



## Stories of Suffering and Success: Men's Embodied Narratives following Bariatric Surgery

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### Abstract

*This paper draws on research exploring how men narrate their long-term experiences of Weight Loss Surgery [WLS] and is specifically focused on findings relating to male embodiment. Whilst there is concern about increasing obesity and the possible role of bariatric [WLS] surgery in ameliorating this, there has been little research to date exploring men's longer-term experiences of this. For the purposes of the present study, interviews were conducted with five men who had undergone bariatric surgery at least four years previously. The transcribed interviews were subjected to narrative analysis with the additional incorporation of Watson's (2000) "male body schema" into this process in order to facilitate focus on the embodied nature of the storied accounts obtained. The findings suggested two seemingly contrasting storylines: "ongoing struggles" and "success". Struggles related mainly to control over eating habits and the visceral challenges of long-term side effects following surgery. Despite these struggles, the men ultimately presented an overriding storyline of embodied "success" in how the surgery had assisted them to live more normatively male lives. Importantly, narratives around struggles were presented as more private stories in contrast to the public emphasis on success. The silencing dynamic implicit in this suggests the likelihood that other men encountering similar experiences would be reticent to reveal their struggles, thereby perpetuating their suffering and leaving popular obesity and weight loss narratives unchallenged.*

### Introduction

Notions of success predominate in marketing and media representations of the rapidly proliferating range of Weight Loss Service [WLS] clinics (Glenn, McGannon, & Spence, 2013). Drawing on seemingly authentic patient stories, private clinics promote WLS as an opportunity to become of normal weight and to live both longer and more successful lives (Glenn et al., 2013; Groven & Hofmann, 2014; Salant & Santry, 2006). Side effects and complications are very rarely mentioned within such accounts. On the contrary, these stories tend to highlight only the positive outcomes of WLS, including positive changes in bodily appearance,

self-esteem, social relations and lifestyle (Groven & Hofmann, 2014). In addition, scholars have illuminated how such stories are also highly gendered. Whereas women's stories emphasize changes in body image, marital status and self-esteem, men's stories focus on a healthier and more active lifestyle, typically featuring them in sport clothes and running a marathon or playing soccer (Groven, Galdas, & Solbrække, 2015; Salant & Santry, 2006). In similar vein, Glenn and colleagues found that Canadian news media texts emphasized a fairy-tale narrative in which women were portrayed as becoming happier and more sexually attractive after undergoing WLS (Glenn et al., 2013). However, whilst women were the focus of most examples, men were not

exempt from their own version of the “happy-ever-after” story. Men’s promise of a better life related to better health and improved vigour, both of which feed into the notion of men’s identity being dependent on hard work, physical strength and fortitude (Glenn et al., 2013, p. 637). Glenn and colleagues suggest that such rhetorical strategies establish WLS as a solution for both men and women, but do so in gender-specific ways, reinforcing limited notions and stereotypes in respect of gender and health (Glenn, Champion, & Spence, 2012). As such, potential users of WLS are offered a selective story, one that furthers its potential as a treatment that will ensure successful outcomes of a gender-acceptable nature. This raises a key question: How do these “public” stories intertwine with personal stories? What stories are told by men and women when asked to elaborate on their own experiences following WLS?

In their study of patient narratives *prior* to undergoing WLS, Newhook, Gregory, and Twells (2012) found striking differences with regard to how men and women narrated their experiences. Women’s stories revolved around their sense of identity as “fat” women and their ongoing efforts to compensate for their sense of shame about having a fat body. By contrast, men’s stories revolved around their efforts to resist being regarded as “fat” individuals, emphasizing instead their image as “big guys”. Such findings indicate that men and women’s presentation of their embodied self is somewhat different, with clearly gendered meanings embedded within their stories. Newhook et al.’s (2012) study did not, however, elaborate on either women’s or men’s narratives *after* undergoing surgery.

In contrast, Natvik, Gjengedal, Moltu, and Råheim (2015) explored men’s health and well-being after undergoing bariatric surgery. They found that dramatic weight loss enabled the men to become increasingly proactive and independent in their daily lives despite suffering from various side effects and complications. However, given their phenomenological focus, they did not elaborate on the potential challenges WLS can represent to men’s embodied sense of self, including their masculine identity. Seeking to shed light on this matter, Groven and colleagues (2015) used a thematic analytical approach to explore men’s bodily changes following WLS. Their principal finding was that the men tended to negotiate bodily changes following WLS in profoundly ambivalent ways. Although they praised the surgery for improving their health and self-esteem, they also emphasized their efforts to make sense of and manage side effects and complications.

The present paper further explores men’s longer-term experiences following WLS, building on the previous findings by adopting a different, narrative analytical, approach in order to focus more specifically on embodied aspects of gender. The core question examined here is:

*How do men narrate their sense of self and long-term experiences after WLS, and how are cultural norms of masculinities embodied within their stories?*

### Theoretical Framework: Masculinity and the Body

Robertson (2007) points out that early sociological work on men and embodiment tended to be more theoretical than empirical. However, Connell’s (1995) early empirical case study work highlights some of the ways in which (male) bodies are both agents and objects of practice within a wider system of gender relations. Within this wider system of gender relations, hegemonic configurations of masculinity practices often emphasize success, strength, stoicism and self-sufficiency, amongst other practices. Other forms of practices then become either marginalized or subordinated to these hegemonic configurations by a range of material and representational techniques. This generates a drive for men to engage in more hegemonic masculine practices (or at least to be complicit in them) in their everyday lives because of the social (masculine) capital this confers (Connell, 1995). In this way, masculinities are thus intimately related to bodies such that “true masculinity is almost always thought to proceed from men’s bodies” (Connell, 1995, p. 45). Hegemonic configurations of practice require particular (strong, able, skilled) male bodies that are then simultaneously (re)produced and reinforced through engagement in such practices. Drawing on this work, Watson’s empirical work, based on field notes of his observation at well man clinics as well as 90 in-depth interviews, suggests that masculinity is embodied in a number of ways. He developed a “male body schema” (Robertson, Sheikh, & Moore, 2010; Watson, 2000, pp. 115-116) highlighting four main modes of male embodiment:

- (i) *normative*
- (ii) *pragmatic*
- (iii) *experiential*
- (iv) *visceral*.

While *pragmatic* and *experiential* modes of embodiment are respectively the locations of an individual’s social identity, *visceral embodiment* furnishes an indirect – in the sense of not being consciously experienced – grounding with the natural world: it is about the mainly hidden physiological bodily processes and therefore is not usually directly perceived by others or the self except when it surfaces through the experiential body or when it becomes the object of medical treatment or observation. This mode can be recognized as a level of embodiment that is prior to the social world (Watson, 2000, p. 120). *Normative embodiment* is most essentially linked to culturally anticipated and expected standards about bodily shape and size, which in turn are linked to social and cultural constructions of gender.

The inferences of the embodiment modes comprising Watson’s schema are summarised in Table 1.

**Table 1: Watson's Male Body Schema**

<i>Normative embodiment</i>	Is associated with body shape revolving around <i>normal, standard or idealized accounts of bodily shape(s)</i> , and how men relate to these variations
<i>Pragmatic embodiment</i>	Revolves around <i>men's desire for a well-functioning body</i> which is paramount in order to fulfil specific roles, such as father, husband and worker, required in the social world
<i>Experiential embodiment</i>	Is <i>the primary site for the experience of emotion</i> , in the sense of experiencing well-being (or discomfort and pain) or saying that you feel good (or feel terrible) when someone asks you how you are
<i>Visceral embodiment</i>	Involves the <i>indirect biological processes</i> , usually unconsciously experienced, that support bodily function and, to an extent, determine bodily shape

A growing body of research on embodied masculinity has uncovered the complexities and ambiguities that often exist in the relationship between men and their bodies. Robertson extended Watson's work and looked specifically at the interrelationship of Watson's four modes of embodied masculinity in everyday life and within an "ill-health" context (recovery from a heart attack) (Robertson, 2006; Robertson et al., 2010). This work shows that, alongside functionality, men also place value on body shape and appearance, both of which have been shown to play an important role in influencing men's experiences of health and illness. Such research is relevant to the present study given that WLS involves radical changes in both bodily appearance and bodily functioning. Building further on this body of research, the authors applied Watson's "male body schema" as an analytical lens to the narrative stories the participants provided in order to examine how cultural norms of masculinities were embodied within these accounts.

## Methods

This study draws on in-depth individual interviews to explore how men narrate their long-term experiences following bariatric surgery. Utilising narrative analysis, and incorporating Watson's male body schema into the process of analysis, the aim was to gain new insight into the gendered embodied aspects of men's long-term experiences following bariatric surgery. Hence, the emphasis was first and foremost on how the men narrated their experiences, starting from their lives before surgery, through their initial post-surgical years, to their present situation. In addition, we followed the approach effectively adopted by Robertson (Robertson, 2006; Robertson et al., 2010) in incorporating Watson's male body schema to facilitate the exploration of the embodied nature of these narrated experiences.

Narratives are important to people in giving meaning to lived experiences and guiding future actions (Bruner, 1991; Polkinghorne, 1988). People make sense of lived experiences by linking together the past, present and

future into a coherent, meaningful whole. Narrative is also part of everyday social practice; people tell each other stories as a way of making the world intelligible to themselves and to others, and plot structures highlight the key messages the storyteller wants the listener to take from the story (Bruner, 1991; Polkinghorne, 1988). Narratives thus serve as a way of understanding one's own and others' experiences and of connecting and seeing the consequences of experiences and events over time (Bruner, 1991; Polkinghorne, 1988). In this way they are also important from a researchers' point of view, as stories told can provide important insights that help produce new knowledge of relevance both conceptually and practically. Even though individual stories are personal and unique, linked to particularities in the individual's life, they are simultaneously shaped and nourished by stories that are common in a culture. Specifically, individual accounts are not gender-neutral, and stories common in culture have gendered scripts implicitly or explicitly present; the publicly knowable self is invariably gendered. Riessman's (2003) work exploring masculinity and multiple sclerosis highlights the range of possible masculine styles, or ways of being masculine, present in the men's narrative performances. Similarly, Gray and colleagues' (2002) narrative accounts of men with prostate cancer shed light not only on contemporary forms of hegemonic masculinity, but also on how performances of masculinity were renegotiated by these men in this ill-health context (Gray, Fitch, Fergus, Mykhalovskiy, & Church, 2002). Understanding the gendered nature of men's narratives was key within the present study. In recognition of this, within the research process attention was paid to previous learning with regard to interviewing men. In particular, many of the suggested approaches outlined by Oliffe and Mróz (2010) – such as conveying an expectation that they will talk, creating a casual and non-threatening atmosphere, and allowing the men elements of control of the interview – were utilised, as were the lessons learnt about consideration of power and professionalism from Brown's (2001) experiences of interviewing men about health.

Finally, personal narratives usually include *dramas*, or *turning points*, of various kinds that represent unexpected and drastic changes in the narrator's life. Such dramas are paramount, in so far as they affect the person's choices and experiences in significant ways (Bruner, 1991; Mattingly, 1998). In this paper, analysing how various dramas are embedded in the men's narratives helps demonstrate what is at stake for them as individuals, including their sense of gendered-self, and how such dramas affect their recovery process following WLS.

### Participants

This paper originates from a larger study approved by Norway's National Committee for Medical and Health Research Ethics. The men included in this study had all undergone irreversible gastric bypass surgery more than four years previously. They were recruited by the first

author through a support group and an organization offering help and guidance to individuals undergoing bariatric surgery. Information about the study was published on the home pages of these two recruitment facilities, as recommended by the national committee for medical ethics. The written informed consent of all the participants was obtained before the interviews, the venue for which was chosen by each. Generally the interviews were conducted in a quiet café, or at the participants' work place. Two interviews were, however, conducted telephonically as requested by the participants concerned.

Demographic details of the five participants recruited for the study are provided in Table 2. Due to ethical considerations, pseudonyms have been used throughout. In addition, specific details concerning work, place of residence and family life have been omitted in order to protect the participants' privacy.

**Table 2: Participants**

Pseudonym	Age	Time since Bariatric/ Gastric Bypass Surgery	Marital Status	Work
Jens	24	5 years since surgery (public hospital)	Single Dating girlfriend No children	Working full time in an administrative job, although several periods on sick leave. The same job that he had prior to his surgery.
Roy	40	4½ years since surgery (private clinic).	Single No children	Working in the service industry. Changed job since surgery.
Olav	39	4½ years since surgery (private hospital)	Married 2 children	Working in a leading position. Changed job since the surgery.
Heine	42½	5 years since surgery (public hospital)	Single (divorced) No children	Working in the health service.
Sondre	46	6 years since surgery (public hospital).	Married 3 children	Working as a farmer and in industry (manual labour work).

Notions of what constitutes an adequate sample size in qualitative research vary. Guest, Bunce, and Johnson (2006) demonstrate that as few as six interviews can provide data saturation, whilst Sandelowski (1995) suggests that a sample of ten may be "too large for certain kinds of narrative analysis" (p. 179). Others have demonstrated that the concept of saturation itself may not in fact be relevant in the context of narrative analysis given that it is case-based, and not category-based like grounded theory (Walker, 2012). Whilst, as Fusch and Ness (2015) point out, the ideal is to have qualitative data that is both thick (quantity) and rich (quality), practical constraints often make this difficult to achieve. Taking all these factors into account, the five interviews conducted for the present study did provide

sufficiently rich data to enable identification of important "similarities across the moments", which are a key feature of narrative analysis (Riessman, 1993, p. 13).

### Interviews

Interviews were structured chronologically following a timeline divided into the men's life-situation before and after undergoing WLS. The first author conducted all the interviews and began by asking the participants to talk about their life prior to undergoing surgery, including their accounts of how they came to decide to undergo surgery. The men were then asked about life after surgery, including their present life-situation. In this way, participants were encouraged to tell their

stories, with the interviewer's role centered on listening, asking follow-up questions, and requesting examples to clarify various aspects of their respective accounts. Whilst the interviewer did not specifically ask about gender or masculinity, if issues arose that suggested aspects of this within participant narratives these were then followed up to elicit additional information and clarity. Both interviewer and participants were thus active in co-constructing the accounts provided, even though in somewhat different ways. On average, each interview lasted one and a half hours, and, with the participants' permission, the interviews were recorded and subsequently transcribed verbatim.

### Analysis

Analysis of the transcribed material proceeded in stages inspired by Riessman's structural narrative approach (Riessman, 2008). This involved analysis of *how* the men's narratives were structured, with regard to beginning, middle and end. During this stage, the transcribed texts were analysed line-by-line searching for plots, dramas and critical turning points in each participant's pre-and post-surgical stories. In the process, variations and similarities in the men's stories were identified. For the purpose of this paper, the emerging narratives were subjected to a second layer of analysis both by the person who had conducted the original work and by two co-authors independent of the original analysis. This second layer of analysis was focused more specifically on where gender and masculinities were at play within the stories narrated. As mentioned earlier, this process was aided by bringing Watson's (2000) male body schema into the process of theoretical, analytical interpretation, as has previously been carried out by others interested in researching gendered embodiment (Robertson, 2006; Robertson et al., 2010). In sum, applying this "male body schema" lens within the narrative analysis process helped identify two contrasting embodied storylines in the men's accounts, namely one of success and one of suffering. These storylines of success and suffering are elaborated on below and linked back to Watson's body schema and other relevant research on embodied masculinities.

### Results

In line with the chronology of stories as demarcated by a beginning, middle and end, the findings of this study are presented in two main sections: the men's experiences prior to surgery and following surgery. The men's experiences prior to surgery are presented under the following two thematically descriptive sub-headings: "Restricted bodies, restricted lives" and "Weight 'wars' and emotions". The men's post-surgery experiences are presented as interrelated through the following sub-headings; "In better shape, but struggles continue" and "The story of success".

### Before Surgery

#### *Restricted bodies, restricted lives*

The men's narratives commonly referred to pre-surgical lives with increasingly problematic bodies. Work, in particular, became increasingly challenging as they gained more and more weight. As Heine put it:

*I experienced that when I worked full time I was completely exhausted ... I was exhausted after a day at work. I had pain in my body, in my legs, in my muscles, so that I felt like being very passive at home.*

Like other men in the study, Heine emphasized the importance of keeping his job. Despite some shifts in modern masculinities, paid employment remains an integral part of male identity (Olliffe & Han, 2013) and threats to employment have been shown to take a particular toll on men's mental health (e.g. Artazcoz, Benach, Borrell, & Cortès, 2004). Heine's narrative thus becomes representative of a particularly gendered fear of not having a body fit for work; of not having a body suitable for expected pragmatic embodiment. Doing their best to stay in their jobs – struggling to "hang in there" – made them frighteningly aware of their increasing limitations and the potential threat to their male-self-identity. These difficulties in functioning at work, but also in social and physical activity, were presented as key motivators for action.

As the men gained more weight, their problematic bodies also became more apparent, to themselves and others, in terms of appearance. The men's accounts commonly referred to regular experiences of the critical gazes and comments of others, as well as experiences of being ignored because they were larger and heavier than other men. This is exemplified by Olav:

*People do not listen to the fat guy .... It is the tall, handsome and slim man who gets the attention. I did not look good, and I was wearing wide clothes. I was very fat, I had a big stomach and big tits, so there was no doubt, I was fat .... My fat was stored in my stomach, my tits and in my face ... and, of course, looking like that, you do not regard yourself as a hunk. You look down on yourself, which is not good, because that affects your mental health. And it turns into a vicious cycle.*

Olav's story illuminates how being larger and heavier than other men impacted on his sense of male-self as well as on his health. His own critical gaze intertwined with the critical gaze of others, and became embodied as an ongoing reminder that he was less attractive, less masculine, than others.

The men's narratives of their long-term experiences of WLS surgery typically refer to a past characterized by such a vicious cycle, which reflects broader social and cultural tropes about the perceived unlivability of obesity (LeBesco, 2004; Monaghan, 2008; Throsby, 2009). Within this narrative, the obese body poses a medical, aesthetic and physical impediment; it literally gets in the way of living a "normal" life (Lupton, 2013). But these "normal lives" are not gender neutral, and the men's narratives specifically emphasized their fragile identity as employee, father, husband and friend. This implies that the men's *pragmatic embodiment* was increasingly challenged. Following Watson's (2000) body schema, the *functional* use of their everyday, pragmatic body to fulfil hegemonically expected male roles became problematic. Alongside work and leisure functionality, the men experienced restrictions in terms of their *normative* embodiment; in terms of their shape and appearance (Robertson, 2006). Important examples above suggest that not conforming to required gender normative bodily representations also acted to further restrict the men's opportunities for socializing and work progression. Representations of their non-normative embodiment, and the physical limitations placed on their pragmatic embodiment, restricted access to hegemonic masculinity practices and associated positive social status; it limited access to forms of masculine capital. The men's stories therefore point to an ongoing battle with their gendered-bodies in the past, a battle that variously involved help from health professionals in their efforts to lose weight through diets and exercise regimes.

### **Weight "wars" and emotions**

Such battles could be both the result of and a prelude to emotional distress, particularly as the battle was "lost". Failure to lose weight through repeated dieting and lifestyle interventions was a reminder to the men of their inability to have or take control. Rather than losing weight, they gained weight, and, over time, more and more weight. As Olav describes:

*I had constantly been on a diet during a period of 15 years, all the time aiming to lose weight, but still it was impossible to get those kilos off. I had to be on a strict diet in order to lose perhaps a couple of kilos, but obviously this was not something that I could do in the long run. I wanted to live an ordinary life, but when I did, the kilos returned, and then they returned with some extra kilos. For that is how the body works. It prepares for war. And when there is war, then it is okay to have some extra kilos just in case.*

Olav's story illuminates difficulties in losing weight and how, despite ongoing efforts on his part, his body resisted the changes he was trying to make. In effect,

he was fighting a "war" against his own body that he could not win. By using the metaphor of war, Olav simultaneously reiterates a sociobiological narrative suggesting different mechanisms for men and women in laying down body fat for specific social roles – in this case, men being anatomically and physiologically prepared for war. Indeed, as Reeser (2010, p. 106) suggests, war and sports are two of the few discourses in which reference to bodily masculinity is culturally normative. It is no surprise, then, that the men used such a metaphor, given that this is a dominant gendered narrative for embodied masculinity and has come increasingly to be the way that public health, health promotion and the media have portrayed this for men (Monaghan, 2008).

Another challenge, linked to the men's narratives of failed dieting, revolved around their struggle with food and eating. This particular struggle was related to the men's emotional life. For example, Sondre related this struggle to his problematic marriage and subsequent divorce, talking about food as a means of avoiding other kinds of addiction such as drugs:

*I could sit up all night eating as a means of comforting myself; rather than drinking alcohol I turned to eating. I ate when nobody could see me. I would claim that you get just as addicted to food as others do to drugs (but I have never been into drugs, to make that clear). The more I ate, the more food I wanted. I could eat a huge dinner and lay down on the couch afterwards and eat chips. And I felt terrible doing it like that, but I could not stop.*

Some were even more explicit about their emotional eating as a means of coping with not only negative, but also positive, feelings. As Heine recalls:

*To me food was a means of coping with emotions in my daily life. To be explicit, I ate to cope with all kinds of emotions, both positive and negative emotions. This means that I could become ... I would eat when feeling happy or sad, tired or excited ... I could eat until feeling uncomfortably full, and still continue to eat ... I did that.*

Again, the men's stories refer to a past described in terms of a vicious cycle where eating as emotional release led to weight gain, low self-esteem and further emotional problems often linked to their embodied male-self.

Specifically, the men's narratives referred to a past with a silent and private struggle with food and eating representing efforts to deal with various problematic emotions while simultaneously reproducing these. Hiding

overeating from others (as Sondre states in the excerpt above, eating “when nobody could see”), they would occasionally eat and eat, only to feel emotionally worse afterwards. This interrelatedness of food and emotions resonates with Robertson’s research on male embodiment when he notes that “emotions and the communication thereof are fully embodied and therefore dealt with (successfully or not) by bodily action(s)” (Robertson et al., 2010, p. 707). For the men here, one could argue that dealing with various emotions through “excessive” eating was a rather unsuccessful way of coping.

The men’s narratives of long-term experiences with WLS typically refer to a past in which *normative* embodiment becomes intertwined with *experiential* and *pragmatic* embodiment, shaping (in the sense of limiting) the men’s opportunities in everyday life and generating a sense of self as less confident (and thus less masculine) than other men.

### After the Surgery

#### *In better shape, but struggles continue*

When asked to elaborate on their current life-situation, the men emphasized having more fulfilling, social and active lives than previously. To underline this contrast between their problematic pre-surgical lives and their fulfilling post-surgical lives, the men used terms such as “fantastic”, “wonderful” and “great”. In the words of Sondre:

*My life-situation now is very good. I have never been in better shape than I am now. I am not into marathons or stuff like that, but it works very well, both in terms of my work, hunting and everything, so I cannot complain.*

In similar vein, Jens elaborated on how being more active involved exercising on a regular basis, feeling more self-confident and being inspired to date women. Five years after the surgery, Jens feels optimistic about the future, emphasizing how his life has now completely changed for the better:

*I have no regrets, if I were to compare my life-situation now compared to previously, my life is extremely much better today. I’ve reconquered the control over my body. I’ve reconquered my health so that I can actually live a happy life. And not the least, I have reconquered my self-confidence that was actually not there before ... I feel strong, both physically and mentally. And I know that I can actually do whatever I desire to do. I have kind of reconquered my life. I keep comparing my life now to my previous life and previously I just existed, and had given up hope ... so I more and more became an*

*empty shell and now I have filled my shell with something new ... So my life is very, very much better compared to previously.*

In the men’s accounts, the surgery invariably represented a positive turning point in terms of both functionality and appearance. These parts of their stories represented a positive spiral that helped them to re-build aspects of masculine capital. In short, they looked (*normatively*) good – slimmer and fitter; they felt (*experientially*) better – more self-confident; and they performed (*pragmatically*) better – being more physically and socially active. These changes were visible to everyone, and friends, colleagues and family members took part in affirming these positive changes.

However, with regard to the present situation, the men’s accounts also showed that food and eating remained problematic years after the surgery, even though in somewhat different ways than previously. Restricting food intake remained an ongoing struggle for the men. Whereas they could only eat small portions of food during the first two years following surgery (due to the physical restrictions it imposed), they later found themselves increasingly able to eat larger portions. These experiences were often narrated as dramatic turning points, such as in the case of Olav:

*We went abroad on vacation in 2011 and during that vacation we went to restaurants every day ... And eating out in restaurants every day the intestine started to expand, I think. I messed it up because I could not stick to eating the proper portions of food.*

These turning points often marked the beginning of yet another vicious cycle in the men’s narratives. Once again, Olav could not control his eating and was eating the “wrong” food, resulting in significant weight regain. Trying to limit food while desiring to eat large portions became a daily struggle resembling struggles before having surgery, and during the past months he had regained more than 10 kilos, which he experienced as “terrible” and “mentally tough”. In particular, he found it mentally tough (re)experiencing the development of “belly, breasts and hips again”. His fear of losing control (something “real men” do not do) is then compounded by being made corporally visible through the development of a *normatively female body shape*; his “failure” to practise control as men “should” becomes publically signified through a feminised body. Olav’s story demonstrates this ongoing struggle and illuminates the intense *drama* that regaining weight represents. It is first and foremost a *personal drama* that he is trying his best to deal with on his own whilst simultaneously recognising it as visible to others. In order to present himself as a male-gendered character within his narrative, he emphasizes how he had not sought professional help to deal with his weight regain,

having felt confident that this was something he could control himself:

*I know I can control it .... I must simply try a bit harder and eat less, exercise more and eat the proper food ... then I will manage to stabilize it. Because the system is still working, it is just that I must ... it is still a daily struggle ... in my opinion life is still the way it was before when I was obese ...*

Based on his previous experience, Olav draws on his *experiential embodiment*, feeling confidently optimistic that this is something he will manage on his own and positioning himself as an expert in understanding his own body. In this way, his previous experiences are regarded as his primary source of knowledge as he embodies the hegemonic masculinity practices of self-control and individualism. Roy's story similarly points to food and eating as still problematic. As previously, he feels the urge to overeat, particularly in situations involving emotional distress:

*I will probably always have a problematic relationship with food. Like last month, my father became acutely ill and had to go to hospital. Then my boss started to complain about my work and push me with losing my job. Then I turned to food, and I ate a lot. But I was exercising, I managed to stick to my activity plan, so I did not feel too bad, I did not have a bad conscience about over-eating at all actually. And I think a lot lies there actually, that, okay I did it, I overate, and I have to take responsibility for that ... but I know that I am extremely active, so it will not affect one gram of my weight ... so I must not feel bad about overeating. If you feel guilty about overeating then I think you will be more troubled.*

Roy's story illustrates how his problematic relationship with food is somewhat ameliorated by his intense exercise regime. Even though he is still struggling to restrict his food intake, his ability to exercise hard stops him regaining weight and reduces anxiety about the possibility of this happening. The men's narratives thus oscillate between difficulties in maintaining or keeping control and those of disciplining the body by means of physical activity.

The men's narrative of long-term experiences of WLS surgery was also often one of hope and recovery – one in which the men positioned themselves as pro-active agents in their determination to overcome their struggles. Indeed, the narratives illuminated the various ways the men found to deal with these struggles. Whilst emotional eating and the desire to overeat was an ongoing urge years after the surgery, regular exercise was presented as

positive in its effects on emotional well-being and as a practical way of ameliorating episodes of over-eating. The significance given to exercise in the men's stories mirrors public narratives and previous empirical work indicating that men are more likely to emphasise the merits of exercise and downplay dietary approaches to weight control (e.g. Kiefer, Rathmanner, & Kunze, 2005). In this sense, the men are embodying gender-acceptable accounts of managing this "weight war".

Another major challenge, tightly interwoven with the men's efforts to restrict food intake, revolved around their efforts to limit acute episodes of illness. At first, these illness-episodes were experienced as dramatic. They threatened *pragmatic embodiment* by preventing completion of tasks at work, impeding driving, and so forth, and altered the men's *experiential embodiment*, as they felt sick, dizzy, tired and generally out of sorts. Nevertheless, the dramatic elements of these episodes also had recovery aspects, as they forced the men to focus on finding ways to understand and make sense of them as well as deal with them. For Heine, avoiding such acute illness episodes, which he termed "dumping", involved ongoing efforts to limit intake of carbohydrates and sugar:

*I get in trouble if I eat quick carbohydrates. I try to limit bread, cookies, sugar and food containing sugar ... For example, if I eat sugar, then I get dumping shortly after. I get a severe dumping reaction – meaning that I feel sick and uncomfortable, tired and exhausted and dizzy. I must go and sit down for a while and rest. It is really uncomfortable.*

For Heine, knowing how often and how much carbohydrate he can eat before becoming ill is an ongoing process and he is constantly on the alert in trying to make sense of this:

*I still do not know where to draw the line, but if I have eaten carbohydrates two days in a row, then I have to eat less the next day. But if I have eaten slow carbohydrates or low carbohydrate food then I can tolerate eating more. I have figured this out based on my own experience, and I have discussed it with others having similar kinds of experiences ...*

One of the men was more troubled with this than the others; in addition to "dumping", Sondre experienced episodes of hypoglycaemia<sup>1</sup>, or so called *late-dumping*. He states that this had started approximately two years after the surgery after having eaten "a lot" of food and was totally unexpected:

<sup>1</sup> Low blood sugar.



*You become foggy and then you become destructive and irritated, and when you go far enough into hypoglycaemia then you don't understand what you are doing. ... If I eat too much and work too hard after meals, for example physical work, then I am "straight in the basement" after approximately one hour. But when I manage to take in a slice of bread after 30 minutes, then things will be fine.*

Sondre relates these acute episodes to hypoglycaemia, indicating that there is something happening inside his body beyond his control although recognised through his *experiential embodiment*; that is, through the sensations these visceral changes generate.

It is significant to note the contrasting experiences of Heine and Sondre and how they learned to self-manage these episodes through adjusting their food intake and diet. Whereas Olav's narrative shows how he strove to avoid episodes of dumping by restricting his intake of carbohydrates and sugar, Sondre's narrative reveals a contrasting approach where, through experience, he had learned that certain foods helped to prevent such episodes. Despite this difference, both men can be seen to draw on the importance of their *experiential embodiment* as the principal way of understanding their *visceral* body and in knowing what is required to avoid such episodes and thereby maintain *pragmatic* functioning. The effort made to self-manage these episodes points to an embodied knowledge that enabled the men to regain control, once again highlighting the interrelatedness of the *experiential body*, *visceral embodiment* and *pragmatic functioning* (Robertson et al., 2010; Watson, 2000). Through bodily sensitivity, means were thus found of managing physiological processes (the hypoglycaemia) and preventing them disrupting daily functioning at work and elsewhere.

Managing this process took time and effort, as they had to be constantly on the alert in respect of symptoms and reactions, as well as needing to reflect on the food they had eaten and the time that had elapsed since their previous meal. As such, these findings tally with Mattingly's argument regarding the embedding of dramas in people's recovery narratives (Mattingly, 1998). More precisely, Mattingly points to dramas as paramount in the sense that they represent turning points affecting the person's choices and experiences in significant ways.

### ***The story of success***

The men's stories all ended with accounts of how life had changed for the better despite various challenges related to food and eating, weight regain and side effects. Each story was, in other words, a "success story" emphasizing the positive results of the surgery. As Olav concludes:

*I feel that I have covered most of it now. My life was negative before, and now it has changed and become totally positive. I have only positive things to say about this.*

Problematic aspects of the surgery were generally downplayed or obfuscated by the need to present a positive account. This tendency to end the interviews by emphasising the successful aspects of the surgery and recovery seemed surprising given that the men's narratives also revealed yet another storyline, one of suffering. Indeed, three of the men (Heine, Sondre and Jens) suffered significantly problematic side effects and complications, some of them life-threatening. Heine's and Sondre's health issues have been recounted above, and Jens's story below vividly illuminates the nature of the suffering that can occur. Not only had he almost died from complications, but he was also about to lose his job:

*I've undergone nine reconstructive surgeries to have it removed and fix my body, if I can put it that way ... . It seems like following each of the surgeries under anaesthetic a larger percentage of my brain loses some of its capacity. I can sense that especially when it comes to my energy level and my work capacity. I used to be a working horse like no other working horse previously... . And today, I cannot keep it up anymore.*

Despite these various post-surgical complications and side effects, Jens regarded himself and his "new" life-situation as successful in a number of ways:

*I am still very glad and I can live a normal life ... . I am very pleased. I have worked so hard to build my body ... . And I couldn't care less about some scars ... . Of course, I do want to look as good as possible, but if you compare it to my life prior to WLS then it is much better now. My self-esteem and my bodily acceptance are very good now ... . And although I have had to cope with many complications, I still have a positive mindset, you know ... . So, given the changes, I'd claim my story is one of success. I do not want to twist it into something negative.*

Structurally, by pointing to his story as "one of success" when wrapping up the changes he has gone through during the past years, Jens not only depicts success with undergoing and adjusting to surgery, but he also pictures a process with a happy ending: he has reached a goal and achieved something important. He, along with the other men in the study, has won the battle against his own fat. However, as the sequences above illustrate, Jens's story of success runs alongside another story of continuous struggle. So, the war continues;

this “suffering” story is open-ended, and “success” is simultaneously achieved yet never fully achieved. The men’s stories are embedded in uncertainty and the knowledge that they may still lose or give up their struggle.

Despite struggling with post-surgical challenges of various kinds, in closing the interviews by outlining the successful outcomes, the men also emphasized how this was largely made possible through their own ongoing efforts to exercise, be active and control their food and diet. As such, they were providing explicit key messages not only about the positive outcomes of the surgery but, importantly, their role in this. This can be interpreted as a particular presentation of self. According to Mattingly, a narrative is marked partly by the use of rhetorical techniques aimed at being persuasive (Mattingly, 1998, p. 8). Personal stories provide “insider” perspectives on what it is like for a person to experience illness and bodily suffering as well as recovery and healing (Mattingly & Lawlor, 2000). Furthermore, stories may offer a prime avenue for healing itself where healing is defined, in part, by a recovery of the self (Mattingly & Lawlor, 2000). As a kind of *presentation of self* they thus tell us something about the storyteller and how he seeks to reveal himself to those listening to the story (Ahlsen, 2014; Goffman, 1956/1990; Riessman, 1990).

In emphasizing their decision to focus on successful, positive aspects of their new life-situation, as well as their determination to handle ongoing struggles on their own, the men identify themselves as rational and self-disciplined persons in control of themselves and their situation. Post-surgical challenges are something they can manage, something they are able to deal with. Embodied hegemonic masculinity practices of autonomy and self-control are thus clearly embedded within the men’s “successful” recovery story. This is particularly important in relation to issues relating to obesity and weight loss, shrouded as these issues are in demeaningly moralizing discourses.

## Conclusion

This paper began by asking how men narrate their long-term experiences of WLS. It sought to explore and understand what these stories say about their changed life-situation and the gendered nature of this, given that the surgery generates both health promoting results and more problematic complications and side effects. The paper provides original insight into these longer-term experiences, and responds to Groven et al.’s (2015) call for further, in-depth research on the integrated nature of these experiences with embodied norms of masculinity. The depth added to this previous work is attributable to the application of Watson’s *male body schema* (Robertson, 2006; Robertson et al., 2010; Watson, 2000) to the analysis of the men’s *narratives*. Taken together, the findings highlight shifting positions

in the men’s narratives. There is war and there are battles and there are moments of triumph and success, but there are also moments of setbacks involving dramas of various kinds. Summarizing these findings, one could conclude that the men’s stories reveal two contrasting storylines, namely one of embodied success and one of embodied suffering. *The storyline of success* is related to the men’s dramatic weight loss, thanks to their ongoing efforts to change their lifestyle, enabling them to act and interact in new ways as compared to previously. In this storyline, the surgery itself represents the major turning point, from living restricted to more fulfilling lives and triggering lifestyle changes. The plot involves a radical change from living unsuccessful to successful lives: from inactive to active, from emotional distress to emotional satisfaction, from anti-social to social, from hopelessness to hope, from fat to slim. They explicitly and implicitly emphasize this success using phrases and terms similar to those of the public WLS clinic success stories. There is a linear plot, suggesting that surgery was the smart (and right) choice. As such, this storyline also reflects the cultural story of success – a storyline emphasizing agency, in which the men’s normative and pragmatic embodiment is enhanced, as such enabling them to engage in more hegemonic masculine practices.

The storyline of suffering, by contrast, relates to the men’s efforts to make sense of and recover from side effects affecting aspects of their body schema in often complex and unpredictable ways. Here, the experientially embodied nature of food and emotions plays a major role, as also do changes related to the men’s shifting visceral embodiment. In this storyline, their visceral embodiment is under constant threat, and this threat is somewhat uncontrollable, as it involves unpredictable dramas. Metaphors play a dominant role in this story, as a means of expressing the men’s suffering when verbalizing their experience. Due to changes in their viscera, the men’s *pragmatic embodiment* (and agency) is under constant threat. The storyline of suffering points to a lonesome struggle often involving feelings of not being taken seriously or understood by doctors, along with the risk of being exposed as an unsuccessful bariatric patient. The story of suffering reveals the uniqueness of each individual story, with the dramas embedded in the men’s respective narratives differing significantly. These dramas not only invoke various experientially embodied emotions, but also represent major turning points in terms of the men’s making sense of their changed and changing bodies. Threatening their pragmatic and normative embodiment, these dramas – or the recovery aspect of these dramas – rely on the men’s efforts to make sense of, and control, their visceral embodiment.

There is no doubt that, for these men, life prior to surgery was restricted through a physical inability to engage in as many aspects of work and social life as

they wanted to or had previously been able to engage in: they were limited in their *pragmatic embodiment*. It was also evident that their non-normative male bodies acted as a cultural signifier of subordinated and marginalized masculinities restricting access to certain forms of *material opportunities*, as is attested to by their accounts of their reduced prospects in social and work settings. Collectively, these experiences impacted heavily on the men's emotional and mental well-being.

Following surgery, the men were keen to emphasize the positive changes they had experienced, including their improved (normative) appearance and their now renewed ability to engage in a wide range of activities. There was an improved sense of (male) self as they (re)engaged in expected roles and, in the process, accrued the masculine capital that accompanied this; that is, they enjoyed a *renewed pragmatic embodiment* and some of the experientially embodied joys that went along with that. However, post-surgical narratives also highlighted the ongoing challenges that the men faced, particularly in terms of control over food intake, weight (re)gain and post-surgical complications, which would all suggest some ongoing issues with *experiential* and *visceral embodiment*. Despite these challenges, the men all concluded their interviews by placing an emphasis on their experience as a "success story".

Positioning oneself as the protagonist in a success story can be paramount when it comes to strengthening or preserving one's self-esteem. This is especially relevant in respect of the stigma generally associated with WLS. Regarded as a drastic intervention only to be offered when all personal, individual efforts to lose weight have failed, people undergoing WLS risk being labelled as

"cheats" opting for a quick fix as opposed to engaging in a strict regime of exercise and regular diet; efforts often associated with hegemonic masculinity practices of discipline, will power and strength of character (Throsby, 2012). At the same time, success narratives, like those published by private clinics, acclaim WLS as a uniquely effective medical intervention like no other intervention for obesity, provided that the person undergoing such surgery is capable of adjusting and making the necessary lifestyle changes. Within this domain, stories of the "ideal patient" are common, indicating the good (morally right) way to be a bariatric patient. This ideal patient is compliant, having demonstrated the "work" required to achieve long-term success (Drew, 2012; Throsby, 2012). Such presentations of the "ideal" patient also provide a conduit for weeding out people less likely to succeed, where success is measured in pounds on the weighing scale or numbers in a lab report (Drew, 2011; Glenn et al., 2012).

Collectively, the men's stories reveal two contrasting *embodied* storylines – success and suffering. However, the men's concluding emphasis on the successful aspects points to some ways that suffering storylines are more likely to be hidden, buried beneath popular narratives of successful weight loss and personal transformation, and thereby silenced. The implications of this silencing could involve reinforcing stigma, lack of support, pain (physical, social and psychological), and self-blame. These storylines are rarely told, heard or accepted; instead, they are quieted, and because of this other men encountering such embodied experiences may be reticent to reveal them, thus perpetuating their own suffering and leaving popular obesity and weight loss narratives and discourses unchallenged.

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