23(1), 53–83.

Saguy, A. C., & Riley, K. W. (2005). Weighing both sides: Morality, mortality, and framing contests over obesity. *Journal of Health Politics, Policy and Law*, 30(5), 869–923.

Schaffer, R., Kuczynski, K., & Skinner, D. (2008). Producing genetic knowledge and citizenship through the internet: Mothers, pediatric genetics, and cybermedicine. *Sociology of Health & Illness*, 30(1), 145–159.
Scheper-Hughes, N. (2004). Parts unknown: Undercover ethnography of the organs-trafficking underworld. *Ethnography*, 5(1), 29–73.

Shah, M., Simha, V., & Garg, A. (2006). Long-term impact of bariatric surgery on body weight, comorbidities, and nutritional status. *Journal of Clinical Endocrinology & Metabolism*, 91(11), 4223–4231.

Sharman, M., Hensher, M., Wilkinson, A. M., Williams, D., Palmer, A., & Ezzy, D. (2015). What are the support experiences and needs of patients who have received bariatric surgery? *Health Expectations*, 20, 35–46.

Sjöström, L., Lindroos, A. K., Peltonen, M., Torgerson, J., Bouchard, C., & Sjöström, C. D. (2004). Lifestyle, diabetes, and cardiovascular risk factors 10 years after bariatric surgery. *New England Journal of Medicine*, 351, 2683–2693.

Spaniolas, K., Kasten, K. R., Celio, A., Burruss, M. B., & Pories, W. J. (2016). Postoperative follow-up after bariatric surgery: Effect on weight loss. *Obesity Surgery*, 26, 900–903.

Sundbom, M. (2014). Laparoscopic revolution in bariatric surgery. *World Journal of Gastroenterology*, 20(41), 15135–15143.

Throsby, K. (2008a). Happy re-birthday: Weight loss surgery and the “new me.” *Body & Society*, 14(1), 117–133.

Throsby, K. (2008b). “That’s a bit drastic”: Risk, blame in accounts of obesity surgery. In F. Alexander & K. Throsby (Eds.), *Gender and interpersonal violence: Language, action and representation* (pp. 83–99). Palgrave Macmillan.

Walkerdine, V. (2009). Biopedagogies and beyond. In J. Wright & V. Harwood (Eds.), *Biopolitics and the “obesity epidemic”: Governing bodies* (pp. 199–207). Taylor & Francis.

Whyte, S. R. (2009). Health identities and subjectivities. *Medical Anthropology Quarterly*, 23(1), 6–15.

**Author Biography**

Zoë C. Meleo-Erwin is a qualitative health researcher who examines the ways in which digital technologies facilitate the creation of both identity and community around health and illness. Her primary research explores how individuals decide to have weight loss surgery, pre- and post-surgical experiences of embodiment, and the post-operative relationship between weight loss surgery patients and their home surgical clinics. Her research interests include health disparities, structural determinants of health, weight-based stigma, food-based health movements, and decision-making around vaccination.