"I USED TO BE FAT"
A QUALITATIVE ANALYSIS OF BARIATRIC SURGERY PATIENTS

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Steven W. Fife

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Morehead State University, 2019

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Obesity continues to be a growing threat to public and individual health in the United States of America. As of 2015-2016 an estimated 39.8% of adults in the United States are considered obese (Carroll, Hales, Fryar, & Ogden, 2017). One way of overcoming obesity is by undergoing bariatric weight loss surgery, which has been routinely shown to be the most effective method of treating obesity (Hollywood, Ogden, & Pring, 2012) and in 2017 approximately 228,000 people in the United States underwent the procedure (American Society for Metabolic and Bariatric Surgery, 2018). The dramatic weight loss common to these patients can create changes in several aspects of self-concept leading to changes in social roles.

Current literature primarily examines mental health and physical health concerns of both pre-operative and post-operative bariatric surgery patients with a focus on surgical outcomes, but there are studies on weight stigma and its impact on society and the effects of bariatric surgery

on psychosocial health. These studies show that weight stigma is a prominent avenue for discrimination (Puhl & Heuer, 2009) while also playing a role in self-identity (Kubik, Gill, Laffin, & Karmail, 2013).

This study is a qualitative analysis of bariatric patients using a symbolic interactionist framework incorporating labeling theory and modern looking glass theory to explore changes in self-concept and how those changes influence social roles and interactions. In-depth interviews with five post-operative bariatric surgery patients were conducted as well as a netnographic study of eight online bariatric surgery support groups comprised of approximately 120,000 members.

Themes found in this study include changes in self-concept, individual attempts by participants to control how they are viewed by others, and changes in social roles. This research found results in line with previous studies about the impact of weight loss on self-concept and internalized weight stigma but, expands on these findings to include examples of individuals taking an active role in shaping their new identity and the roles they play in society. Changes in career occurred, as did changes in relationships, and parental status. Interview data were corroborated by the netnographic study of online bariatric support groups. Finally, I conclude by calling for a holistic model of well-being in bariatric service centers to provide support for these changing social roles and show a need for additional research into the impact of digital interactions and communities on self-concept.

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Chapter 1: Introduction

Obesity in America

Defined as having a body mass index $\geq$ 30, obesity has reached epidemic levels according to the Centers for Disease Control and Prevention (Magallares & Schomerus, 2015). As of 2015-2016 an estimated 39.8% of adults in the United States are considered obese and this number continues to climb despite growing public awareness of the dangers of being obese (Carroll, Hales, Fryar, & Ogden, 2017). Medical expenses in combination with missed time and production at work related to obesity costs an estimated 153.38 billion dollars a year in America (Centers for Disease Control and Prevention, 2018) and as we get larger so does this figure.

A considerable amount of research has been conducted regarding the public health, personal health, and economic costs of obesity and statistics like these provide a broad picture of obesity in America. While they are a crucial tool for policy makers and health industry officials (combating the problem and creating public awareness) these broad picture statistics do not sway individual ideas about obesity. According to one study in the *Journal of Health Politics, Policy and Law* "contrary to the views of health experts, most Americans are not seriously concerned with obesity, expressing relatively low support for obesity-targeted policies, and still view obesity as resulting from individual failure rather than environmental or genetic sources." (Oliver & Lee, 2005).

From an individual standpoint there are a host of medical maladies whose risk climbs with our expanding waistlines. These include high blood pressure, type 2 diabetes, coronary heart disease, stroke, clinical depression, anxiety disorders, some cancers, and most notably an increased risk for all causes of death (Centers for Disease Control and Prevention, 2018). Again,

ample research has been done examining how obesity influences individual health and using this data as a tool, medical professionals routinely advocate for weight loss with their patients sometimes even employing scare tactics to elicit action.

It should be noted that while the academic, medical, and lay communities roundly accept that there is a global obesity epidemic there are detractors. One figure in the ongoing debate is Dr. Traci Mann who in a 2017 article claims that there is "no obesity crisis" (Foster, 2017). Dr. Mann asserts that current obesity research shows that obesity only shortens lifespans at the highest weights and that a focus on exercise rather than weight could lead to a healthier society (Foster, 2017). The article goes on to point out that obesity itself is not the culprit that shortens life spans but that it is correlated with 3 things known to do so, "being sedentary, having a lower income, and not getting enough medical care." (Foster, 2017). There is a case to be made that our obsession with beauty and the perpetuation of a fat-phobic society play a role in the manufacturing of a "crisis". Additional recent research indicates that negative experiences with medical professionals can result in women with a high body mass index to avoid seeking medical care which in itself may have negative health repercussions (Mesinger, Tylka, & Calamari, 2018). While this ongoing debate is acknowledged the present study assumes the position that current levels of obesity create negative health implications for individuals and society.

Bariatric Surgery

Exploring the public health, personal health and economic implications of obesity is important and continues to be fertile ground for researchers hoping to stem the tide of weight gain in the United States. These studies have shaped our approach to obesity treatment helping medical researchers find novel and effective ways to combat the epidemic. Chief among these is bariatric surgery, a revolutionary creation of modern medicine that is becoming the gold standard in the fight against severe obesity.

At present bariatric surgery is the most effective method to treat obesity (Hollywood, Ogden, & Pring, 2012). Several techniques have been developed since the inception of bariatric surgery, all aimed at reducing caloric intake through restriction of stomach size. Two of the most widely used procedures today are Vertical Sleeve Gastrectomy and Roux-En-Y. The first, the Vertical Sleeve Gastrectomy or VSG, is a laparoscopic surgery wherein
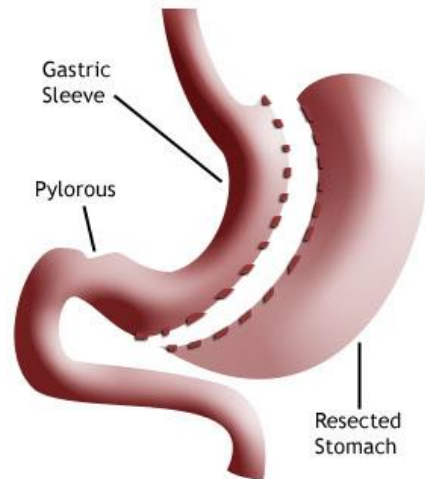
Vertical Sleeve Gastrectomy

approximately 80% of an individual's stomach is removed and the remaining portion is sealed
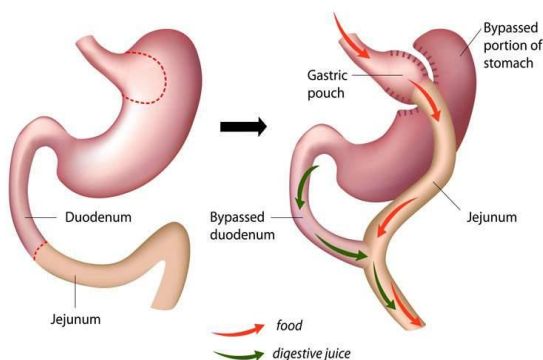
Roux-En-Y

with staples, sutures, and/or various other sealers. According to the American Society for Metabolic and Bariatric Surgery in 2017 approximately 228,000 people had bariatric surgery in the United States. Of those 228,000 people 59.39% or 135,409 underwent the VSG (American Society for Metabolic and Bariatric

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Surgery, 2018).

The second procedure, also performed laparoscopically, is the Roux-En-Y (commonly referred to as a bypass or an RNY). In this surgery most of the stomach is bypassed introducing food directly to the jejunum where it then mixes with digestive fluids. Of the total 228,000 bariatric surgeries conducted in 2017 the RNY comprised 17.8% or 40,584 people (American Society for Metabolic and Bariatric Surgery, 2018).

Both surgeries restrict the amount of food that can be consumed in a single sitting and have shown to be highly effective at helping severely obese people lose a substantial amount of weight as well as curing weight related diseases like type-II diabetes. My own struggle with obesity began with sleep apnea and led me to have a Vertical Sleeve Gastrectomy in April of

2018. I have lost 120 pounds in 10 months and no longer have sleep apnea or high blood pressure. My medical successes are commonplace among bariatric surgery patients and stories like mine are shared in bariatric surgery centers nationwide (see figure to the left). The psychosocial ramifications of these surgeries and the rapid weight loss that accompanies them however is researched far less often.

A review of the literature regarding interpersonal relationships and self-concept of bariatric patients yields results primarily focused on the influence of psychosocial changes on surgical outcomes or individual mental health. While this is an important avenue of research, the changes experienced by these patients could shed light on other emergent social concerns. Our

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ability to interact with others and share information has reached a scale never before seen in human history. Online communities are a new, pervasive component of social interaction and as communicative technology grows, expanding its reach globally, so too must sociological study evolve.

This study seeks to add to the body of knowledge by exploring changes in self-concept and the impact of those changes on the experiences, interactions, and interpretations of bariatric surgery patients. The effects of rapid weight loss on individual psychology will be examined, as well as changes in social interactions. Studying individual patients and online bariatric communities can provide a greater understanding, from a symbolic interactionist viewpoint, of self-concept's influence on social interaction.

Examination will be conducted from a symbolic interactionist perspective using qualitative methods including in-depth semi-structured interviews with bariatric patients. The central focus of these interviews will include changes in self-concept, self-talk, self-expression, sociocultural roles, and interpersonal interactions. Additionally, a netnographic study of various online bariatric support groups consisting of approximately 120,000 members will be conducted to supplement findings from interviews and provide sociological context for bariatric population. The netnography will further highlight the volume of interactions made possible by modern communications technology, as well as showcase examples of how social media perpetuates changes in symbol generation and interpretation finally calling for continued research into digital communities.

Chapter 2: Literature Review

Psychosocial Considerations of Bariatric Patient Treatment

Literature that explores changes in post-surgery psychological concerns and changes in self-concept following radical physical change are limited. One recent study examines marital instability after brain surgery (Kreutzer, et al, 2016) and another explores the effects of personality on psychological well-being following coronary Artery Bypass Surgery (Ruiz et al., 2006). However, these studies tend to focus on surgical outcomes or the exacerbation of existing psychiatric disorders. I found very few studies, however, that study individuals who may not meet the threshold for a psychiatric diagnosis but whose lives are dramatically altered by these procedures and the weight loss that accompanies them.

In a study titled *The impact of a bariatric rehabilitation service on weight loss and psychological adjustment – study protocol* a randomized control trial of bariatric patients examined the impact of bariatric rehabilitation services (BRS) on weight loss outcomes and psychological considerations (Applegate & Friedman, 2008). Participants either received the standard bariatric care which includes a pre-surgery psychiatric screening but no postoperative care or they received BRS which addresses dietary control, self-esteem, coping and emotional eating. They predicted that participants of BRS would not only see better surgical results but that the additional post-operative care would mitigate the effect of psychological changes that occur with bariatric procedures (Hollywood, Ogden, & Pring, 2012). The research found that providing psychological care both pre and post-surgery does improve surgical outcomes and quality of life for participants which leads to fewer revisions and reduced public healthcare expenditures. Studies like (Hollywood, Ogden, & Pring, 2012) are an important step toward gaining an

understanding of the effect obesity has on our mental health but fall short of any detailed psychosocial analysis. Overweight individuals, who may have lived their entire lives with the stigma of obesity, will likely see profound changes in their psychosocial behaviors and interactions after weight loss and more research is needed in this area.

Post-Surgery Support

The clinical treatment approach of many bariatric centers includes in person support groups. These groups allow a safe space to share successes and failures, to talk about diet challenges and workout routines, and to gain a sense of community with others who understand the trials of bariatric life. They can be an invaluable resource for patients, but a considerable number of patients fly to Mexico for surgery, where it is more affordable. This limits access to postoperative support. Those people that have surgery in the Unites States usually have access to monthly support group meetings with their bariatric providers, but a substantial portion of these individuals are unwilling to make long trips to providers for these meetings, so they turn to online support groups for information and a sense of community.

Online support groups cater to group affiliations and identities beyond the label of "bariatric patient". There are groups for newcomers, men, women, the LGBTQIA+ community, marijuana enthusiasts, and many more. From a symbolic interactionist perspective because so many bariatric patients engage in online support communities and the quantity of interactions specific to the physical, and psychosocial changes that take place with dramatic weight loss is higher than it would be with face to face interactions alone, there are more opportunities for adjustments in self-concept (Charon, 2004). This study seeks to incorporate data from these

interactions in digital communities to explore how they contribute to changes in self-concept for bariatric patients.

The Stigma of Obesity

Before 1980 "6.5% of children ages 6–11 were overweight or obese and 5% of children ages 12–19 were overweight or obese" (Lawrence, 2010). By 2004 these percentages had ballooned to 18.8% for children ages 6–11 and 17.4% for those 12-19 (Lawrence, 2010). Obese individuals are routinely characterized and/or judged by their weight and these stigmas aren't simply relegated to being mocked or bullied. Between 1999 and 2009 the rate of weight related prejudice and discrimination rose by 66% (Puhl & Heuer, 2009).

Overweight people are frequently thought of as "lazy, unmotivated, lacking in self-discipline, less competent, non-compliant, and sloppy" (Puhl & Heuer, 2009). These labels are part of American cultural socialization and are carried with obese people as part of their self-concept affecting their self-talk, self-judgement, and ultimately their role in society (Link, Cullen, Struening, Shrout, & Dohrenwend, 1989). The cultural acquiescence to weight discrimination leads to inequalities in the workplace, schools, medical settings, and every other facet of the day to day lives of obese people (Puhl & Heuer, 2009). The simple truth is if you're overweight in America, you can't escape being the "fat one" and that identity is carried from childhood for many patients of bariatric surgery. Those who choose to undergo bariatric surgery may find themselves thin within 18 months post-op and then have to learn a new way of interacting with society. After a lifetime of being teased, bullied, discriminated against, and otherwise sanctioned by society, the "fat" label no longer applies, and this is not an easy

transition for some. This leads them to seek out support and information from any source and a substantial portion engage in online bariatric support groups.

The Effects of Bariatric Surgery on Psychological Health

Studies that examine psychological health of the bariatric surgery population tend to concentrate on surgical outcomes or on reductions in mental and physical disorders. The authors of the article *The Impact of Bariatric Surgery on Psychological Health* examined 27 articles related to the psychological impact of bariatric surgery on obese patients (Kubik, Gill, Laffin, & Karmail, 2013). Their review found that "weight loss surgery improves self-esteem, self-confidence, and expressiveness. These changes appear to be correlated with major improvements in body image and weight-loss satisfaction after surgery" (Kubik, Gill, Laffin, & Karmail, 2013). The review completed by Kubik et al is a thorough and detailed analysis of current literature with respect to the psychological concerns of bariatric patients but as with other studies that explore self-concept little attention is given to how these changes impact social interactions.

Examination of the parts to understand the whole is an integral part of scientific inquiry and from a symbolic interactionist point of view our self-concept is a crucial part of our whole (Charon, 2004). Biologists study cells, DNA, and individual genes (the building blocks of life) to better understand complex biological processes and even life itself. Physicists look at subatomic particles and have a field of study (quantum theory) that explores the smallest constituent pieces of the universe to learn more about the system as a whole. Symbolic interactionism uses this same approach, seeking out the smallest components of society, our individual perceptions, interactions, and interpretations of symbols, (Charon, 2004) to gain a better understanding of how these pieces shape the whole.

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A dissertation written by Karla K. Carwile-Ivankovich in 2015 examined self-esteem and its correlation to healthcare. Specifically, it examined "whether or not there was a correlation between self-esteem and the extent to which healthcare professionals were perceived to stigmatize obese minority patients through their anti-fat attitudes" (Carwile-Ivankovich, 2015). They found that there was a strong evidence of a link between low self-esteem and perceived weight stigma (Carwile-Ivankovich, 2015). Carwile-Ivankovich examined minority patients but obese individuals in my own research have routinely made claims of weight discrimination regardless of race, ethnicity, age, gender, or socio-economic status. This is a perfect example of individual self-concept affecting social interpretations and interactions. Obese individuals who need medical care can put off that care owing to fear of what the doctor will say. To quote one of my interviewees "Every time I would go to the doctor, they told me my problem was caused by my weight. It didn't matter if I had a cold, cancer, or a broken bone the question of my weight always came up. It's like all they saw was a fat person." Research like Carwile-Ivankovich's is an important step toward gaining a holistic understanding of obesity's impact on social health but it is the exception.

Studies like *The relationship between weight loss and psychosocial* (Thonney, Pataky, Badel, Bobbioni-Harsch, & Golay, 2010)*, Two-year trends in psychosocial functioning after adolescent Roux-en-Y gastric bypass* (Zeller, Reiter-Purtill, Ratcliff, Inge, & Noll, 2011)*, and Short-Term Psychological Outcomes in Severely Obese Adolescents After Bariatric Surgery* (Järvholm, et al., 2011) also examine psychosocial health following bariatric surgery but the focus is primarily on measures of reduction in depression, anxiety, and other mental health concerns. They corroborate similar findings indicating that across populations a significant weight loss leads to improved self-esteem, lessening anxiety and depression, and a general

higher quality of life. These psychological considerations make substantial contributions to understanding bariatric patients and it is the purpose of this study to expand on this psychological bedrock by providing analysis of self-concept changes in context of social interactions.

The Spread of Data in the Information Age

Communication is at the heart of what it is to be a human being. It gives us the tools needed to form bonds, groups, communities, cultures, nation states, and our global society. The spoken word was a monumental evolutionary achievement that, as far as we know, is unique to the human race. Any introductory course in sociology will point out that language is a cultural universal and a cornerstone of society that makes the generational perpetuation of a culture possible (Giddens, Applebaum, Duneier, & Carr, 2018). The internet facilitates communication on a grand scale making our world a miniscule place. According to a US Census Bureau report published in 2017 by

Majority of Americans now use Facebook, YouTube
% of U.S. adults who say they use the following social media sites online or on their cellphone

YouTube 73%
Facebook 68
Instagram 35
Pinterest 29
Snapchat 27
LinkedIn 25
Twitter 24
WhatsApp 22

Note: Pre-2018 telephone poll data is not available for YouTube, Snapchat or WhatsApp.
Source: Survey conducted Jan. 3-10, 2018. Trend data from previous Pew Research Center surveys.
"Social Media Use in 2018"
PEW RESEARCH CENTER

the year 2015 in America 86.8% of all households had a computer in them and 77.2% had an internet subscription (Ryan & Lewis, 2017). A report published by Pew claims that "Roughly two-thirds of U.S. adults (68%) now report that they are Facebook users, and roughly three-

quarters of those users access Facebook on a daily basis." (Smith & Anderson, 2018). Social media has forever changed the face of communication on a global scale. At the end of 2018 there were 3.9 billion people (51.2% of global population) online (International Telecommunication Union, 2018). The sheer scale of the human race's ability to communicate and interact with one another has exploded since the birth of the internet and as this percentage grows so to do the number of interactions between people and cultures.
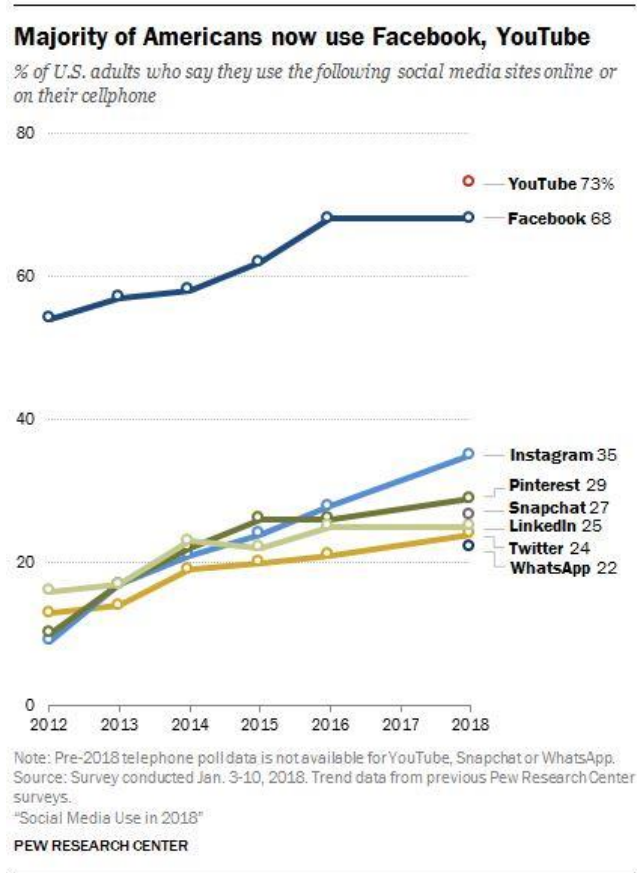
From a symbolic interactionist perspective, it is important to understand how these advances in communicative technology creates new methods of interaction as well as new symbol generation and interpretation. Examined through this lens exploration of online bariatric support groups could be instrumental in gaining a greater understanding of the role digital interactions play in self-concept change. Literature that examines these support groups is sparse but available. In *Content and accuracy of nutrition-related posts in bariatric surgery Facebook support groups* (Koball, et al., 2018) the accuracy of content shared on bariatric support groups was studied. They found that "Over half of the posts contained inaccurate content or information that was too ambiguous to determine accuracy; 7% of posts were found to be inaccurate or inconsistent with American Society for Metabolic and Bariatric Surgery nutrition guidelines and expert registered dietician opinions, 22% of posts were found to contain both accurate and inaccurate information, and 24% of posts were considered too ambiguous and required more context to determine the accuracy" (Koball, et al., 2018). Indeed, my own research found widespread misinformation being shared on these forums.[1]

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[1] One statistic attributed to an article in *Counseling Bariatric Surgery Patients* by Dan Orzech claims that 80-85% of patients get divorced citing Dr. John Pilcher, MD, FACS. However, in correspondence with Dr. Pilcher he states that "I'm pretty sure I never made a statement indicating that 85% of bariatric patients get divorced. As you're probably aware there is a significant bump in divorces during the few years after bariatric surgery, but I believe the rate is well less than 50%. Separately as a concern, I've never published any literature about divorce rates. So, I have to conclude the citation is false."- Dr. John Pilcher MD, FACS

Another study of note is *'The only chance of a normal weight life': A qualitative analysis of online forum discussions about bariatric surgery* (Willmer & Salzmann-Erikson, 2018) hoped to "describe shared values, feelings, and thoughts among visitors to a web-based forum for those undergoing bariatric surgery" (Willmer & Salzmann-Erikson, 2018). They found that a substantial number of bariatric patients have hopes of gaining a "new life" from bariatric surgery and that these extreme/unrealistic expectations were "rooted in the stigma and discrimination that they experienced in their everyday lives." (Willmer & Salzmann-Erikson, 2018). Studies like these paint a picture of the complex interactions, both internally and with others, that take place online. Additionally, they showcase a need for further exploration of the effects digital communities have on our self-perception, self-judgment, identity, and self-concept.

Conclusion

Currently available literature explores the physical and psychological health considerations of bariatric patients largely focusing on surgical outcomes. While there is some research that looks at the various components of self-concept these too are framed by surgical outcomes and mental health. What seems to be missing from the body of knowledge is a contextual framework for how change in self-concept associated with bariatric surgery impacts social roles, relationships, careers, and day to day life. This includes how new thought patterns shape changes in social interactions both in person and in digital communities. To begin filling that gap this study focuses on individual interviews and corroborates themes discovered with data gathered from digital bariatric communities.

Chapter 3: Theoretical Framework

Symbolic Interactionism

It could be argued that our ability to communicate with one another is the single greatest evolutionary advantage afforded to humanity. Society, as we know it, would not exist without the sharing of knowledge and symbolic interactionism provides a framework for examining that sharing along with all other human interaction. Because my own research centers on changes in self-concept, a key component of symbolic interactionism, it is ideal for this study. Furthermore, it provides the tools needed to understand social and internal interactions and the interplay between the two.

Symbolic interactionism is typically associated with the work of philosopher George Herbert Mead and you can gain an understanding of basic symbolic interactionism by looking at who and what influenced Mead; pragmatist philosophy, behaviorism, and the work of Charles Darwin. (Charon, 2004). Although Mead published several articles while at the University of Chicago, it was his students, particularly Herbert Blumer, posthumously publishing his lectures and notes that solidified Mead's influence on symbolic interactionism (Charon, 2004). According to Blumer symbolic interactionism is comprised of three assumptions and these assumptions lead to three premises (West & Turner, 2018).

"Assumptions & Premises:

Assumption 1.) Individuals create/derive meaning from the communication process.

> *Premise 1.) Humans act toward things based on the meaning created/derived then attributed to those things.* (Blumer, 1969)

Assumption 2.) Self-Concept is motivation for our behavior.

> *Premise 2.) Meaning is derived from social interaction with others and society.* (Blumer, 1969)

Assumption 3.) There is a unique relationship between the individual and society.

> *Premise 3.) Meanings are modified through and handled by an interpretive process (thinking/inner dialog).* (Blumer, 1969)*"*

Building on the work of George Mead and Herbert Blumer, Joel Charon created the five central ideas of SI (Charon, 2004) and taken collectively these five ideas make up the bedrock for the sociological examination of human interaction.

Five Central Ideas

1.) *The role of social interaction:* Focusing on the nature of interaction itself SI rejects the notion of a passive organism merely being acted upon by its environment. Our societies are comprised of interacting individuals. People change continuously because of these interactions giving rise to societies and then changing those societies through further interaction. It is a continuous, ongoing process of human beings acting in relation to one another. We are influenced by the actions of others but also influence the actions of others in a complex and dynamic system. We are simultaneously acted upon by our

environment and act upon our environment. "Social interaction is almost always central to what we do." (Charon, 2004)

2.) *The role of thinking:* "Human action is caused not only by interaction between individuals but also by interaction within the individual." (Charon, 2004) While the interactions we have with others is important so too are the interactions taking place within ourselves. The constant dialog we call thinking shapes our actions in any given situation influencing our actions. (Charon, 2004)

3.) *The role of definition:* Each of us experiences our own version of reality. The things around us are not experienced objectively but rather pass through the filter of the definitions we give them over time. These definitions are the result of collective social interactions and our own thought processes and we decide how to react based on the definitions in use. For example, when presented with a dog one individual may act by petting the dog because their definition is of a pleasant furry human companion while someone else may feel intense fear and avoid the dog because their definition is a perceived threat. Both people are presented with the same stimuli but the difference in cumulative social interactions and internal thinking creates a different definition and therefore a different reality. (Charon, 2004)

4.) *The role of the present:* Our past experiences shape our definitions, but our actions are the result of what's happening now, in the present. "Cause unfolds in the present interaction, thinking, and definition." (Charon, 2004) What we do in a given situation is ultimately dependent on our definition, our thinking process, and our interaction in that moment. We may have past experience that defines a dog as a threat but if a current

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interaction provides new information to contradict that definition our actions will change accordingly. (Charon, 2004)

5.) *The role of the active human being:* "symbolic interactionism describes the actor as a being who interacts, thinks, defines, applies his or her past, and makes decisions in the present based on factors in the immediate situation." (Charon, 2004) The view of SI, unlike other perspectives, is not one of a passive entity being acted upon but that of an actor. We participate in, use, and shape our environments rather than just responding to them. (Charon, 2004)

Given the work of Mead, Blumer, and Charon symbolic interactionism appears to be the best fit for work involving self-concept and will be the primary theory used here. However, symbolic interactionism is not without its criticisms. In an article published in 2008 Sheldon Stryker states that "Mead's social psychological work constituted a conceptual/theoretical frame, not a theory per se." and that "frames are not subject to direct tests of truth" (Stryker, 2008). This is a common issue of contention where SI is concerned but as "conceptual/theoretical frames" provide amble opportunity for new theory generation and multiple methods research, it is still the most appropriate framework for this study.

The Self

A key ingredient in our interactions with the world around us is our ability to examine and communicate with ourselves. We can understand our self and therefore we can specify to the self information about the self in a situation (Charon, 2004). Our ability for self-perception allows us to understand others and to appraise ourselves (Charon, 2004) giving us a contextual framework for interaction and the ability to act on our environment and the

actors in it and not simply be acted upon. Through the course of our lives we refine our

interactions and develop stable patterns of behavior tied to our sense of self. We develop a

self-concept.

As previously stated, self-concept plays an important role in symbolic interactionist

theory. It encompasses several key ideas about the self without which symbolic

interactionism wouldn't make sense. Self-concept is "the totality of the individual's thoughts

and feelings with reference to himself [or herself] as an object" (Charon, 2004). It's the

picture of ourselves each of us carries in their mind and while it does change throughout the

life course it is different than self-image which pertains to specific situations and influences

our actions in every situation (Charon, 2004).

One aspect of our self-concept is self-judgement (Charon, 2004). Each interaction with

the environment, others, or ourselves provides an opportunity for self-analysis and positive or

negative self-talk. We could, for example, score well on a test and make positive self-

judgements about how hard we studied our how smart we are, or we could make a social faux

pas and put ourselves down. This train of positive and negative self-talk could be considered

"self-esteem"; "The self is something we judge, evaluate, like or reject, love or hate."

(Charon, 2004). This concept is vital when examining the rapid physical and psychosocial

changes of bariatric patients. The internal dialog changes that occur when one loses a

dramatic amount of weight should cause a revision to our self-esteem. Where once someone

would look in the mirror and think "I'm disgusting. Look at those rolls, and that fat." Now

they might say "Wow! I can't believe how thin I look. I'm hot stuff."

It isn't just our own self-judgment that that is important though. While we are examining

ourselves in the mirror, we not only make our judgements about our self, but we imagine the

judgement of others and feel positive or negative about those as well (Charon, 2004). Imagine for a moment that you are in a crowded elevator and loudly pass gas. Perhaps your boss is there, or someone you're attracted to, or even just a large group of strangers. The anxiety you experience you by imagining the situation is an example of perceived judgement from others. This implies that even imagined social norm violations can impact our self-esteem and therefore our interactions.

This idea of imagined judgement from others is called the looking glass self. This theory, credited to James Cooley, states "that one's self-concept is a reflection of one's perceptions about how one appears to others (Shrauger & Schoeneman, 1979). Cooley contends that our self-concept develops from childhood based on how others respond to us (Shrauger & Schoeneman, 1979). The looking glass self provides a bedrock on which symbolic interactionist thought can be built and this study will use Cooley's looking glass self in conjunction with modern theories of self-concept like those of Joel M. Charon.

The last component of self-concept is our identity, which is the name we call ourselves (Charon, 2004). For symbolic interactionists this is an important notion because words themselves are symbols. This means that by naming ourselves we become "an object toward which we direct symbolic communication" (Charon, 2004). Each of us can have multiple names (man or woman, lawyer, father, sociologist, etc.…) some of these are easily changed and others are not. Some are central to our identity and others are not. "Fat" is an identity that can be changed, though not always easily, and for some has been a central component of who they are for their entire lives. Now, we turn to labeling theory.

Labeling Theory

Labeling theory states that we ascribe attributes of social roles (labels) placed on us to ourselves, providing an explanation of one way we interact with ourselves as objects. This holds with the view in symbolic interactionism that we act upon ourselves as objects just as we would any other object or symbol. Labeling theory first emerged in the 1930's but didn't gain prominence until Howard Becker's work *Outsiders* was published in 1963 (Prus, 1975). A theory concerned with social deviance and crime labeling theory argues that "powerful individuals and the state create crime by labeling some behaviors as inappropriate" (Encyclopædia Britannica, 2019). These theorists go on to claim that even when efforts are made to help deviant individuals conform/reform (rehabilitation) that they are pushed further into deviant behavior due to the labels placed on them and the reactions of society based on said labels. This is sometimes likened to a self-fulfilling prophecy where "deviants" adopt those labels and internalize the associated identity (Encyclopædia Britannica, 2019).

Since that time, the work of other social scientists, notably Bruce Link, have created a modified theory that expands on labeling theory, including a five-stage process as it pertained to mental illness (Encyclopædia Britannica, 2019).

Modified Labeling Approach (Link, Cullen, Struening, Shrout, & Dohrenwend, 1989)
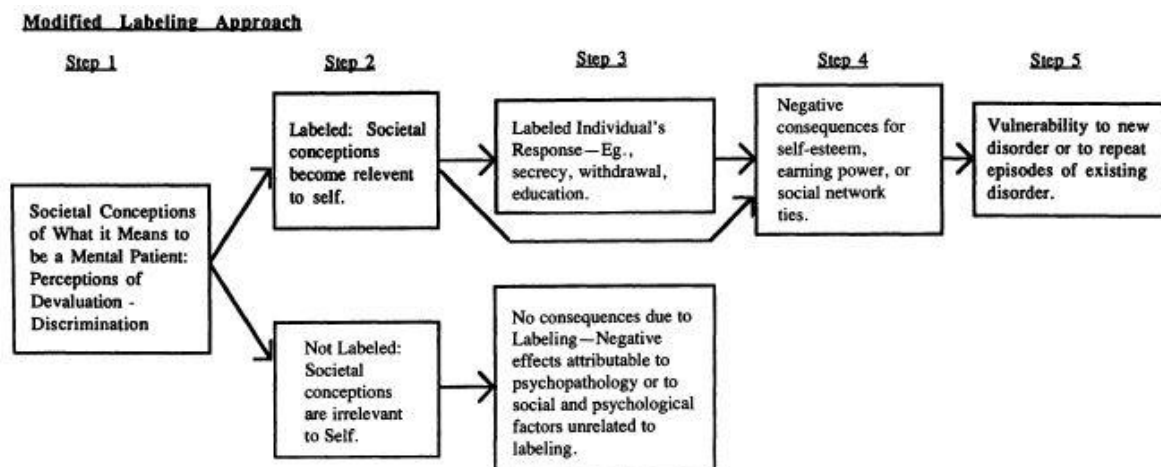
Link et al claim that even if labeling doesn't produce mental illness by itself it can nevertheless still lead to negative outcomes (Link, Cullen, Struening, Shrout, & Dohrenwend, 1989). Socialization leads us all to a set of beliefs based on our culture and its norms and while Link specifically addresses socialized beliefs about mental illness his modified labeling theory can be applied to any label/identity about which a culture has a socialized belief system; in this study it is obesity.

While obesity is not a criminalized social norm violation it is certainly stigmatized in American society (Puhl & Heuer, 2009). In the past 20 years the prevalence of childhood obesity has increased and the stigma these children face has kept pace (Lawrence, 2010). To borrow from Link if a child develops obesity and maintains that state into adulthood, they will undoubtedly adopt the various stigmas and labels associated with obesity and incur possible negative consequences of those labels. Following the modified labeling theory flow chart for an obese individual might look like the following.

Step 1: Societal conceptions of what it means to be obese.

Obese persons are lazy, unmotivated, lacking in self-discipline, less competent, noncompliant, and sloppy (Puhl & Heuer, 2009).

Step 2: Labeled: Societal conceptions become relevant to self.

The labels listed in step one are thrust upon the individual either by others or by themselves.

Step 3: Labeled individuals response.

The obese individual will respond to the labels in some way. They might adopt one of the socially acceptable "fat tropes" like the jolly fat guy or the funny one, they may retreat from society, hide their eating habits etc.

Step 4: Negative consequences for self-esteem, earning power, or social network ties.

You are subject to discrimination because "the prevalence of weight discrimination in the United States has increased by 66% over the past decade, and is comparable to rates of racial discrimination, especially among women. Weight bias translates into inequities in employment settings, health-care facilities, and educational institutions" (Puhl & Heuer, 2009). Additionally, your internal dialog is impacted by the labels associated with being obese. You see yourself as "lazy, unmotivated, lacking in self-discipline, less competent, noncompliant, and sloppy" (Puhl & Heuer, 2009). You also ostracize yourself from family and friends cutting ties to your social network because you have adopted the "obese" label and all the social conceptions that come with it.

Step 5: Vulnerability to new disorder or repeat episodes of existing disorder.

Adoption of the "obese" label and its associated stigmas contributes to new physical, mental, and social concerns.

Conclusion

Self-concept is a complex multifaceted idea that involves socialization, interactions with society, interactions with those close to us, and interactions with ourselves (Charon, 2004). The theories and concepts mentioned here (symbolic interactionism, looking glass self, and labeling theory) have many overlapping ideas but also each contribute something unique to the study of the self. Symbolic interactionism provides a bedrock for understanding interaction and communication upon which looking glass and labeling theories stand. Looking glass self showcases the active component of these interactions (Giddens, Applebaum, Duneier, & Carr,

2018) and details how each of us participates in shaping our identities while labeling theory explains how outside influences can shape us (Gecas, 1982). To borrow a term, our self-concept is intersectional and can best be understood in that context. If we hope to gain a greater understanding of how and why the self changes as well as what influence those changes have on our interpretations and interactions in society, we must consider all sources of influence and be open to the possibility of discovering new components in our exploration.

Chapter 4: Methodology

The current study uses a qualitative research design. When formulating the design my first concern was ontology or, what is the nature of reality. Whether nature is objective, things exist as they are independent of outside observation, or subjective and created by the observer. Objective ontology easily lends itself to quantitative methods because if there is one fixed reality it can be observed and measured in a manner that would be consistent regardless of the observer (Giddens, Applebaum, Duneier, & Carr, 2018). Qualitative methods on the other hand focus on individual experiences (Giddens, Applebaum, Duneier, & Carr, 2018) and therefore are subjective in nature. Self-concept being deeply personal, individual, and subjective (Charon, 2004) a qualitative approach is the most logical choice for this study.

The second consideration when designing a research project is epistemology, which deals with concepts of knowledge; what do we know, how do we know it, what can we know, etcetera (Martinich & Stroll, 2019). Individual self-concepts are, again, deeply personal and individual and as such, truly "knowing" someone's self-concept would require a level of interpersonal understanding that is not achievable. We would need to hear their internal dialog, feel their emotions, and experience the world as that person which at present is an impossibility. If we are unable to "know" something as objective fact, we must rely on subjective meanings and interpretations from the subjects themselves. One approach to attain these meanings and interpretations is through the use of ethnographic research methods.

Ethnography

Ethnography, described as "a cocktail of methodologies that share the assumption that personal engagement with the subject is the key to understanding a particular culture or social setting." (Kozinets, 2015) comes to us from anthropology and is a collection of research practices geared toward description and understanding of cultures, groups, or particular social settings (Kozinets, 2015). It's a flexible discipline that provides rich information integrating a myriad of research techniques from both quantitative and qualitative ideologies and relies heavily on the researcher's interpretation. Throughout the course of the past century ethnographies have been conducted on "almost every race, nationality, religion, culture, and age group" (Kozinets, 2015) as well as non-human groups such as chimpanzees, gorillas, dolphins, and wolves (Kozinets, 2015).

Ethnographies tell a story. They help us gain a more cogent understanding and appreciation for the "other" and sometimes even provide a deeper appreciation for ourselves. The current research relies on several ethnographic techniques (including some modern digital ethnographic methods) in its attempt to showcase the lives, communities, interactions, and internal thought processes of bariatric surgery patients. The use of multiple methods of data acquisition and analysis will provide both breadth and depth of information while also incorporating modern communal spaces and group settings (online communities and groups) to examine the impact of online interactions as well as traditional ones.

Interviews

Data collection for this study began in earnest from August of 2018 through February of 2019 but, being a bariatric patient myself I have been immersed in this community since October of 2017. Snowball sampling, which uses referrals from research participants to help locate additional subjects, (Oregon State University, 2010) was used to find respondents for in depth interviews. A total of seven respondents were selected for interviews, consisting of five females and two males all of whom had undergone bariatric surgery and were at varying post-operative stages and socio-economic backgrounds. Of these seven subjects six agreed to be interviewed and five gave consent to use their interview; four females and one male. While these demographics are not ideal, they are indicative of overall bariatric surgery populations wherein "women constitute 85% of all bariatric surgery cases, with men only constituting 15% in the United States" (Moore & Few-Demo, 2017).

Respondents were then contacted via phone, text message, or through Facebook and arrangements were made to conduct interviews in a private setting; primarily office space on Morehead State University's campus. Each interviewee was provided an informed consent form (see appendix) which detailed the purpose of the interview, the purpose of the study, and how their privacy would be safeguarded. Additionally, each was informed verbally by the interviewer that any question they were uncomfortable answering could be skipped, they could stop the interview at any time for any reason, that they could rescind their permission to use their story at any time for any reason, how their privacy/anonymity would be secured, and how their data would be disposed of after the study had concluded.

Before interviews began each respondent was asked for and provided consent to have their answers saved via audio recording for further analysis. Interviews were conducted face to

face or through digital communication mediums (Facebook messenger), consisted of 26 questions (see appendix for list of questions), and lasted from 32 minutes to 49 minutes in total duration. Recordings of the interviews were then transcribed, read, and re-read then coded for recurrent themes using grounded method which is an inductive method of data collection and analysis that is systematic and yet flexible allowing for theories to take shape rooted in the data itself (Charmaz, 2014). This line-by-line analysis was used to derive simple context and meaning then, focused coding further refined these results and tied emerging themes together in larger concepts.

Netnographic and Digital Ethnographic Techniques

I began this research because as a bariatric surgery patient myself I wanted to explore how this procedure and the associated weight loss could influence my life. I was relentless in my pursuit for information about, the medical impact, the possible effects on my family, and the ways it could potentially change my marriage and like other millennials I sought out information on the internet. Eventually I found my way to online bariatric surgery support groups. I began with membership in one group, but quickly found a few others that catered to subgroups within the bariatric community.

These support groups were a treasure trove of "information" and I found myself participating in discussions and asking questions about the surgery itself and life afterwards. I saw people sharing the most intimate aspects of their lives and interact in this virtual community just as they might with their closest friends in real life. This realization is when I decided that any study of bariatric surgery patients would require examination of these digital communities to be complete and the best way to do that is through netnography.

Netnography is a method of online research that comes from ethnography. It is used to better understand social interaction in modern digital communications using a specific set of research practices related to data collection, analysis, research ethics, and representation. It is rooted in participant observation techniques and is an interpretive method that adapts traditional ethnographic techniques to digital communities (Kozinets, 2015). It uses "online and mobile data sources to arrive at ethnographic understandings and representations of online social experience." (Kozinets, 2015). The data sources used for this study were 8 bariatric support groups online (see table right) constituting approximately 120,000 members but due to privacy concerns and the ease with which people can be found online I will not divulge which online platforms hosted these groups. Among these groups are general bariatric support as well as some specific subgroup

Group	Members
A	51,978
B	44,403
C	17,070
D	2,958
E	1,031
F	855
G	781
H	11
Total members	119,087

Online Bariatric Group Member Totals

communities including LGBTQIA+, men only, cannabis enthusiasts, groups for specific surgery dates, philanthropic groups, and groups for newbies (people less than 2 years out from their surgery). The wide array of community specific support groups online includes groups for women only, which I would have liked to study, but gaining access to a women's group when you identify as a cis-male would not only be intrusive, but would change the dynamic of that group rendering observations invalid. However, given that the overwhelming majority of bariatric patients are women (85%) I don't feel that excluding a women only support group from observation will have a negative impact of study data.

The first step of data acquisition was retrieval of archived conversations. A total of 100 conversation threads were randomly selected from these groups. These conversations were then copied and pasted into a word document for analysis and coded using grounded theory. After thematic coding was completed these conversations were used in the generation of a word cloud for further analysis.

The second phase of data collection was through participant observer interactions in online bariatric support groups. Here detailed observations of live interactions among bariatric patients were observed and at times interacted with to gather more complete data. As a participant observer, I started 2 conversation threads on each group for a total of 16 conversations. Each conversation began with an informed consent disclaimer (see appendix) and asked participants to tell me about their life before surgery or after surgery. These conversations were then copied to a word document and grounded theory method was used to code and analyze these interactions focusing on any emergent themes, concepts, or patterns.

Archived and participant observer conversations were then combined and searched for instances of self-talk. These self-talk occurrences were then categorized as pre-surgery or post-surgery and then further categorized as positive or negative in nature, for example:

"*My Confidence Has Gone Way Up, I'm Loving Life Again, Depression has decreased, my desire to do more in life and to get involved has gone up everything is better since I had surgery*" would be categorized as both post-operative and positive in nature while

"*I have the same issues, I have been overweight my whole life, depression is a real issue, self-doubt and all that*" is both pre-surgical and negative in nature. After being categorized filler language was removed leaving only contextual words so,

"I have the same issues, I have been overweight my whole life, depression is a real issue, self-doubt and all that" becomes *"Issues, overweight, depression, self-doubt"*.

When coding and categorization was complete a total of 897 instances of self-talk were found (see table right). Microsoft Excel was then used to create a graphic breakdown of this information (see appendix) and data were then uploaded to an online word cloud generator creating a visual representation and textual analysis of pre-surgery versus post-surgery self-talk (see appendix).

PRE-Surgery Total Negative Self-Talk	PRE-Surgery Total Positive Self-Talk	POST-Surgery Total Negative Self-Talk	Post-Surgery Total Positive Self-Talk
472	96	49	280

Total Positive Self-Talk	Total Negative Self-Talk		Total Instances
376	521		897

Self-Talk Data

A word cloud is an efficient tool for analyzing large volumes of text (Kozinets, 2015). Words that appear more frequently are represented as a larger font size making it easy to see themes, commonalities, and ideas that may not have been evident in initial coding. For example, the Cornell University copy of the Gettysburg Address is written as

"Fourscore and seven years ago our fathers brought forth, on this continent, a new nation, conceived in liberty, and dedicated to the proposition that all men are created equal…"

(Cornell University, 2013).

Taking the text of the Gettysburg Address in its entirety and putting it through a word cloud generator results in the visual

Word cloud of Gettysburg Address

representation shown here. We can see that "dedication", "nation", and "people" are prominent words used in Lincoln's speech and taking care to examine this cloud in context one theme that emerges is the resolve or "dedication" that Lincoln felt toward his nation and its people. By using this technique in combination with grounded theory analysis a more complete understanding of online bariatric support groups was obtained.

In conclusion, it is the goal of this study is to tell the story of radical self-concept change and to explore the links between weight and self-concept. The bariatric community provides an ideal population for study given that the change they experience is both rapid and dramatic. To get at the heart of this populations' community, as well as the individuals within it, multiple techniques for data gathering and analysis are needed. It is for this reason that I have chosen to incorporate netnographic and digital ethnographic techniques into my study. Furthermore, while it would have been possible to draw conclusions based solely on interviews, modern day life is increasingly lived online, and it is the opinion of this researcher that excluding the digital component of present-day life leads to incomplete data.

Chapter 5: Analysis

This study collected and analyzed data from two sources, the first was in-depth qualitative interviews with post-operative (between 1 and 5 years) bariatric surgery patients. The second source was a netnographic study of online bariatric support groups consisting of approximately 120,000 members. Themes that arose during the course of interviews and data collection included changes in self-concept evidenced by negative self-talk pre-weight loss and positive self-talk post-weight loss, attempts by participants to control how they are viewed by others, and changes in social roles. These themes will be explored using concepts from symbolic

interactionist theory and labeling theory to showcase the rapid complex changes that emerged as a result of weight loss surgery.
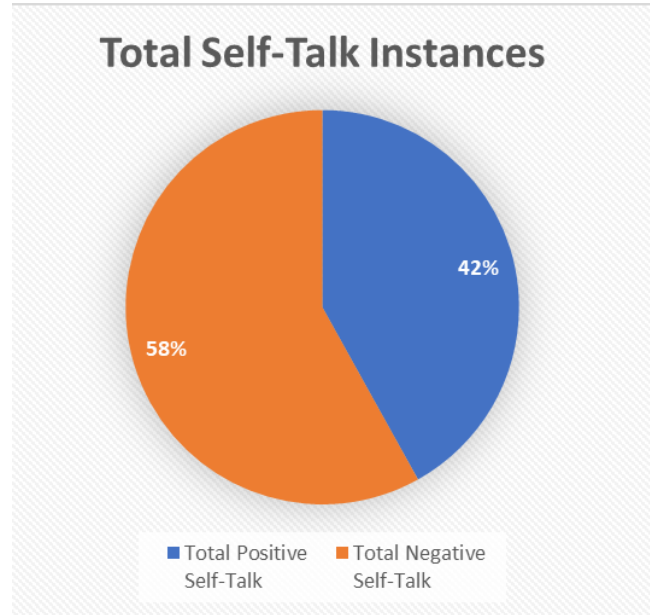
Pre-Surgery

It was apparent with the first question how the interview subjects envisioned themselves before they lost weight. When asked to talk about their life before surgery responses included:

Interview Respondent 1- *I have always been the "chubby one". I averaged 230ish in college and after college, even though I had a job where I was more active, I still gained weight. When I left that job, I had jobs where I was sitting, either in a cubicle or in my car and for that 10 years I consistently put on weight climbing to 331 pounds. I tried different diets or exercise but always fell off the wagon.*

Interview Respondent 2- *I have bipolar disorder and before surgery it was hard to manage. I had very low self-esteem, was easily irritated, and angry at everything because I was just very unhappy. I hated the way I looked and hated the way I felt. Every day activities had the ability to trigger a meltdown whether it was somebody didn't put the milk away or I put on a pair of pants that didn't fit or I wore a t-shirt that showed my belly. I was miserable. I was absolutely miserable.*

It was common for respondents to detail exactly how they had gained weight over time and usually incorporated some mention of depression along with negative self-talk. An overwhelming majority of participants had negative things to say about themselves so, to further explore this idea, I turned to the data collected from the online bariatric support groups. These data were collected from archived conversations of these groups as well as researcher led discussions. These conversations were transcribed, collated, then coded for instances of self-talk. Once these instances were found they were further categorized into pre-surgery incidents and post-surgery incidents, then coded further still into instances of positive self-talk and negative self-talk. A total of 897 instances were coded, 568 of which were pre-surgery and 329 post-surgery.

Collectively, 58% of all instances were negative in nature while 42% were positive.

Once all conversations and instances were coded, they were then uploaded to a word cloud generator to create a visual representation of what was said (see figure left). This first cloud contains all instances of self-

talk both pre-surgical and post. The larger the word in the cloud the more frequently it occurred in the data so in this visual the words *fat, hated,* and *confidence* figure prominently indicating that participants used them repeatedly when talking about themselves. However, because some words were used in both positive and negative self-talk instances and 42% of these words
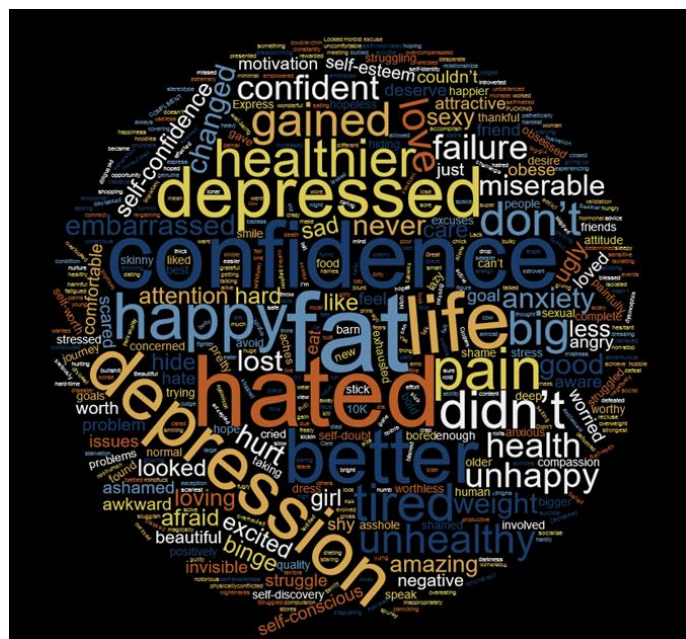
Pre-Surgery

are positive while 58% are negative it is hard to derive adequate context from this cloud. That issue is less of a factor in subsequent word clouds because percentages of positive and negative instances are nowhere near the approximate 50/50 split, we see here.
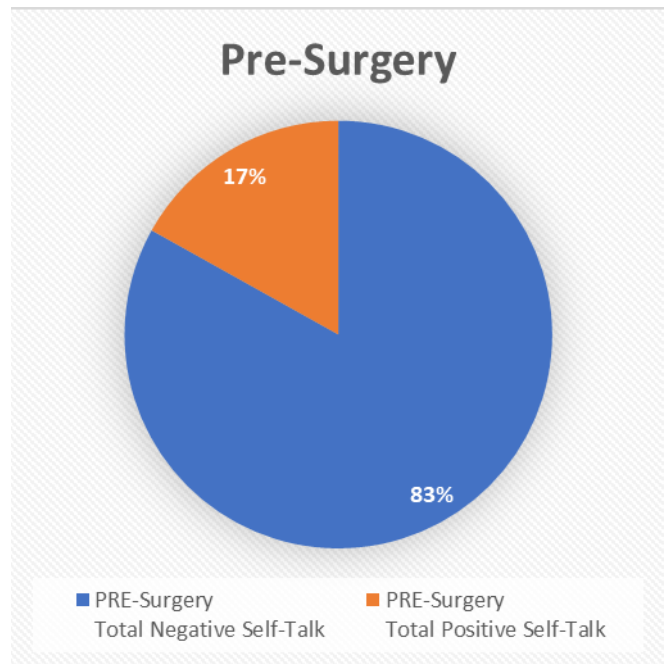
Of the 568 pre-surgical instances 472 (83%) were coded as negative and 96 (17%) were positive. A substantial majority of patients talking about themselves pre-surgery do so negatively. Overweight people in America feeling bad about themselves is hardly surprising when we consider the prevalence of weight stigma and discrimination in our society. According to Bocchieri, Meana, & Fisher, 2002 "The stigma of obesity is widespread. The belief that weight can be controlled, and that obesity is a manifestation of character deficits seems to grant the general public permission to be openly unkind to those who are considered most obese." (p.156) and this notion appears to hold true even when talking about one's self. Our culture considers overweight people "lazy, unmotivated, lacking in self-discipline, less competent, non-compliant, and sloppy" (Puhl & Heuer, 2009, p. 941) and we are all socialized to accept these notions even when applied to ourselves.

This has been described as the ''last safe prejudice'' in American society (Bocchieri, Meana, & Fisher, 2002) as illustrated in the billboard shown here. Discriminating against and demeaning the overweight is a part of our cultural zeitgeist and when we consider labeling theory it makes perfect sense that your self-talk, self-judgement, self-concept, and even your role in society are impacted by carrying that stigma/label with you (Link, Cullen, Struening, Shrout, & Dohrenwend, 1989).

Using the transcriptions of these 568 instances of pre-surgical self-talk I once again generated a word cloud to provide a visual representation of these instances. If you can imagine that the collective discussions of pre-surgical bariatric patients on these support groups were one individual, then this word cloud would be a thought bubble for that person.

In this graphic (left) the larger the word the more frequently it occurred in the discussion. Words like *fat*, *depressed* and *hated* feature prominently indicating that they are commonly used when overweight individuals talk about themselves while the words *happy, confidence* and *like* are lost in the jumble of tiny script as you can

imagine they would be in the internal dialog of these individuals.

Online Group Participant- "*I struggled with who I was as a person before surgery. My self-worth was gone, I had no confidence, I struggled with anxiety, my depression was at an all-time high, I was mean to basically everyone because I was unhappy, so I tried making everyone else equally unhappy. At my highest I was suicidal, highly depressed, and never cared anything about myself.*"

Phrases like this one from a bariatric group thread illustrate the deep pain shared by these participants. While the word cloud is a tidy way to condense hundreds of conversations into one easily digested infographic it is a sanitized version of the conversation and does not, in my opinion, adequately show the deep psychosocial impact obesity has on an individual.

Post-Surgery

In contrast to the pre-surgical self-talk the post-surgical conversations were largely positive. Interview subjects spoke of having a new life or being a new person. Of the five respondents interviewed three had advanced in their chosen career fields, one was preparing to interview for a supervisor's position, and one had gone back to complete a graduate degree.

Respondent 1- *"Since surgery, it like I've rediscovered who I am. My confidence has soared, and I ended up getting my dream job because of it."*

That same sense of zeal was found in the online groups. People readily bragged about their accomplishments whether weight loss related or otherwise sharing stories of workout

routines, new jobs, new and improved sex lives, and even posted before and after photos to showcase their successes, many of which were pics in their underwear that before would have never been shown to anyone much less broadcast on the internet.

Bariatric group member- *"My confidence has skyrocketed, I'm loving my life, my depression has decreased, my desire to do more in life and to get involved has gone up, everything is better since I got the gastric sleeve."*

Post-Surgery

15%

85%

■ POST-Surgery
Total Negative Self-Talk

■ Post-Surgery
Total Positive Self-Talk

In total 329 incidents of post-surgical self-talk were found and coded. Of these 280 (85%) were positive and 49 (15%) were negative. Again, these conversations were uploaded to a word cloud generator and this new cloud showcases a dramatic shift in thought from pre-surgery conversations. Where once words like "hate" and "fat" were prominent now we see "confidence" displayed as the most frequently used word surrounded by "better", "life" and "healthier".

Online Group Participant- "*What I have gained is more confidence in myself and my ability to express myself better. I don't shy away from situations like I did before, and I stick up for myself more.*"

The label "obese" and socialization of weight stigma remains, but it no longer applies to these individuals. With the weight gone they now have permission from society to like themselves and to see themselves in a positive light for perhaps the first time in their lives. They feel free to shed their old social role as "the fat one" and whole-heartedly embrace a new role of their own making. This brings me to the next theme that arose, a desire to control the narrative and actively shape the way people see them.

Controlling the Narrative

In 2018 68% of adults in the United States reported they use Facebook and of those roughly 75% use Facebook at least once a day (Smith & Anderson, 2018). From a symbolic interactionist point of view, modern society's ability to have thousands of interactions a day with one another online is an unprecedented opportunity for weight loss patients to shape their new self-concept and to be shaped by peers in an interactive media format.

Charles Cooley's looking-glass self suggests that the reactions we receive in social settings, which now includes digital settings, create a mirror in which we see ourselves (Giddens, Applebaum, Duneier, & Carr, 2018). Over time however Cooley's theory has been modified and refined and in a 2003 article titled *The Looking Glass Self: An Empirical Test and Elaboration* authors Yeung and Martin suggest that we do not just passively accept the view others have of us but engage in active behaviors to shape their view to match our own (Yeung & Martin, 2003). This would seem to be at odds with labeling theory which suggests we adopt the values, norms, and behaviors of the labels placed on us by society, but in studying the bariatric surgery population both theories appear to work in tandem.

The picture to the right is a post I made on a bariatric group. It is indicative of other posts you would see and has 2,500 likes and 407 comments. That is nearly 3,000 interactions in a single day. That is nearly

Today is my 5 month surgiversary and I am 1.6 lbs away from losing 100 lbs. I am actually dressing like I give a shit about my appearance for a change.

2.5K others   407 Comments

3,000 people reinforcing my confidence to share pictures of myself, my willingness to share personal information about my weight loss, my desire to spend time online, and my image as "attractive". What isn't shown here is the half dozen other pictures I took before choosing this one to post. I chose this picture because it best exemplified the new image of myself that I want to cultivate, and I am not the only weight loss patient that's trying to control my story.

Interview participants contextualized their answers in an apparent effort to shape the interviewer's interpretations. For example, detailed descriptions of previous weight loss efforts were offered up with the implication that the *"lazy"* label associated with overweight people is inaccurate. This then leads to statements about weight loss surgery being a medical necessity and this distinction is important because it is designed to contradict another social stigma that having bariatric surgery is the *"easy way out"*. In one interview the phrase *"medically necessary"* was used eight times. This participant stated that their doctor told them

"*You can't eat right; you can't exercise every day and fix what's happening here.*"

Using this doctor (authority figure/expert) as a foundation they shape the narrative of their decision to have surgery as out of their control.

Interview Participant 3- "*So it wasn't really even a choice for me it was medically necessary in order for me to survive my 30's and beyond medically I had to have the surgery.*"

Statements like this were made by most interview participants several times during the interview process and similar accounts or attempts to frame their surgical choice were a frequent occurrence in the online support groups as well. Joel Charon's *Symbolic Interactionism: An Introduction, An Interpretation, An Integration* states that the self is a social object just like symbols and that actors are able to interact with the himself or herself in the same way they can interact with objects in the outside environment. This allows us to take some control away from our environment as we do not simply respond to stimuli but to act back on ourselves (Charon, 2004). This suggests that not only are participants trying to influence the way others see them but because of the social stigma surrounding weight loss surgery perhaps they are trying to control the way they view themselves as well. Additionally, three of the five subjects interviewed stated that they kept their surgery a secret for as long as they could and many people in the online groups choose not to disclose their surgery to the general public presumably because they fear judgment from family, friends, and society indicating anticipation of future interactions and active steps to avoid situations that might alter their own self-concept. One interview subject that did disclose their intention to have surgery stated that they got a mix of reactions ranging from things like *"good for you"* to *"you don't need it"*. The most memorable response coming from their family, *"My father was insistent that I should not do it. He was the toughest one to convince."*

Changing Social Roles

The last theme that emerged during the course of this study was change. Changes in physical health and mental health of post-surgery bariatric patients have been researched especially in the context of improving surgical outcomes and long-term success. This study does

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not focus on these changes but instead concentrates on changing social roles that result from changes in physical and mental health.

Changes in relationships were a major concern for participants that had yet to undergo surgery and their fears were exacerbated by continued posts about divorce after weight loss. On average there is one post a day either announcing a divorce or asking questions about divorce. Some group moderators even start conversations with the intention of allowing members to share their divorce or relationship stories. While a concern about divorce is understandable given the changes these patients are undergoing, one study showed that patients reported stable marriages and improved sexual functioning 1 year after surgery. At three years post-surgery, marriage satisfaction among these patients "matched marital satisfaction and sexual satisfaction of married nonobese controls." (Applegate & Friedman, 2008, p. 138). Additionally, Applegate & Friedman contest the 85% divorce rate for bariatric patients statistic shared in the online groups stating that after 5 years the divorce rate for bariatric populations was 21% or 6 of 29 patients (Applegate & Friedman, 2008).

Relationship change was also brought up by the interview subjects, beyond divorce, loss of friendships was common story shared.

Interview Subject 1- *"Now that you mention friends, I did have a very close friend that I considered one of my best friends. They are very overweight and so we kind of commiserated, we were the fat girls and we would go out and get ice cream or we'd get lunch, and we could binge and that was something that we shared together. Food was something we shared. Since I had the surgery, and I was worried about this, she has pulled away. We actually don't even talk anymore. I think part of it is because she struggles to accept that I lost weight. We've talked about it before she kind of ghosted me; she didn't want to have surgery, which was fine and I*

told her I supported whatever decision she made but I think where I've lost so much weight I was no longer the fat friend and that made her feel like the fat friend and I know how hard that was. I remember having skinny friends when I was fat and as much as you love them it's still really hard to be friends with them."

The "fat friend" is a social role many weight loss surgery patients have filled. You play the part of the funny one or the one with a "great personality". After you lose the weight you don't fit that part anymore and relationship dynamics change. Some relationships can weather these changes, and some can't but every participant I interviewed talked about changes in relationships in some way.

Interview subjects also experienced changes in their careers. Some went back to school for advanced degrees while others found themselves accepting positions in jobs described as their "dream job."

Interview Subject 2- *"I had a career change after the surgery. About 6 months post-op my dream job came open and I went for it. I went into the interview process with complete confidence that I would get, and I felt like it was just the perfect moment to get in. Since then, I've had a promotion and I started working on my doctorate and so I feel like professionally it's been an incredible achievement. I feel like I'm getting everything I ever wanted really."*

Interview Subject 4- *"Before, I would say really probably, the last 3 or 4 years were really rough for me with regards to employment. I worked with…within the [omitted for privacy] system, and I had to dress professional which really stressed me out because I didn't like dressing and I didn't like wearing dress clothing. I was always self-conscious didn't want to engage with people because I didn't like myself. After that I went to a [omitted for privacy]*

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setting where it was much more relaxed, and I could get away with wearing my leggings. But again, I didn't feel like I was a professional at that point, so I was damned if I do and damned if I don't. I either had a job where I had to wear regular clothes and I hated them and I hated myself in them or I had a relaxed job where I wore what I was comfortable in but I also hated myself because it didn't feel like a job. Since surgery my confidence has soared. I actually ended up getting my dream job working in an industry I love, and I was offered a full-time position as an [omitted for privacy]. I love getting dressed in the morning and coming to work and looking nice and… I have a lot more energy so I'm more engaged with my job. I used to be so tired and sluggish all day. There were actually times at my previous job where I would fall asleep in the middle of the day. I'd close my office door and I'd literally take a nap because I could not function through the whole day. I don't have that problem anymore."

These changes in employment status warrant further research as this study cannot answer questions about why this change occurs. It could be an increase in self-confidence that gives weight loss surgery patients the courage to pursue their dream careers or it could be that thinner, more "attractive" individuals aren't discriminated against in the same way overweight people are. "Weight bias translates into inequities in employment settings, health-care facilities, and educational institutions, often due to widespread negative stereotypes that overweight and obese persons are lazy, unmotivated, lacking in self-discipline, less competent, noncompliant, and sloppy" (Puhl & Heuer, 2009, p. 941). Whatever the cause a change in employment status is common for weight loss surgery patients.

The last major change in social roles I want to mention is parenthood. Being obese can cause issues with fertility including Polycystic ovarian syndrome (PCOS), oligo-ovulation, and anovulation and although there is limited data on the subject, overall fertility has been seen to

improve after bariatric surgery (Narayanan & Syed, 2016). While researching bariatric populations for this study one interview participant became pregnant, I personally saw 37 post-surgical pregnancy announcements in the online forums and searching archived conversations for that same time frame revealed more than 250 new pregnancies after weight loss. Having a child comes with a new label (mom or dad) and that label carries implications about our place/role in society that forever changes the way we view the world and interact with others.

While improvements in reproductive health certainly account for some of these pregnancies other factors must be considered. Bariatric surgeons routinely warn their patients about hormone fluctuations affecting sexual function and desire as they lose weight. One study in the *Journal of American Medicine Association: Surgery* found that "women were observed to have statistically significant improvements in all the hormone levels of interest with the exception of DHEA-S. At postoperative year 2, all hormone levels, including DHEA-S, were significantly improved from baseline. Women experienced significant improvements from year 1 to year 2 in total testosterone and follicle-stimulating hormone levels" (David B. Sarwer, et al., 2014). Apart from improved hormone levels women also reported improved sexual function, satisfaction, and desire including improvements in arousal and lubrication furthermore "Women who reported the poorest quality of sexual functioning prior to surgery reported dramatic improvements in functioning 1 year after surgery, comparable to those women who reported the highest quality of functioning before surgery" (David B. Sarwer, et al., 2014, pp. 30-31).

This too is a common topic of conversation in the online forums. Time and time again people would share stories with intimate details about their new sex

lives. Several groups even had specific weekly forums led by group moderators that specifically addressed the subject of sex after weight loss and it was commonplace to see sexually suggestive pictures posted. The in-person interviews were no exception to this topic of conversation either even though none of the questions participants were asked specifically addressed their sex lives. When asked about how their relationship with their significant other has changed interview subject one praised how supportive their partner was adding "*And the sex is better*." As they finished their remarks.

Interview Subject 3- "*My sex life has changed as well. Sex is longer and I do not feel as exhausted afterwards.*"

Interview Subject 5- "*Sex has always been fun, no matter my size, but these days, I'm more flexible, my drive has increased, and honestly, my options in partner have drastically expanded. My confidence has skyrocketed, which makes me willing to experiment with more than just missionary.*"

It should also be noted that men routinely post online about increases in penis size as they lose weight. This change undoubtedly impacts sexual function and desire but also effects these men's self-concept. Men that were willing to talk about this change routinely said it made them feel more masculine or younger. They also used words like "proud", "strong", and "animalistic" when talking about themselves in a sexual capacity a dramatic change in positive self-talk for some.

"Sexual self-concept is a major component of sexual health and forms the core of people's sexuality" (Potki, Ziaei, Faramarzi, Moosazadeh, & Shahhosseini, 2017). Overweight individuals routinely report that they don't feel sexy because of their excess weight and that is a contributing factor to their negative self-talk. Having hundreds if not thousands of positive interactions about sex in online support groups in combination with improved sexual function in interpersonal interactions helps to reshape the way they consider themselves in turn leading to changes in self-esteem and adoption of new sexual scripts.

Chapter 6: Conclusions

The dramatic weight loss that occurs with bariatric surgery provides a vehicle for shifts in personal identity, social interactions, interpretation of symbols, and social roles. Labeling theory suggests that because our society attaches negative connotations to the label "overweight" individuals who have this label thrust upon them will internalize those negative ideals applying them to their own self-concept (Link, Cullen, Struening, Shrout, & Dohrenwend, 1989). With weight loss comes an opportunity to reevaluate how that label applies to them and thus to change how they see themselves.

This study found a change in self-talk from primarily negative interactions to predominantly positive ones and using symbolic interactionism, which asserts that with each new interaction we are continually altering our interpretations of the reality around us, and because we act on ourselves as objects (Charon, 2004) this change in self-talk represents a change in the interpretation of the symbolic self. No longer do these individuals see themselves as "lazy, unmotivated, lacking in self-discipline, less competent, noncompliant, and sloppy" (Puhl &

Heuer, 2009, p. 941) but now begin to adopt the label of "healthy" which has a more positive interpretation in society.

Interview Subject 1- *"Since surgery, it's like I've rediscovered who I am… my confidence has soared…. I love to go shopping; I love to dress. I used to just wear sweatpants and t-shirts and try and hide myself and now I'm wearing stylish clothes. I love to look good. It's just… I feel like a different person and I like this person."*

Statements like the one above are common and illustrate how these individuals experience this change as a metamorphosis or a rebirth, they see themselves as an entirely different person. This new identity is then presented to society, which as suggested by modern looking glass theory (Yeung & Martin, 2003), is actively cultivated through interactions with others and interactions with the self. Each of these interactions helps to refine the new self-concept which in turn influences change in social roles. These new or altered social roles could occur in any domain of cultural interaction but this study focused on employment, relationships, and family. These 3 domains were shown to be subject to major change including new careers, loss of long-term relationships, and pregnancy and these kinds of changes permanently alter the roles we fill in society.

In reviewing the literature, it was found that bariatric centers have systems of support in place for post-surgical mental health and address mental health concerns as a part of the patient intake process (Hollywood, Ogden, & Pring, 2012) but these measures center on surgical outcomes. Measures of physical health and mental health are important, but there is change that occurs outside the scope of medicine after weight loss surgery. Therefore, it is the

recommendation of this study that a holistic model of well-being be adopted by bariatric service centers to provide support for these changing social roles in addition to patients physical and mental health. The addition of a life coach along with psychotherapy could help smooth the metamorphosis from the "fat" label to the new "healthy" one.

This study found similar results to previous research on bariatric populations including deeply internalized weight stigmas, depression, negative self-ideation of overweight individuals, and improved self-image after weight loss. This study, however, adds to the body of knowledge by analyzing digital bariatric communities; a population that is largely unexplored. In these online support groups, we found further evidence regarding the influence of weight stigma on the individual which, given the rising obesity rates in America and the volume of interactions taking place in these groups, has potential to greatly influence modern society. Evidence that dramatic weight loss can not only affect your mental health status but also your self-concept was shown, and this altered self-concept often leads to a reevaluation of one's place in society and life goals. That reevaluation in turn sparks changes in social roles and patterns of behavior influenced and reinforced by interactions in online support groups. Post-surgery participants in this study reported new behaviors uncharacteristic of their former selves like posting provocative pictures online, new styles of dressing, and advocating for themselves. They found new careers, started families, and even lost old friends that could not adapt to the new relationship dynamics and the overwhelming majority report that if given the opportunity they would not hesitate to have this surgery again proclaiming it to be the best thing they ever did for themselves.

I found myself stymied at several junctures during my research. A number of rabbit paths emerged that warranted further exploration but due to time and funding concerns these will have to be included in further studies. The use of snowball sampling limited randomness of interview

subjects which creates a barrier for generalization of findings. The impact of this limitation was mitigated by the use of online bariatric forums, but this does not eliminate the issue entirely. In future studies an increased number of interviews would provide more information. The addition of these netnographic methods helped to incorporate data from communities not typically studied but these methods are not without limitations of their own. When collecting data from online sources context can get lost in translation. Online communications have adopted new methods of conveying subtext apart from traditional means, but everything collected is sanitized by the individuals posting and community guidelines. To thoroughly explore digital communities, like these bariatric support groups, you would need a team of researchers including linguists and communications experts. Furthermore, you would need to incorporate substantially more data over a longer period of time than this study was capable of gathering or analyzing.

Throughout this study I have consistently felt like I was raising more questions than I was answering. Does gender inequality effect the degree to which weight stigma is internalized? In further research the weight self-stigma questionnaire should be administered both pre-operatively and post-operatively to help explore the role of gender inequality in internalized weight stigma. Additionally, personality assessments like the Myers-Briggs Type Indicator would provide quantifiable data of any personality changes that occur in this process and longitudinal case studies of individual patients could provide more detailed data on long-term adoption of new social roles. The addition of more researchers with expertise in online communities and digital communications would provide a thorough analysis of the impact digital interactions have on the self and provide new avenues of research to better understand the rapidly changing communication schemas of modern society. It feels as though I have just scratched the surface of

this topic but that is the way of a bariatric patient, we nibble the edges and take small bites often leaving things on the plate for later.

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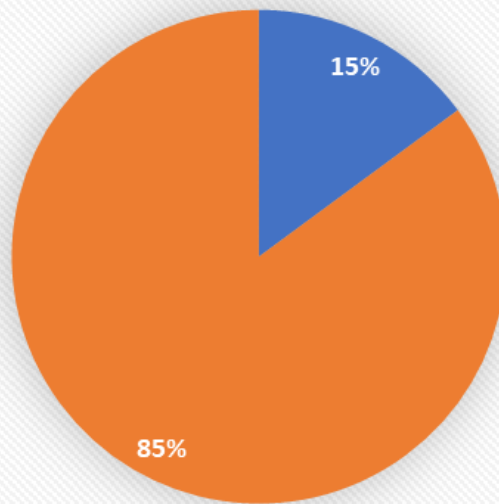
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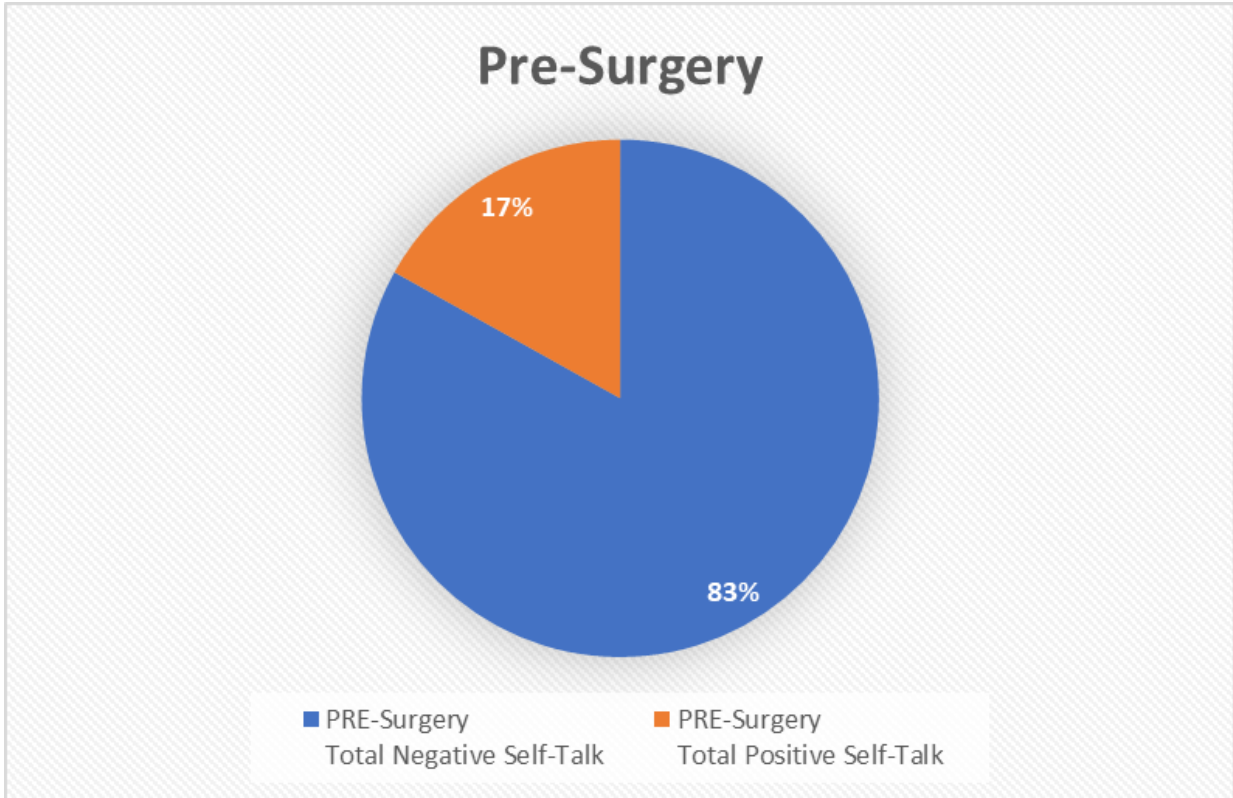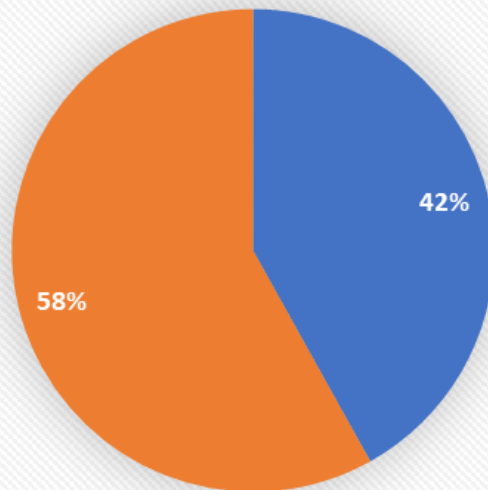
Pre-Surgery

17%

83%

■ PRE-Surgery
Total Negative Self-Talk

■ PRE-Surgery
Total Positive Self-Talk

Post-Surgery

15%

85%

■ POST-Surgery
Total Negative Self-Talk

■ Post-Surgery
Total Positive Self-Talk

Total Self-Talk Instances

42%

58%

■ Total Positive
Self-Talk

■ Total Negative
Self-Talk

Pre-Surgical Word Cloud

Post-Surgical Word Cloud

Pre and Post-Surgical Combination Word Cloud

INFORMED CONSENT FORM

Dear Respondent:

I am a graduate student in the field of sociology at Morehead State University conducting research on changes that may occur to individual self-concept as a result of bariatric surgery. I am requesting your help with this project. In order to participate you must be 18 years of age or older and have had or be considering bariatric surgery. This study has been reviewed to ensure that participants' rights are safeguarded and there appears to be minimal risk of discomfort associated with the interview questions. Although your participation will strengthen conclusions drawn from this study know that you are free to decline to answer any question you do not wish to answer. Furthermore, you are also free to discontinue your participation at any time.

The answers and information you provide will be kept strictly confidential and your anonymity will be preserved. Specifically, all audio recording will be stored in an encrypted file on an encrypted USB drive only accessible by myself. All notes, observations, forms, and any other physical data collected will be stored in a locked desk, in a locked office only accessible by myself. Additionally, once all data has been used and the study has concluded it will be destroyed. Results from the study will be made public in a fictionalized form using false identities, and omitting any direct quotes ensuring that no one person can possibly be identified. Please feel free to ask for help if something doesn't make sense to you or you have any questions. If you experience any discomfort as a result of the questions asked, please contact me directly by phone at (606) 783-2656 or by e-mail at swfife@moreheadstate.edu. If you decide to participate, please print your name on this form and sign it. Your signature indicates your willingness to participate and that you understand the conditions of your voluntary participation and the general purpose of this study.

Thank you for your cooperation.
Name:_____
(Please Print)
Signature:_____

Interview Questions

1. Tell me about your weight history and your life before surgery.

2. How would you describe your life since surgery?

3. What other weight loss methods did you explore before settling on bariatric surgery and how successful were they?

4. Were you hesitant about getting bariatric surgery? Why or why not?

5. Why did you finally decide to have bariatric surgery?

6. How did people in your life react when you decided to have surgery? And how did that make you feel; did you feel judged?

7. Do you attend bariatric support group meetings or are you a member of online Bariatric support groups?

8. What kind of support do you feel is most beneficial to you?

9. What expectations did you have before surgery?

10. How have those expectations changed since surgery?

11. How has your life changed since surgery?

12. Tell me about your eating habits before surgery versus after surgery.

13. How did you dress before surgery and how do you dress now?

14. What was work like before surgery compared to since surgery?

15. What is going to the doctor like now compared to pre-weight loss?

16. How would you describe your relationship with your S.O. before surgery versus after?

17. What has been the hardest adjustment for you since surgery?

18. What do you think has been the hardest adjustment for the people in your life since surgery?

19. Have the activities you do with the people in your life changed since surgery? How?

20. Do you feel like you have a different role with the people in your life than you did before surgery?

21. Have you made any new friends or lost friends since surgery? Why do you think that is?

22. Do you think people see you differently since your surgery? How?

23. Do you see yourself differently since surgery? How?

24. What do you think about when you see overweight people in public now?

25. What do you feel are your major successes and failures since surgery?

26. If you had it to do all over again would you still have bariatric surgery?

Online Participant Observer Informed Consent Statement

I am a graduate student and a bariatric surgery patient. I am working on my master's thesis which explores how bariatric surgery effects our self-concept. If you would like to take part in this study, please participate in this conversation thread. I will be using the information provided to draw conclusions and as such will archive this conversation for later use. Rest assured that I will take every precaution to ensure all participants' anonymity. At no point in time will any private information be shared, I will not use names of individuals or groups, and no one will be directly quoted in my report. If you do not wish to have your information included in this study, please do not post on this thread. Thank you for your participation and good luck on your journey.