Obesity Surgery: When Less Is More

A review of

Obesity Surgery: Stories of Altered Lives
by Marta Meana and Lindsey Ricciardi
$49.95, hardcover; $18.95, paperback

Reviewed by
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Fat bias is one of the most persistent of prejudices and can be expressed with little fear of censure. Prejudice against the obese can be found in many arenas of human functioning, beginning in childhood and continuing into adult life, affecting dating, mental health, employment, or acceptance into college (Brownell, Puhl, Schwartz, & Rudd, 2005). It even affects health care. Health-care professionals alter their behavior with an obese patient, providing less than optimal treatment because the equipment is not of the correct size and, more important, because professionals (including psychologists) share the prejudice.

Now, our latest public health crusade, reducing obesity, has granted new credibility to the fat prejudice. It remains controversial how serious the health risk is and at what point the health risks really begin to accrue (Oliver, 2006). Few argue that as a country, the average weight of our citizens has increased steadily and that the health problems associated with obesity—for example, hypertension, diabetes, and heart disease—have also increased. It is
also the case that the superobese, that is, those more than 100 lbs. overweight, have increased as a proportion of the general population.

The most dependable method of producing weight loss—that is, surgery—causes dramatic, rapid weight loss in comparison with the behavioral prescription to eat less and exercise more. It is also controversial and increasingly popular. While the basic surgical procedures to reduce obesity have been available for decades, their use has accelerated in the last decade. The number of obesity surgeries performed in this country and around the world has grown from less than 13,000 in 1998 to close to 200,000 in the past year. The surgery has become less and less invasive and progressively safer, but remains a major surgical procedure with all of the attendant risks. Current mortality estimates are about 3 per 1,000 surgeries, one third the rate of 10 years ago (Encinosa, Bernard, Steiner, & Chen, 2005). The overwhelming proportion of recipients is female, 80–85 percent, a further reflection that the obesity stigma attaches itself most strongly to women.

The current standard of care for obesity surgery specifies comprehensive medical and psychological assessment prior to surgery as well as extensive education and support before and after. It is the task of the assessing psychologist to identify obstacles to treatment, such as unreasonable expectations regarding the surgery, as well as readiness to make the demanding but necessary lifestyle changes. The postsurgical regimen calls for reduced consumption of specific foods, a low-calorie diet, and increased physical activity. Some programs require adoption of these lifestyle regimens prior to the surgery.

What is novel about *Obesity Surgery: Stories of Altered Lives* is how effectively it renders the full impact of obesity surgery in the words and from the perspective of the recipients. The sheer extensiveness of the psychological impact is astounding. Reduction in body size can profoundly alter the formerly obese person's relationships, positively and negatively, with spouses, potential romantic partners, children, siblings, friends, coworkers, even complete strangers. Much of this is well known to researchers in the field and clinicians who work with a bariatric population. The empirical work on the psychological characteristics of obese individuals, the stigma of obesity, and the outcomes of bariatric surgery is extensive and largely consistent. By contrast, the narratives of these individuals make vivid the human effects of the surgery in a way that a well-designed empirical study never could.

I will mention just two areas of human functioning where the narratives of obese surgical patients in the book are especially striking, at least to me—how the fundamental sense of oneself changes and how the dynamics of close personal relationships are disrupted by the surgery. Over the course of a life, an obese person's fundamental definition of him- or herself is influenced, among other things, by the persistent social prejudice against the obese. The prejudice is pervasive and often covert, affecting social behavior as simple as going grocery shopping or making a transaction at the bank. The people who were interviewed had struggled with obesity for many years and had attempted repeatedly to lose weight. Compared with many who chose the surgery, they were well prepared for it. While the
reasons varied, all described themselves as having become so desperate that a major surgical intervention with a risk of death was deemed a reasonable alternative to life as it had been.

While the life-threatening medical complications of severe obesity have been well documented, the narratives describe how truly confined these people's lives had become. One person could fit in only a particular kitchen chair and did everything from it: cooking, self-care, and parenting; most household tasks were delegated to children and spouse. She had not gone to the grocery store for five years because it was physically too demanding (p. 39). Some of the most poignant presurgical stories were about parents so limited in their lives that they could not walk a block to a park to swing their children, pick up a toddler, or even attend their child's school and sporting events.

One might think that with eliminating the prejudicial characteristic and becoming more mobile and healthier in so many ways, the changes in self-image could only be positive. The subjects of the book frequently found that not to be true. For example, a presurgical career setback or interpersonal rejection could be readily explained by one's obesity, but postsurgery? For some, weight loss promised to remedy all of their disappointments since any failures could be explained by social bias against the obese. After surgery, it became necessary to confront the fact that other basic characteristics of the person were important and needed modification.

As profound as the effects might be on the person's understanding of him- or herself, it is not surprising to find that they also alter the dynamics of close personal relationships. Again, most people anticipated only positive changes. Many expected surgery to increase physical attractiveness, which mostly did happen, although drastic weight loss can produce large, unsightly folds of skin that might also require surgery. The unexpected effect of surgical changes was that they were not always welcomed by the person or by a partner. Becoming more attractive to a romantic partner would also make someone more attractive to alternative partners. Spousal fears of infidelity, jealousy, or changes in power or status due to improved attractiveness destabilized several marriages. Some marriages reestablished a new, viable relationship; others dissolved.

A similar result occurred with friends. With weight loss, comparisons among friends changed. Some people might befriend an obese person because he or she is always available to socialize and to sympathize or is worse off than themselves. Or they may enjoy the satisfaction of being thinner than someone else. Once the obese person changes, the equilibrium in the relationship is disrupted. Several formerly obese patients lost their network of friends and ended up questioning the basis of relationships in the first place.

Clinical psychologists who work with the obese are in general very ambivalent about obesity surgery; this includes even those who conduct evaluations of surgery candidates and declare them ready to receive the surgery. At the same time a psychologist may assert that a candidate is ready for surgery, there is also a hesitancy about the whole procedure. While this book is about the effects of bariatric surgery on the recipients, many of the same factors may be at play with the evaluating psychologists.
For example, those who do not undergo the surgery themselves, such as family or friends, sometimes see the surgery as an easy, quick fix. Most psychologists know how hard it is to follow the behavioral recommendations—eat less, exercise more. Somewhat irrationally, the surgery can appear to be the easy answer. Psychologists are also likely to realize that seemingly purely positive outcomes can have entirely unexpected negative consequences, as is well documented in this book. Furthermore, bariatric surgery is a dramatic intervention that produces far more rapid changes than most clinicians experience in their typical work. Thus, I strongly recommend that those who evaluate candidates for weight reduction surgery read this book.

Another concrete benefit of this qualitative investigation has been to translate the results into a 14-step program, Through Thick and Thin, for preparing for the surgery and for life afterward. While most patients are probably reasonably educated by the surgical team about physical effects of the surgery and the subsequent medical regimen that needs to be followed, I suspect patients are not as well educated about the social and psychological effects of the surgery. The Through Thick and Thin program can help with that. While designed to prepare the person for surgery and after, it can certainly be used by someone who has already had the procedure. After reading of the many unexpected and profound effects of the surgery, I suspect any further assistance would be appreciated.

References