

EMPIRICAL STUDIES

“My quality of life is worse compared to my earlier life”

Living with chronic problems after weight loss surgery

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Abstract

Weight loss surgery is commonly regarded as improving individuals' health and social life, and resulting in a happier and more active life for those defined as “morbidly obese.” However, some researchers have started to doubt whether these positive outcomes apply to everyone and this article explores this doubt further. More specifically, we focus on the experiences of women whose life situation became worse after weight loss surgery. The material draws on qualitative interviews of five Norwegian women undergoing the irreversible gastric bypass procedure. Our findings illustrate that the women lived seemingly “normal” lives prior to the surgery with few signs of illness. Worries about future illness as well as social stigma because of their body shape motivated them to undergo weight loss surgery. After the surgery, however, their situation was profoundly changed and their lives were dramatically restricted. Chronic pain, loss of energy, as well as feelings of shame and failure for having these problems not only limited their social lives but it also made them less physically active. In addition, they had difficulties taking care of their children, and functioning satisfactorily at work. Accordingly, the women gradually felt more “disabled,” regarding themselves as “outsiders” whose problems needed to be kept private. The results highlight some “subtle” consequences of weight loss surgery, particularly the shame and stigma experienced by those whose lives became dramatically worse. Living in a society where negative impacts of weight loss surgery are more or less neglected in research as well as in the public debate the women seemed to suffer in silence. Their problems were clearly present and felt in the body but not talked about and shared with others.

Key words: Obesity, weight loss surgery, women, chronic illness, health

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Introduction

Obesity is regarded as a modern lifestyle problem, causing severe illness such as cancer, diabetes, and heart problems as well as stigma, discrimination, and psychological problems (Carr & Friedman, 2005; Ferraro & Kelly-Moore, 2005; Malterud & Tonstad, 2009). To avoid these problems, individuals with a BMI greater than 25 are strongly advised to lose weight (Fogelholm & Kukkonen-Harjula, 2000; Jain 2005). Obtaining weight loss often requires professional treatment. In particular, patients diagnosed as “morbidly obese” are offered dietary advice, behavioral skills training and regular exercise organized by health professionals (Ogden, 2006). Traditional lifestyle interventions produce good initial weight loss,

but follow-up studies indicate that the lost weight is regained (Christiansen, Bruun, Madsen, & Richelsen, 2007). In real terms nearly 95% of those who lose weight by means of lifestyle interventions regain it within a few years (Greenberg & Robinson, 2009).

In light of the failure of traditional interventions, an increasing number of individuals are offered surgery. In the United States, the number of weight loss surgeries increased by nearly 450% between 1998 and 2002, and doubled between 2002 and 2004 to more than 125,000 adults (Wysoker, 2005). This pattern can also be seen in Scandinavian countries, and in Norway the number of weight loss surgeries increased from 400 in 2005 to 1200 in 2007 (Social and Health Department of Norway, 2007). In order to be regarded as eligible to undergo weight loss

surgery, one must generally have a BMI greater than 35, have one or more obesity related comorbidities (such as diabetes, sleep apnea, mobility restrictions, emotional distress), and/or have repetitive experiences of weight cycling (Aasheim, Mala, Søvik, Kristinsson, & Bøhmer, 2007; Hoffman, 2010; Murray, 2008). Jane, who is quoted in the title of this article, is a 48-year-old Norwegian woman whose life became worse after weight loss surgery. In the interview, she compared her current situation with her life 3 years previously. In particular, she experienced that the onset of several symptoms gradually made her chronically ill, restricting her life dramatically. She is not the only one with such experiences after weight loss surgery. During our study on the experiences of individuals undergoing gastric bypass operations, 5 of our 22 participants lived with severe health problems that they claimed were caused by the surgery. The phenomena that these individuals' lives had changed radically to the worse made a strong impression on us. Their lives had been profoundly altered and they felt "trapped" in a situation that they were struggling to deal with and adapt to. In reviewing the literature, however, such "worse life experiences" were hard to come by. On the contrary, we found hundreds of articles focusing on the *positive* aspects of weight loss surgery. According to these studies, surgery was regarded not only as the most "effective" treatment in terms of rapid and dramatic weight loss, but it also seemed to prevent weight gain within the first years after surgery (Buchwald, 2002; Buchwald, Avidor, Braunwald, Jensen, & Schoelles, 2004; Jain, 2005). Moreover, the dramatic weight loss was associated with a reduction in diabetes and hypertension (Puzziferri, Blankenship, & Wolfe, 2006). Numerous studies have also reported positive changes in terms of quality of life within the first 5 years after surgery (De Zwann, Lancaster, & Mitchell, 2002; Ogden, Clementi, Aylwin, & Patel, 2005). By comparison, few scholars have explored how individuals describe the impact of surgery on their lives. Bocchieri, Meana, and Fisher (2002) as well as Magdaleno, Chaim, and Turato (2010) concluded that their participants highlighted many positive consequences of surgery. The participants considered the process as one of "being reborn." In a similar vein, Ogden (2006) underscored how dramatic weight loss after surgery resulted in improved psychological health. Furthermore, improvements in psychological health appeared to generalize to other areas of life, "enhancing the participants' psychosocial functioning," according to Ogden's conclusions (pp. 289–290).

Taken together, these studies seem to picture surgery as a turning point in the patients' lives, indicating that life will be significantly improved

in terms of health, social, physical, and mental well-being compared to previously. A similar pattern can be traced in the public arena. Newspapers, magazines, web pages, as well as personal autobiographies consistently use before and after photos to illustrate the "new me" as fundamentally distinct from the previously "fat self" (Salant & Santry, 2006). Moreover, weight loss surgery is commonly presented as the "only" option if "obese" persons want to prevent major illness and lose weight on a permanent basis (Hoffman, 2010). However, as Throsby (2009) points out, the presumed transition from a pathological existence to a vital, active, and healthy life does not necessarily mean that the surgery is an uncomplicated procedure. For those who have tried all other options, surgery still carries significant risks. According to recent studies, nearly 20% of the patients report having chronic side effects such as infection, malnutrition, internal bleeding, vomiting, diarrhea, tremor, pain, and other intestinal and digestive problems (Buchwald et al., 2004; Maggard et al., 2005). Moreover, 2.2% of the patients have been reported to need reoperation due to various complications (Sjöström et al., 2004). These quantitative studies indicate that some patients might experience severe sufferings after weight loss surgery. In this article, we will explore how chronic side effects and complications are experienced from a first-person perspective. And if we return to Jane, she sets the tone for our research questions. Additionally, four other women have paved the ground for our interest in "worse life" experiences after weight loss surgery. Our focus in this article is to further illuminate how these "worse life experiences" are expressed and lived. We do this by focusing primarily on the individual's own accounts, as they expressed them in qualitative in-depth interviews. More specifically, we ask how these "worse life experiences" came about, as accounted for by the women themselves. Additionally, we explore how increasing health problems after the operation acquired significance in the women's lives, including their relations to others.

Methodological approach

In line with our research questions, we have chosen a methodological approach that values the first-person perspective. Swedish philosopher Svenaeus (2000) offers a perspective grounded in the writings by Hans Georg Gadamer. In particular, Svenaeus refers to Gadamer's emphasis on health as a phenomenon inseparable from the individual's own perspective:

Health is not a condition that one introspectively feels in oneself. Rather it is a condition of being there, of being in the world, of being together with other people, of being taken in by an active and rewarding engagement with the things that matter in life. ... It is the rhythm of life, a permanent process in which equilibrium re-establishes itself. This is something known to us all. (Gadamer, 1996, p. 145)

In these suggestions, health is described as a process of self-reestablishing equilibrium as well as being involved with things that matter in life. To be healthy involves being together with other people in a cultural world, and this world is characterized by being relational. Another philosopher who is well known for his relational emphasis is Merleau-Ponty (2002) who points to our existence as bodies directed to the world. This perspective is based on the body as our primary means of experiencing the world. As body-subjects we move around, perceiving our surroundings. In its directedness toward the world, the body exhibits a bodily intentionality. Not only do we constantly find ourselves within the world, but we continually move toward the world and organize it in terms of projects, and so forth (pp. 101–123). Hence, the body is relational in the sense that it is inseparably connected to its surroundings, as aptly expressed in the following extract:

But we have learned in individual perception not to conceive our perspective views as independent of each other; we know that they slip into each other and are brought together finally in the ting... In reality, the other is not shut up inside my perspective in the world, because this perspective itself has no definite limits, because it slips spontaneously into the other's, and because both are brought together in the one single world. (p. 411)

As indicated here, subjective experiences are understood as both individual and relational at the same time, which might be of relevance when exploring the impacts of bodily change in conjunction with weight loss surgery. When a person loses a considerable amount of weight, she is likely to become visible in new ways. However, it is not only the individual's outward appearance that is likely to change after weight loss surgery. Indeed, the gastric bypass procedure performed on the women in our study also alters the viscera of the body in terms of anatomy and physiology.¹ To gain an insight into these changes we will be drawing on Drew Leder's perspective of the "inner" body. According to Leder

(1990), our inner body tends to be absent in everyday life. More specifically, he points to the taken-for-granted experience of the viscera when we are healthy and feeling well. When we become ill, however, our experience of the inner body is likely to change. As Leder argues, chronic illness involves the body as a functional unity including both visceral functions and the surface body. However, the two layers are different in terms of perception. The "inner" body—comprising the visceral organs—have a greatly decreased number and variety of sensory receptors compared to the surface body, as well as a limited repertoire of motor responses (pp. 21–39). In this sense, the inner body is regarded as an "ambiguous space" largely unavailable to our conscious awareness and command.

In line with the phenomenological perspectives outlined above, Svenaeus argues that illness might be regarded as an obstruction health. Everything that goes on without paying attention to it when one is healthy—walking, thinking, eating—now offers resistance. More specifically, he points to the ill body as being the "out of tune" colored by feelings of pain, weakness, and helplessness (p. 97). Svenaeus suggests that such a restricted way of being in the world can be understood as a form of "homelessness." In our analysis, we will bring these perspectives on health, illness, and body in touch with our empirical material. More specifically, we will explore how the women's increasing health problems can be understood as a process of losing one's primary "home-likeness" in the world as well as living "between" cultural notions of the slim body as a "nice achievement" and the private "inner" body as an extremely difficult and painful "place" to be.

Participants

As already stated, this article is part of a larger study including 22 Norwegian women having undergone weight loss surgery within the previous 6 years (Groven & Engelsrud, 2010). Twelve of them were recruited through a health clinic offering rehabilitation for those undergoing bariatric surgery in the eastern part of Norway. An additional 10 were recruited through the website of an organization that provides information and support for those undergoing bariatric surgery. The women were aged 20–55 years, and they were living in the eastern part of Norway (in towns, cities, or rural areas). Prior to their surgery, the women had a BMI ranging from 43 to 54. Some struggled with comorbidities (including diabetes, high blood pressure, and discomfort during physical activity), whereas most of the women emphasized that they were not having any particular health problems prior to their surgery.

Some of the women had struggled with what they termed “emotional eating” prior to the surgery, whereas others emphasized that they did not have an “eating problem” prior to their surgery. Most of the participants were working in professions providing service or care, doing office work, or having a job in academia at various levels. Some were management-level supervisors with responsibility for personnel, whereas a few had been on disability benefits and had been unemployed for some years. Most of the women were married or cohabiting, whereas a few were separated or in the process of a divorce, and three were single. All but four of the women had children.

The participants were in different phases of post-surgery. Two of the women had had the operation less than 1 year previously (8 months and 11 months, respectively). The vast majority had undergone surgery more than 2 years ago, whereas a few had undergone gastric bypass more than 3 years ago. At the time of the interviews, most of the women had a BMI ranging between 26 and 35—which indicates that they had experienced dramatic and rapid weight loss after the surgery. By contrast, a few had gained some weight after the surgery. Bearing these diverse but also similar backgrounds in mind, the participants represented a deliberate sample of information-rich participants. In Patton’s (2002, p. 230) words, “those from which we can learn a great deal about issues of central importance to the purpose of inquiry.”

Interviews

To investigate the experiences of our participants we considered individual in-depth interviews to be relevant, and we were inspired by the “open narrative interview” as described by Kvale and Brinkman (2009, p. 155). The interviews—all of which were conducted by the first author—started with the women being asked to tell their “personal story”—from the decision to undergo surgery up to their present life situation. Still, clarifying questions were occasionally asked by the researcher conducting the interviews, for example “Can you tell more about that?” Similarly, the women were encouraged to elaborate on experiences that needed clarification or expansion of a topic. This approach gave the women an opportunity to talk about many nuances in their experiences—a strategy that resembles Kvale and Brinkman’s emphasis on interviews as collaboratively produced experiences as mutual data material of researcher and participant (pp. 155–170).

In telling their stories, five women differed from the others in their emphasis on negative experiences after the surgery. Prior to their surgery, these five women had worked outside the home in professions

providing service, care, or doing office work. They were aged 25–45, and except for the youngest and oldest woman, the three others had children. Four of the women were either married or in a relationship, whereas one of the women was a single mother. Hence, in terms of their socio-demographic characteristics, there were no specific differences between these five women compared to the other participants. Still, our general impression from these five women was that they spoke more or less without restraint about the increasing health problems that had occurred after the surgery indicating that this was a topic of great importance to them. This is not to say that the other 17 women emphasized only “desirable” outcomes after the surgery. On the contrary, their experiences revealed ambivalence as well as ongoing challenges that they were struggling to adjust to. In particular, they emphasized ambivalent experiences in conjunction with food and eating as a consequence of the surgery—which affected their lives in profound ways, including their relationships with others. More specifically, the side effect termed “dumping syndrome” was associated with major challenges, including episodes of sickness and bodily discomfort.² These findings are highlighted in a previous article (Groven & Engelsrud, 2010) and are therefore not included in the present article. Nevertheless, whereas the majority of the women repetitively emphasized that they had “no regrets,” and would “do it again,” the five women on which the present article draws emphasized that their situation had become more restricted compared too previously. These women made a strong impression on us, and prompted us to showcase some of the “subtle” consequences of weight loss surgery.

Ethical considerations

The study was approved by the Research Ethics Committee of Medicine in Norway (REF 6.2009.88). Information about the study was given to the participants together with a letter requesting them to participate. They were informed about the voluntary nature of joining the study and their right to withdraw at any time. After receiving their informed consent, one of the researchers (Groven) contacted the women by telephone in order to confirm their agreement and to arrange the interview. Individual interviews were then conducted at a place of the participants’ own choosing. The interviews were tape-recorded with the women’s permission. To maintain confidentiality, the participants are given the fictive names of Jane, Kirsten, Mary, Kina, and Charlene throughout the article.

Analysis

Our analytical process was inspired by what Kvale and Brinkman terms the “bricolage” approach. This is a way of analyzing subjective experiences where the researcher may use several techniques and concepts (p. 233). As indicated previously, our analysis started during the interviewing process where the “worse life experience” appeared to be embedded in the personal stories of the women. By transcribing the tape-recorded interviews, spoken words gradually became written texts that could be carefully analyzed. This process consisted of several phases that somewhat overlapped and interplayed. For the sake of clarity, however, we will describe it more stepwise. First, the material was read through a couple of times to get a general impression of each woman’s personal story. Then, the material was studied more closely with the aim of structuring each woman’s experiences in terms of themes. Such an approach is closely related to Van Manen’s (1997, p. 93) descriptions of a thematic analysis. According to Van Manen, thematic aspects of lived experience can be uncovered from the participants’ descriptions by a “selective reading” approach. This meant that we carefully read each transcribed interview asking ourselves questions such as: What statements or phrases seem particularly essential or revealing about the “worse life” experiences being described by this particular woman? How did this “worse life experience” come about, as understood by the woman herself? Statements and phrases that seemed to illustrate our research focus were then highlighted by different colors and given different headings. We then conducted collaborate discussions, with particular emphasis on how highlighted examples might open up a deepened and more nuanced understanding of the women’s “worse life” experiences. Thus, phrases were examined, reinterpreted, omitted, added—which enabled us to structure the lived experiences into various themes, as recommended by Van Manen (p. 79). Moreover, when we reread the entire material searching for similar as well as contrasting experiences *between* the women, we discovered how they were constantly comparing their present life situation to their lives before the surgery. This prompted us to “merge” seemingly related themes into five main themes through which the women’s comparisons between “old” and “new” lives were valid. To structure these findings, we have chosen to present them chronologically under the following thematic headings: “Healthy, but worried about their situation,” “A positively life-transforming period,” “Unexpected pain and loss of energy,” “The radical change of bodily appearance,” “Feelings of being damaged on

the ‘inside’,” and “Comparing one’s old life with the new life.” Finally, we conducted a more “critical interpretation” of the empirical material, as recommended by Kvale and Brinkman (p. 207). This critical interpretation involved contextualizing the women’s experiences by using our theoretical framework as well as previous research. In doing so, we went beyond what the women explicitly expressed so as to reveal the opinions and relations that were not evident at first glance. Verbatim extracts and shorter quotations from the transcribed material (as well as reflections in relation to the interviewing process—as experienced by the first author) have been included in order to show what the various interpretations are based upon.

Findings

Healthy, but worried about their situation

Prior to the surgery, the women emphasized their lifestyle as being actively involved in various activities such as working outside the home, taking care of children, engaging in social relations, volunteering at the school, and taking part in children’s activities. Their healthy and active life included exercise and few signs of illness. As Kirsten expressed her commitment to exercise at the local gym “It was fun. I was completely hooked.” The women described their life as similar to “a normal” life.

Although they described themselves as healthy and their lives close to “normal” they also emphasized ongoing worries about the future. Their worries were related to the “risk” that overweight might cause serious illness or disability. This was a risk that all of them referred to in the interviews. Kirsten, for example, worried about her “bad knee” that had occurred after a sports injury in her teens. She firmly stated that her problems would become worse if she did not lose weight on a permanent basis. In the interview, she envisaged a future of inevitable health decline unless she had surgery: “I did not have any of those obesity related diseases that you read about in the media My knees hurt a bit. But, it did not bother me that much I really did not have any of those obesity related problems.” While Kirsten worried about incremental health decline, others expressed the concern that “risk to health” was something that could happen suddenly. Jane described herself as a “ticking bomb” in terms of heart disease. She feared that it could happen any time, as it had happened to her mother: “My mother has suffered from two heart attacks. I considered myself to be within the risky group when it comes to heart disease. I worried a lot about having a heart attack, although I felt in good shape

and all of that.” Likewise, Kina worried that she would die suddenly because of her weight. She came to a point in her life where these worries were all she could think about: “I was filled with fear constantly worrying that one day I would no longer wake up in the morning . . . that my heart could not take it anymore.” Worries about risk factors played a pivotal role in the women’s assumptions that “something was about to happen.” They talked about their efforts to find a “solution” to counter future diseases.

The women also shared in common that their lives before surgery consisted of repetitive yo-yo dieting. Their decision to try surgery was reflected upon in the interviews through the long histories of embracing the full panoply of traditional weight loss methods. From all the unsuccessful stories, they seemed convinced that surgery represented a “healthier option” than their endless cycle of losing and regaining weight. As Mary put it “I was not afraid at all. I was convinced that surgery was much safer and healthy than my previous weight loss efforts.” This conviction “triggered” the decision to undergo surgery and one of the motives was to avoid severe illness. However, the women also talked about other worries that influenced their decision to undergo surgery. More specifically, they described feeling miserable and unhappy with the way they looked. As Jane articulated it: “It also had to do with my self-image . . . that I thought everyone thought: ‘Oh my God, here she comes again, the fat bitch,’ you know.” Likewise, the women talked about how they would usually get bad looks and comments from strangers because of their weight. Kirsten, for example, repeatedly had to endure men’s derogatory judgments regarding her appearance when socializing in clubs or pubs on the weekends:

It restricted me in my social life. I was not fond of going out with friends. It prevented me from going to discos or public dance places. It did not stand to do so. I felt like people were staring at me. . . . I am actually very fond of dancing. But . . . people would stare at me and they would make comments, especially as the evening went on. “You are the ugliest person I’ve ever seen” or . . . well, yes, that kind of thing. That was the level of conversation. . . . Men were the worst. That’s the way I felt. Uh. And the people I was with said “You have to learn how to answer back.” “Of course,” and so I had my answers ready and was prepared to say this or that. But when you . . . I wasn’t able to respond to them; I simply became sad. . . . But many times I became annoyed. Why can’t I sit here in peace and . . . without your bothering?

Obviously, negative perceptions of their appearance were influenced by how they experienced that other people reacted to them. Exposure to negative comments from others seemed to reinforce and confirm their views of themselves as unwanted and unattractive women. In this regard, the women’s decisions to undergo surgery were motivated by their desire to become slimmer and more attractive, and thereby more accepted by others.

In summary, their life situation before surgery was that they felt rather healthy and in good shape. At the same time, they felt ashamed of their own appearance as well as socially bothered by attracting negative attention from others. As will be revealed below, the women expressed euphoric feelings during the initial months of surgery and in this period “everything seemed perfect.”

A positively life-transforming period

For the women, the dramatic weight loss that occurred during the initial months of surgery was experienced as positively life-transforming. They felt more attractive than previously, enjoyed positive comments regarding their looks, were working full-time, and were more sociable than previously. To describe their optimism and positive feelings, the women used metaphors such as “honeymoon” and “hallelujah-wave.” As Jane described it:

My weight loss was super. I lost a lot of weight, and everything was great. . . . Six months after the surgery, I had lost 35 kilos. . . . I was really enjoying the “Hallelujah wave then. . . . The Hallelujah wave . . . everything was perfect then. . . . The kilos just disappear. You become super pretty, you put on extra makeup, shopping, my God, I went shopping and shopping. I bought new shoes, I bought nice clothes, wow. . . . Everything was perfect.

During this period, the women were enthusiastically involved in an Internet forum that provides support and information for persons seeking and undergoing weight loss surgery. In this forum they could share their positive experiences with others in the same situation, which gave them a profound sense of belonging. Jane recalls the prosurgical atmosphere in the following manner:

Oh yeah, the hallelujah made you feel really welcome on the forum. You got lots of new friends, you joined others who were also sailing on their hallelujah wave and felt that life was perfect. “Gosh, you look really great, have you lost even more weight?” “Did you buy a new dress?” Right . . . You met like-minded people, and stuff

like that. But this was just a counterfeit thing. . . . Superficial . . . I do not have any contact with these people today, except one of them . . .

As will be revealed later in this article, the participants in our study withdrew from the forum when they started having various problems. In the following section, the women's experiences after the "perfect period" take another direction. More specifically, the feeling that everything is "perfect" gradually begins to fade away.

Unexpected pain and loss of energy

After a few months, the women started to feel tired and out of sorts. They also experienced having less energy in their daily lives. They used expressions like "I am losing all my energy. All my energy," "I forgot everything," "I could not remember," or "I only wanted to sleep." To work, to function in daily life, or be a student became more and more problematic. They had increasing difficulties with completing tasks as well as enduring conversations with others. According to the women, these new and unexpected experiences prompted them to seek answers. Why did these difficulties occur? Who could help them? What could be done? Was there any treatment? When Kirsten asked her surgeon, he tried to calm her down claiming that the side effects would disappear after a few months. However, feelings of energy loss and tiredness did not go away. On the contrary, the women felt more and more out of sorts and described that being worn-out gradually became an overwhelming experience. To feel "totally worn-out" was described as a turning point in the women's lives. From this "turning-point" onward, they felt that the loss of energy forced them to be more inactive. They felt exhausted and did not have the energy to work. Mary compared this situation to "a battery gone flat." During this period, the women also experienced the onset of pain which—like their loss of energy—gradually became more or less persistent. The pain was not located in any particular area; it was perceived in the entire body. At the same time, the pain tended to "move around" making it unpredictable and difficult to comprehend. Moreover, the pain was accompanied with feelings of stiffness that permeated their entire body. These complaints made it difficult to move as freely as they did previously. Neither did they have energy to move. Even a small movement such as turning over in bed was painful and problematic. As Mary articulated it:

But it's not a kind of "ouch" pain, as if I need crutches or something. It's more like a general

aching in my body all the time. So it's part of an overall condition. . . . I have underlying chronic pain . . . a kind of grumbling, basic pain. And sometimes it is . . . more painful . . . for example to get out of bed in the morning. . . . I have to set the alarm a little earlier. On occasion I wake up at night and can't turn over in bed. Uh . . . yes, and it hurts there right now, too . . . I have . . . I have pain actually in my entire body. It moves around, sort of . . . it's a little hopeless . . . a little . . . if I make an appointment because my hip is hurting so badly that I can't walk, then I have to cancel.

As a contrast to Mary's experiences, Charlene described how her pain problems started as an acute pain immediately after the surgery. During the first year, the pain was episodic, mainly in conjunction with eating. However, gradually the pain became more intense, metaphorically described as "a knife being twisted around in her stomach-area." The women described their complaints as completely unpredictable and surprising while at the same time limiting their lives in several ways. Those who previously used to exercise on a regular basis experienced that they barely had the energy to walk to the bus nearby. Long walks and other forms of physical activity would intensify the pain and fatigue. And lying down and feeling completely exhausted became a common experience. As Jane expressed it:

It is painful, it hurts. It is uncomfortable. . . . But not in the manner that I used to get tired during exercise previously. I really get ill in situations where I am physically active now. Physical activity now makes me feel completely worn out. I have to lie down for hours afterwards. It makes me so tired and worn out. I get so fatigued; my body can't withstand anything any longer."

Pain, discomfort, and loss of energy became overwhelming and ongoing experiences. At the same time, the women emphasized that they were unprepared for these experiences to last. Moreover, they felt increasingly trapped in a difficult situation.

The radical change of bodily appearance

As highlighted previously, a "new" and more "acceptable" bodily appearance was one of the motives for undergoing weight loss surgery. But as the months went by, the women experienced how their bodies became more and more undesirable due to loose skin that occurred as a consequence of their weight loss. According to Kirsten, the folds of sagging skin made her look disfigured and unattractive. It was also

problematic in other ways. When the weather was hot in the summer, she easily got infections because of sweating between the folds of loose skin. Additionally, it was uncomfortable to move freely with the sagging skin moving back and forth, impossible to control: "My stomach. . . I have. . . It hangs there. And it bothers me, physically, not only mentally. It is hot and it itches. . . And it is ugly . . . it really bothers me. I shudder when looking at myself in the mirror." Kirsten used the metaphor of "towel of fat" to highlight how bothersome and repulsive she experiences having the loose skin on her stomach. Because Kirsten considered having the skin folds removed, she discussed it with a plastic surgeon who suggested more changes to compensate for the problems of loose skin. In fact, he suggested "the whole package: arms, thighs, and butt." Deliberations about whether to undergo additional surgery to have the excess skin removed created tension among the women. In fact, to be eligible for plastic surgery, they had to lose even more weight, to get below the BMI limit of 27. Kirsten had struggled to get below this limit during the past 2 years, but claimed that her pain and fatigue prevented her from being active. Without activity she could not manage to "lose the last kilos." Due to her inactivity she had started to diet again. She was also uncertain as to whether she had the courage and energy to risk having even more pain than she already had.

The feeling of fatigue continued to dominate their daily lives, and the women repeatedly emphasized how their altered bodies felt "out of balance," like "a machine that was destroyed," or a "hacking machine." Additionally, the women emphasized how their blood values and vitamin levels had changed dramatically after the surgery. More specifically, they constantly struggled with iron deficiency, low hemoglobin percentage, and B12-deficiency. While these levels were previously regarded as "normal" in terms of medical standards, they were far below the accepted level after the surgery. All the changes were clearly perceived in their daily lives, at work, and during activities that were associated with bodily efforts. Mary explained how she occasionally experienced episodes of dizziness where she felt like she was on the verge of fainting:

It feels like I have a rock in the machinery which makes me disabled in my daily life. . . . And it feels like my body is out of balance, which cannot be captured by medical tests. . . . It's as simple as that. . . . And I am struggling with low blood pressure. And my job requires that I move around to the elderly. And occasionally I see stars and nearly faint when I work.

After the surgery, the women had become dependent on various vitamins and pills, as well as regular B12 injections. However, these medical interventions did not seem to "normalize" their values. Charlene struggled with more or less constant tremors after the surgery. The tremors were worst in her hands, an episode that "author one" experienced during the interview. When Charlene reached for a glass of water, she began to tremble uncontrollably. At the outset she thought that this would pass, but 2.5 years after the operation she still experienced these tremors. In addition to her pain and fatigue, these chronic symptoms were annoying and she felt her life had become "worse" after the operation. She explained that the tremor was more or less chronic, and that her physician had prescribed Beta-blockers to alleviate the symptoms. Likewise, Kina was struggling with dizziness, and occasionally experienced losing sensation in her arms and legs. Additionally, she experienced that her legs were "failing" beneath her and she occasionally lost her balance. Over time, these problems seemed to become worse, and eventually it became a daily experience to stumble or try to prevent stumbling due to these balance problems. Obviously, the "hallelujah-feeling" had totally faded, and the "new" body was perceived as weak, dysfunctional, worn-out, and less attractive than previously.

Feelings of being damaged on the "inside"

Due to their ongoing complaints, the women were convinced that something had been damaged inside their bodies during surgery. As Charlene expressed it during our first interview "There is something there that is not right." The surgeons, on the other hand, communicated that her pain and tremor could be explained as "late dumping" a side effect that would gradually disappear as she adjusted her diet. However, when the complaints did not disappear, she was examined at the hospital 2.5 years after the surgery. According to ultrasound and MR-screening, everything seemed fine:

They have taken several screenings. . . . Ultrasound, gastroscopy, but they did not find anything pathological. . . . I have been rejected all the time. This was all psychological. . . . I had mental problems. Because there were so many changes that the body could not keep up with. . . . their explanations made me really annoyed and frustrated. It cannot be reduced to mental problems. I really became ill from being mistrusted.

When the surgeons could not find anything pathological on their screenings, they suggested that Charlene

might have “mental problems” and encouraged her to see a psychologist. Because Charlene so strongly experienced that something was not right *inside* her body, it was difficult to accept that a psychologist could solve these bodily problems. When referring to these experiences in the interview she held the surgeons partly responsible for her problems. She became very ill, and her private financial situation suffered because of she was forced to go on “temporary disability.” She also was unable to tend to her children, a situation that exacerbated her worries:

I could not take care of my own children. I had to hire au pairs that worked nonstop because I was constantly ill. I was lying on the sofa unable to do anything. My life was of the kind that is never discussed in the media . . . the subtle side-effects that accompany the surgery, but are never talked about.

Charlene’s story made a strong impression on us. Especially the first author—who conducted the interview—could not stop thinking about Charlene and the major problems she was experiencing after the surgery. One year after their first encounter, the first author therefore contacted Charlene for a follow-up interview. Three years had then passed since the surgery, and we were anxious to hear how she was doing. Charlene started the interview by emphasizing that “things were better now.” She had been reoperated on 6 months ago. The intense pain was gone, and she felt less disabled than previously. Moreover, Charlene praised her doctor for “believing me” and for “pushing the surgeons” to reoperate her. Even when screenings showed no signs of pathology her doctor took her problems seriously:

I have been rejected all the way. My problems were “psychological.” If it weren’t for my general practitioner, I would never have been re-operated. He has talked to the surgeons numerous times. He insisted that something was wrong. He knew I was not functioning. I had become disabled in most areas in my life. I was only able to work two or three months out of a whole year.

When they finally decided to reoperate her, the surgeons could actually see that complications had developed in her viscera: “Intestinal villi” had developed in several places, along with significant “scar tissue” in the stomach region. Charlene’s situation improved significantly after this second operation and her intense pain and tremor disappeared. But she still suffered from the “explanation” of her problems as “mental” and strongly

emphasized that her bodily sensations and pain were misinterpreted by the surgeons as well as others. Due to these experiences, trusting her “inner body” was challenging for her as well.

Comparing one’s old life with the “new” life

The “old” and “new” life was compared in different ways. Whereas Charlene’s situation improved significantly when she was reoperated on, the other women were still feeling disabled in their daily lives, struggling with various problems. They all emphasized that their life situation had become restricted and had changed for the worse compared to their lives before the surgery. As Jane explains it:

If I were to compare my life-situation today with my life situation before the surgery, it was super. It had to do with . . . I was hoping that my life would improve for the better. . . . I thought everything would be easier when I lost weight. Easier to walk up stairs, easier to play with my children, things would be easier. . . . Instead, I feel more or less disabled. 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 have enough energy to be with my children. I have enough energy to manage doing my job. And after that I have no energy left. . . . I am working. I probably should not be working, but . . . I got a different type of work position just before Christmas, and I think maybe that is what is saving me.

Mary explained that although she had lost considerable weight and her “body is much lighter” she was functioning worse than previously. Fatigue, tiredness, and pain were constant reminders that her quality of life was worse than previously:

I have a body that is functioning worse than previously. But I have a lighter body. . . . My capacity is very limited when it comes to what I am able to coax out of my body during one day. I can function at work, but then I do not have anything left to give in my private life, nothing at all. Then it is empty. After a day at work I am so tired when I come home I can hardly unlock my front door. And I am living with constant pain. Taken together, it feels like I have a rock in my machinery. It is jolting. . . . It is not working like it used to do.

In terms of Kirsten’s experience, the pain she was having in her knees before the surgery had become

considerably worse. Three years after the surgery she was also having pain in the rest of her body, and the doctor now suspected that she had fibromyalgia:

It has become much worse. I really believed that the pain in my knees was caused by my heavy body. But it has become much worse. I was convinced that my knees would become better after the surgery, it would be easier to move around. . . . And then I experienced the opposite. Now I have days when I am not able to move at all. . . .

During our second interview, Kina was still struggling with her balance when she walked and moved. Additionally, she had begun to have problems with her eyesight. On a daily basis, she experienced episodes where she could no longer see clearly. Because of these problems, she was examined by a neurologist. At this point, Kina worried that she was seriously ill with “brain cancer.” However, a few weeks after our second interview, Kina contacted the first author to tell her that she had been diagnosed with MS, and that the neurologists assumed that the surgery had triggered the onset of her symptoms.

The complaints were one aspect restricting their lives. Socializing with others was, according to the women, also very problematic. In particular, it was problematic to talk about their weight. The women had started to gain weight again, a development they experienced as both embarrassing and shameful. When comparing themselves with others who had undergone weight loss surgery, they explained that the feeling of failure was particularly prevalent. Whereas they were previously active in a web forum for people operated on for obesity, they tended to gradually withdraw from discussions on the site. The reason was that they felt that other members were interested only in the positive outcomes from the operation, and they described it almost as a contest to see who could lose the most weight. Those who had undergone plastic surgery would post photos of themselves on the web, according to the women. Kirsten recalls that she tried to start a discussion about symptoms experienced after the operation, but the feedback she received from the other participants was that her contributions were “too negative” and that these negative contributions might frighten persons waiting to be operated on. Likewise, conversations with family and friends were difficult. They were met with comments implying that they were more lively and upbeat when they were overweight. The issue of whether it was right to have the operation was recurrent. As Kirsten puts it; “I have had this operation. And so there is no point in asking whether

it was right to do what you did. What’s done is done.” This kind of feedback implied that the women became hesitant to talk about their complaints. Moreover, they worked hard to deal with their complaints by leading a seemingly “normal” life, and by going to great lengths in order to continue working. Back in their homes after the workday, they had nothing left to give. Comments from others that they had “chosen an easy solution” or “taken the easy way out” were particularly hurtful given their ongoing struggles to function in daily life. Chronic problems coupled with feelings of being “damaged inside their bodies” had profoundly altered their lives for the worse, and the women repetitively emphasized how they felt trapped in a situation that they were unable to get out of.

Comprehensive understanding

Based on five women’s comparisons between their “old” and “new” life situations, obesity surgery seems to have been a “risky” intervention causing “worse-life” experiences. Jane, Mary, Kina, Charlene, and Kirsten were offered surgery, despite living seemingly healthy lives. Their BMI as well as previous attempts to lose weight “qualified” them for surgical treatment. Additionally, “using” surgery to prevent future illness seemed to be part of the decision process. Hence, when individuals undergo such a procedure, a lot is at stake. For some, life might be dramatically changed for the worse if they are unfortunate and become ill or suffer from complications after the procedure. According to our findings, this situation might be associated with a profound sense of entrapment, such as the women described in detail. Their bodily experiences were clearly related to the irreversible operation technique that had divided the stomach into two sections consisting of a smaller upper pouch and a larger lower section. A section of the intestine was then rerouted to the smaller upper pouch thereby bypassing the larger stomach. A procedure that involves altering a healthy stomach and intestine is likely to change the body in profound ways. It involves the entire living and lived body. Bearing these irreversible changes in mind, we regard the women’s experiences of entrapment as an embodied mode of being in the world that pinpoints their pervasive sense of homelessness. In this regard, the women’s experiences have shed light on some aspects that may be part of experiences from weight loss surgery. In particular, our findings pinpoint that women express a need to be understood from their embodied experiences as well as their altered life situation.

Discussion

Cultural norms and values have an impact on our decisions and everyday experiences, including our standard of bodily appearance and our ideas about health. According to Murray (2005, p. 154), stigmas associated with “large” women reflect a negative culture of “collective knowingness” about fatness and the “responsibility” for their appearance as well as health is put on their own shoulders (2005, p. 154). Weight loss in this context, is therefore not a choice, but a moral obligation, as pointed out by Throsby (2009, p. 202). Such cultural assumptions were also evident in our material. The women emphasized how they felt unwanted and unattractive because of their weight. Moreover, they talked about their hopes that the surgery would make them more “acceptable” and “desirable” as women.

Our findings also illuminate how the women’s lives changed in unpredictable ways after undergoing weight loss surgery. From living a rather healthy life they increasingly experienced becoming chronically ill after the operation. By relating these experiences to Svenaeus’s connections between illness and homelessness, deeper insight into their life-transforming situation is gained. Svenaeus argues that living with chronic illness can be understood as a profound sense of “homelessness.” Previous activities that were done without us paying attention to it when we are healthy—walking, thinking, and eating—now offers resistance:

The not being at home, which is a basic and necessary condition of human existence . . . is in illness, brought to attention and transformed into a pervasive homelessness. One of two *a priori* structures of existence—not being at home and being at home, wins out over the other: unhomelikeness takes control of our being-in-the world. The basic alienness of my being-in-the world, which in health is always in the process of receding into the background, breaks forth in illness to pervade existence. (Svenaeus, 2000, p. 93)

The women’s accounts of how their lives were profoundly changed for the worse indicate that they gradually experienced losing their “homelikeness.” They described how their initial excitement regarding the dramatic weight loss was more and more subdued by the onset of a multitude of problematic symptoms. Their problems were experienced as restricting their lives. They could no longer function like they used to. Activities they previously took for granted—like walking to the bus—now became problematic. Hence, the phenomenon of

homelessness is useful in describing how their lives and bodies changed in various, unpredictable ways.

As Svenaeus points out, the understanding of illness as an unhomelike being-in-the-world involves a sense of the body as an alien presence and, at the same time, inescapable. Illness entails loss of freedom as well as imbalance, as accounted for in detail by the women in our study. In particular, the women’s pain problems highlight this ambiguity. For Charlene the intense pain that was perceived in her “inner” body became a sort of hostile monster—an alien presence—impossible to ignore and escape, metaphorically likened to a “knife being twisted around in her stomach area.” Everything other than the pain was overshadowed whenever she experienced these complaints. And the pain forced her to concentrate on what was happening inside of her. Leder (1990) describes such a heightened awareness of the “inner” body as a “dys-appearing” situation in which the body can appear as “other” opposed to the self (p. 3). The focus was on the “inside” body and what might be wrong. For Charlene the pain often became so intense that it forced her to lie down. She had to relinquish the care of her children to others and was unable to work. The pain was maintained and consolidated the unpleasant experiences and, thereby, according to Leder, the pain places an affective “call” upon the patient (p. 73). In other words, Charlene’s attention was occupied by the negative aspect of pain. By comparison, Jane, Mary, and Kirsten did not experience pain to such a dramatic extent. Their pain problems developed more subtly and gradually into a persistent, diffuse pain not located to any particular area. In his analysis of the inner body, Leder claims that the viscera have a greatly decreased number and variety of sensory receptors compared to the surface body. Moreover, visceral sensations are often vaguely situated with indistinct borders. An almost magical transfer of experience is affected along both spatial and temporal dimensions, weaving the *inner* body into an “ambiguous space” (pp. 40–43).

Another aspect that increased the women’s sense of homelessness was the loose skin that gradually became more and more perceivable. Not only was this problematic because it made them less attractive, but the loose skin was also associated with discomfort and infections. Hence, the women’s sense of themselves profoundly altered and alienated them. However, uncertainty as to whether they had the strength to endure additional surgery to remove the loose skin was associated with emotional strain. To risk even more pain than they already had was not attractive and new surgery was not preferable. Nevertheless, knowing that this “possibility” existed added new

worries to their lives, enhancing their feelings of being trapped in a situation that they could not get out of. Moreover, they found it difficult to plan for the future. These findings thereby relate to Leder's (1990, pp. 72–74) perspective of the "absent body." According to this perspective, chronic illness is capable of making the world shrink to the "here and now." However, although the women's lives were restricted to "here and now," the "here and now" also seemed a very difficult place to be. In this situation, the women would think back on their previous lives as healthy and active women. In doing so, the women regarded themselves as "disabled." Moreover, they were uncertain of how their future would be as well as how to cope with a life that they experienced as restricted due to the surgery.

As revealed so far, experiences of alienation and disconnection from oneself are strong bodily sensations pointing to the women's profound sense of homelessness after the surgery. Nonetheless, our findings indicate that feelings of "homelessness" also have a relational aspect. Or—to put it differently—the way they experienced other people's reactions to their problems also seemed to increase the women's sense of "homelessness." When comparing themselves to others who had undergone weight loss surgery, they regarded themselves as outsiders. Likewise, they experienced how attempts to share negative experiences on the discussion forum where they were members, was met with skepticism, anger, or silence from other Internet members. These findings are consistent with previous research on the tendency of discussion forums to focus on the "success" stories. In her article "Happy Re-birthday: Weight Loss Surgery and the 'New Me'," Throsby (2008) summarizes the prosurgical atmosphere in the following manner:

One of the features of the organization and its discussion forums is its very positive approach to WLS. ... It is also relatively rare to encounter a member who has experienced treatment "failure" especially in terms of regaining significant amounts of weight several years after the surgery. ... Instead ... those having negative experiences of surgery (including both serious complications and weight regain) tend to drop out of the discussion forums. (p. 212)

Throsby argues that those who have negative experiences of surgery tend to drop out of the forums, and were therefore not represented in her study. Consequently, her participants represented a homogenous group in terms of experiences, all claiming that their situation had improved dramatically for the better after the surgery. Furthermore, the surgery was described as an opportunity to be

reborn as a more healthy and happy individual. As revealed by our findings, Throsby's suspicions regarding "drop outs" from the forum were confirmed by our participants.

As highlighted by Svenaeus, understanding illness as an unhomelike being-in-the-world also implies unfamiliarity within the surroundings. As a strategy to avoid critical questions and comments from others, the women gradually learned that it was "wiser" to conceal their problems. In this way, their health problems tended to be understood as a private matter that they kept more and more to themselves. Additionally, they were careful not to talk about their weight gain. Gaining weight after the surgery was regarded as embarrassing and something that should not be talked about. In the long run, however, this tendency to "suffer in silence" resulted in their social network becoming more limited. Moreover, it intensified their feelings of being outsiders—of being "homeless" in the world. This line of argument parallels Merleau-Ponty's arguments regarding the relational body. According to his line of argument, the body is relational in the sense that it is inseparably connected to its surroundings (2002, p. 411). Hence, a person's sense of "homelessness" can be understood as both individual and relational particularly illuminated in the way their subjective experiences were felt to be placed in the background of the clinical encounters. Let us, therefore, return to the women's accounts of these "problematic" situations, with particular emphasis on their attempts to resist the "psychological explanation."

Throughout the interviews, the women repeatedly emphasized how they firmly believed that their problems were caused by the surgery. The most common "explanation" that they gave during the interviews was that their "hormone balance" had been profoundly altered during the procedure. Upon seeking help within the health service, however, the women repeatedly experienced how their problems were interpreted as signs of depression and possibly fibromyalgia. Our findings, thereby, underscore the point made by Svenaeus (2000, pp. 153–154) regarding the clinical encounter as a meeting of two different life worlds with separate horizons. The doctor's world, according to Svenaeus, is primarily one of disease, while the patient's world is one of lived illness (p. 154). Svenaeus is critical toward the clinical encounter as a merely scientific investigation where the doctor searches for scientific truths. He sees the clinical encounter between patient and doctor as an "interpretive meeting" where science is an integrated part, but not its true substance. To increase the patient's sense of homelikeness—which he points out should be the main focus of the clinical

encounter—he emphasizes the importance of a dialogue where the patient’s lived experiences are placed in the foreground. Additionally, Svenaeus emphasizes the importance of mutual trust and respect so that a health promoting dialogue can take place (pp. 150–157). Charlene’s experiences illustrate how the surgeons did not seem very “dialogic.” Rather, it seems to be a case of scientific examination, given their focus on medical screenings, aimed at searching for pathological signs that might explain her problems. Our point by problematizing this example is to highlight how pathological complications in the viscera were not visible on either the CT or MR screenings. Moreover, the surgeon’s labeling of her problems as psychological contributed to the intensification of Charlene’s sense of illness. Hence, one could argue that the discrepancy between the patient’s perceptions and the surgeon’s conclusions exacerbated her sense of homelessness.

According to Swedish historian Johannison (1996), the social tendency to display women’s problems as “psychological” can be traced back to the early 19th century. In her book *The Dark Continent*, she illuminates how medical technology contributed to legitimizing specific illness models applying to women. By portraying women as more gendered and bodily than men—making use of biological arguments claiming that they had a more fragile nervous system—medicine legitimized a view of woman as the second (weaker) sex. Through her retrospective glance, Johannison thereby pinpoints the role of medicine in establishing cultural stereotypes of women’s weaker mental state. Bearing these cultural assumptions in mind, Charlene’s resistance to the surgeon’s “psychological explanations” is contextualized. Indeed, she kept insisting on her intuitive feeling that “something had to be wrong.” In doing so, one could argue that she used strategies well documented by feminist scholars. American sociologist Lorentzen (2008) claims that some women deliberately speak from their “experiential” perspective to make their “problems” more valid in the clinical encounter. More specifically, they express two types of experiential knowledge, namely, embodied and emphatic knowledge. “Embodied” knowledge refers to knowledge developed from an individual’s experiences with and perceptions of one’s body as the individual goes through changes caused by normal and abnormal body processes including pregnancy, weight gain or loss, childbirth, illness, and injury. “Empathic” knowledge refers to insight gained from the experiences of other individuals with whom a person identifies in some way. Both these types of knowledge can be considered as bodily sensations or “gut” feelings, according to

Lorentzen (p. 57). Hence, when Charlene continued to emphasize her gut feelings, her efforts seemed to pay off.

By comparison, Jane, Mary, and Kirsten used embodied knowledge pointing to their profound feelings of imbalance and malfunction. Additionally, the women described in nuanced details how they felt “out of tune,” constantly tired, and lacking energy. Moreover, they emphasized that their dependence on medication and vitamin injections seemed useless given the fact that their bodies did not seem to respond to these interventions. Taken together, these examples indicate that the women are constantly on the alert—like in an ongoing stressful situation—after the surgery. Gadamer’s (1996, pp. 144–145) emphasis on equilibrium for an individual’s sense of being in good health is relevant here. More specifically, he points out that health is both a mode of being-in-the-world and a rhythmic process characterized by a profound sense of equilibrium. These proposals are in line with Eastern theories of health. Of most relevance for our study is the mind–body philosophy of Asian philosopher Yuasa Yasuo. Yasuo (1987) highlights the mind–body unity’s ongoing focus on remaining in balance in cases of illness. Thus, being in balance implies that the body has reestablished its equilibrium. Yasuo is particularly preoccupied with the body’s viscera and their significance for a person’s sense of balance. More specifically, he points to the viscera’s connection to the body’s hormone regulation, and that changes in this “connection” might have a significant impact on an individual’s sense of being in equilibrium. Perhaps it is precisely this change in the body’s “homeostasis” that is reflected in the women’s sense of being out of tune—metaphorically described as a body that has “gone out of rhythm” in a never-ending feeling of fatigue or exhaustion? Perhaps the gastric bypass surgery—which anatomically changes the stomach as well as the intestines—has a profound impact on the body’s homeostasis? If so, one could argue that the body is constantly on the alert in its ongoing attempts to reestablish its equilibrium. In other words: A body working non-stop at its highest gear. As already pointed to from our review of the literature, a challenge seems to be the difficulty for medical science to measure or determine this imbalance in terms of clinical findings—or so-called objective findings. Instead it seems to be a strong embodied experience—or a distinct feeling of being in imbalance. In light of a growing body of critical obesity studies, the presumption that overweight causes ill health is thereby once again challenged. The health and esteem enhancing changes of weight loss interventions and health campaigns are not “effective” for everybody (Aphramor, 2005;

Campos, 2004; Gard & Wright, 2005; Monaghan, 2005; Murray, 2008; Oliver, 2006; Throsby, 2008). Central to these writings is the claim that it is possible to be “fit, fat, and healthy,” and that weight loss interventions entail the risk of damaging health and self-esteem (Throsby, 2008, p. 1563).

Methodological considerations

Our material from qualitative interviews has been valuable in highlighting some of the more “subtle” consequences of weight loss surgery. There are, however, some methodological considerations to reflect upon in this article. The first concerns the timing of the interviews. Charlene was contacted 1 year after the first interview because she differed from the others in the severity of her problems. Shortly afterward, however, the interviewer received a message on her mobile phone from Kina emphasizing that her problems had become worse 1 year after our previous meeting and that she would like to be interviewed once again. Because the situations of these two women had changed significantly within the period of 1 year, a second meeting was also planned with the other three women. However, when the interviewer contacted them by telephone to arrange for a second interview, things did not turn out as planned. First, Jane declined because of “serious disease” in her closest family. By comparison, Mary claimed that her situation was the same as previously, so that there was no need for a second interview. Finally, Kirsten did not return the interviewer’s calls. Not answering or calling back was interpreted by the researchers as a sign that she did not wish or was unable to participate in a second interview. Moreover, we concluded it would be unethical to keep trying to get in touch with her, bearing in mind the voluntary aspect of this study. Still, at the end of this article, we cannot help but wonder if our findings would have been different if Kirsten and Jane had been interviewed once more.

Another methodological aspect concerns our choice of sample. It must be noted that the five women included in this article were more or less “deliberately” chosen from a larger sample based on the negative experiences they emphasized during the interview. Hence, we had not planned for this particular article at the outset of our study. Nor did we recruit participants in terms of positive and negative postsurgical experiences. The worse life experiences “came up” gradually as we analyzed the material again and again, searching for similar and contrasting experiences between the 22 women. However, if one relates our findings to recent statistical studies, nearly 23% of individuals undergoing weight loss surgery report having chronic side effects

of various kinds or have been reported to need a reoperation due to various complications (Buchwald et al., 2004; Maggard et al., 2005). The validity of our findings must be related to the interview context in which they have been produced. Moreover, knowledge about these “subtle” consequences of weight loss surgery also acquires relevance in a larger context, especially for health providers and patients who intend to undergo surgery. Patients are entitled to a realistic estimation of possible consequences in making the decision to undergo the surgery or otherwise. In this regard, knowledge about first-person experiences is paramount. By focusing on five women’s thoughts and experiences, we have gained some new insight into this matter, but we are also left with new questions. How can health workers, give hope to women who feel entrapped in an irreversible situation after weight loss surgery? What kind of support can alleviate their suffering? Therefore, the themes revealed in this study need to be further examined in future studies.

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Notes

1. Of 24 nations surveyed worldwide in 2003, two bariatric procedures were found to be most common; namely, the gastric bypass and the gastric banding. There were 80% of surgeries in Australia and New Zealand that used the gastric banding procedure, whereas European countries, the United States, and Canada usually perform the gastric bypass procedure [see, for example, Buchwald and Williams (2004)].
2. Dumping is commonly regarded as a side effect that occurs when patients eat too much food or too much sweet food. See, for example, Deitel (2008).

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