



“I Would Have Sold My Soul to the Devil!” – Bariatric surgery and damaged identity restoration: A qualitative investigation

Journal of Health Psychology

1–14

© The Author(s) 2025

Article reuse guidelines:

sagepub.com/journals-permissions

DOI: 10.1177/13591053251384862

journals.sagepub.com/home/hpq



Álvaro Sicilia¹ , María-Luisa Socías-Serrano¹
and Mark D. Griffiths² 

Abstract

The decision to undergo bariatric surgery remains contentious. Despite high demand, patients face long waits and requirements focused primarily on biomedical parameters (high BMI, diabetes, hypertension), ignoring factors such as social stigma and negative body image that impair mental health. The present study draws on interviews with 23 patients undergoing bariatric surgery to examine the significance of living in a fat body and how this shaped their decision-making. Employing reflexive thematic analysis within a critical realist framework, the findings show a prolonged trajectory of suffering marked by a paradox of hyper-(in)visibility. Participants reported feeling constantly scrutinized yet simultaneously dismissed due to their stigmatized bodies. For them, bariatric surgery was more than a medical intervention; it was a means to reassert agency and reconstruct a damaged identity in a society marginalizing fat bodies. This underscores the importance of integrating identity, agency, and social context into discussions about bariatric surgery.

Keywords

obesity, fatness; bariatric surgery, narrative, subjectivity

Weight stigma encompasses bias, discrimination, and social exclusion directed at individuals with higher weight (Puhl, 2023). According to Goffman (1963), fatness is a socially discredited bodily attribute that marks individuals with a damaged identity. In Western societies, this stigmatization stems from two main perceptions. First, a higher weight body deviates from the Western ideal of thinness, being perceived as “abominable” (Goffman, 1963) or “abject” (Kristeva, 1982) because it crosses socially acceptable boundaries. Second, contemporary culture links the body to an individual’s “inner worth” (Featherstone, 2010), leading to the belief that fatness signifies laziness and permissiveness (Lupton, 2018; Saguy, 2013). This aligns with

neoliberal views, suggesting that having higher weight is a personal choice controlled by willpower (Harjunen, 2021).

Weight stigma and its adverse health implications are widely recognized (Farrell et al., 2021; Gailey, 2014; Hill et al., 2021; Phelan et al., 2015; Puhl, 2023). This stigmatization leads to discrimination and a deprivation of opportunities, which in turn deteriorates an individual's identity (Lewis et al., 2011; Puhl, 2023). According to Nelson (2001), individuals experience damaged identity when perceived as less valuable, capable, or worthy by influential societal groups. Such perceptions restrict their possibilities, prevent them from accessing valuable social positions and roles, and hinder the establishment of social relationships, all of which impact their self-perception. Ultimately, the stigmatization and discrimination faced by individuals with higher weight result in significant consequences, including exclusion and limited prospects (Kim et al., 2019; Puhl, 2023)

Due to associated health risks and financial costs, fatness has been medicalized as 'obesity' (Bray et al., 2017). Influenced by medical discourse defending a global obesity epidemic (Lupton, 2018; Saguy, 2013), regulations aimed at mitigation have traditionally focused on educating the population (Hill et al., 2021). These policies assume that a lack of knowledge about nutrition and lifestyle leads to weight gain. This approach assigns responsibility and blame to individuals with higher weight, reinforcing social stigma (Puhl, 2023). Although for approximately 15 years there has been a call for obesity prevention efforts to focus on environmental and social factors rather than individual ones (American Medical Association, 2013), no significant progress has been made toward eliminating weight stigma (Hill et al., 2021). Consequently, both the physical problems and social impact of weight-related stigma mean these individuals often have a significant drive to lose weight (Farrell et al., 2021; Trainer and Benjamin, 2017).

Bariatric surgery is an effective treatment for rapid and drastic weight loss when other methods have failed (Jiretorn et al., 2024; Ogden et al., 2006; Wolff and Maydell, 2024). However, access is restricted by public health systems due to rigid eligibility criteria and insufficient resources. In most countries, including Spain (where the present study was conducted), adults are eligible when classified as severely obese (body mass index [BMI] ≥ 40 , or ≥ 35 with a comorbidity) (Yumuk et al., 2015). Despite high demand, patients face long waits and requirements primarily focused on biomedical parameters (high BMI, diabetes, hypertension), often ignoring key factors such as mental health and social stigma (Homer et al., 2016). While studies support its effectiveness for both physical and psychological health (Jiretorn et al., 2024; Yumuk et al., 2015), lack of public funding forces many to inaccessible private options, perpetuating health inequalities.

Qualitative research has been essential in showing the complex patient experience surrounding bariatric surgery, a complexity often underestimated by clinical approaches prioritizing only physical outcomes (Griauzde et al., 2018; Ogden et al., 2006). While patients can lose up to 50% of their weight (Yumuk et al., 2015), leading to a shift in eating perception where food becomes functional rather than an obsession, this generally improves control and quality of life (Lyons et al., 2014; Ogden et al., 2006; Wood and Ogden, 2016). However, despite typically positive physical and psychological effects, qualitative research frequently shows a struggle with negative body image, where internalized fatphobia can persist, leading to an identity crisis or “mind-body lag” even after significant weight loss (Lyons et al., 2014; Wolff and Maydell, 2024). This persistence of emotional issues underscores that surgery, by focusing solely on the physical, does not address the patient’s entire suffering. Therefore, qualitative research emphasizes that although bariatric surgery transforms the body, it often neglects the mind, highlighting a crucial need to examine associated psychological effects to optimize patient

care and healthcare outcomes (Ogden et al., 2011; Wolff and Maydell, 2024; Wood and Ogden, 2016).

Previous qualitative research has shown that patients consider bariatric surgery within a context of pain, dysfunction, and pervasive social stigma (Groven and Engelsrud, 2016; Pfeil et al., 2013), often leading to unrealistic postoperative expectations (Homer et al., 2016; Pearl et al., 2019). Although weight-related stigma profoundly motivates the decision for surgery (Cohn et al., 2019; Homer et al., 2016; Jiretorn et al., 2024), qualitative studies have primarily focused on the complex consequences of weight loss on body image, identity, and psychological well-being post-surgery (Jiretorn et al., 2024; Ogden et al., 2006, 2011; Wolff and Maydell, 2024; Wood and Ogden, 2016). This disproportionate attention may be due to body image concerns not being a direct official eligibility criterion, which predominantly considers BMI and comorbidities (Griauzde et al., 2018; Yumuk et al., 2015). Therefore, despite renewed interest in postoperative body image and its mental health impact (Griauzde et al., 2018; Throsby, 2012), this has not yet led to considering body image as a direct justification for surgical eligibility.

Studies on self-reported patient reasons generally indicate that physical health problems are the primary motivators for bariatric surgery, with body image concerns often secondary (Libeton et al., 2004; Pearl et al., 2019). However, it is suggested that standardized preoperative psychosocial assessments, intended more to gauge future commitment than psychological distress, may be compromised by patients underestimating their psychological dysfunction or shaping responses to ensure surgery approval (Griauzde et al., 2018). Similarly, socio-critical research shows that a predominant medicalized narrative of obesity can overshadow the role of stigmatization in the decision for surgery (Sicilia et al., 2025; Throsby, 2007; Trainer and Benjamin, 2017). Bariatric surgery remains highly stigmatized, socially viewed as a low-effort weight loss method (Trainer and Benjamin, 2017; Wolff and Maydell, 2024). Therefore, to avoid accusations of choosing an easy option over demanding lifestyle changes, patients often

medicalize obesity and the surgery to combat this stigma (Throsby, 2007; Trainer and Benjamin, 2017).

This medicalization of obesity shapes discourse, potentially explaining why body image concerns might be relegated in research on reasons for choosing bariatric surgery. Narrative studies show that patients often present their choice as a medical necessity, aligning with dominant medical narratives (Sicilia et al., 2025; Throsby, 2007; Trainer and Benjamin, 2017). For instance, a study by Trainer et al. (2017) showed that stigma was reinforced when bariatric surgery was viewed solely for weight loss, making it seem less valuable than surgery for health reasons. Individuals desiring weight loss felt compelled to legitimize their decision by citing medical motivations. Similarly, Sicilia et al. (2025) found that bariatric surgery participants adopted a narrative of a “sick body” needing restoration to defend against weight stigma and present themselves as deserving of surgery.

In contrast to dominant medical discourse, some scholars challenge the notion of an obesity epidemic and question weight-loss surgery (Gard et al., 2022; Lupton, 2018). Within these critical perspectives, fat activism promotes body diversity and opposes normalized ideals (Bacon and Aphramor, 2014; Cooper, 2016; Murray, 2008), reclaiming “fat” as an affirmative identity (Cooper, 2016; Wann, 1998) and rejecting medical classifications such as “obese” (Lupton, 2018). However, in its effort to empower individuals with higher weight, fat activism has sometimes criticized those who choose bariatric surgery (Throsby, 2012), portraying them as having disowned their bodies and being ‘innocent victims’ of medical discourse promoting body normalization (Murray, 2008; Throsby, 2012; Wann, 1998).

From diverse perspectives, including conventional medicine, critical approaches, and fat acceptance activism, the debate surrounding bariatric surgery often overemphasizes whether bodies *should* be altered due to weight, while neglecting the active role of the individual patient. The present study posits that understanding these interventions requires prioritizing the bariatric

surgery patients' own explanations. Rather than being seen as passive 'cultural dopes', patients are active, knowledgeable agents who navigate their bodies and lives within the constraints of an unequal and discriminatory social order. Therefore, this study explored how individuals narrate their experiences of living in a higher-weight body and how these experiences influenced their decision to pursue surgery. A central objective is to understand the profound significance of wanting to be 'normal' or 'ordinary' in a society that stigmatizes fatness. The study sought to illuminate how experiences of stigmatization play a crucial role in the decision to seek bariatric surgery as a means of modifying the body and restoring a damaged identity, thereby reaffirming patient agency within a context of social limitations. By considering narratives of stigmatization, the study endeavored to foster a more complex and multidimensional understanding of the decision to undergo bariatric surgery, which could inform the debate on eligibility criteria for this intervention

Method

Participants

Twenty-three patients (15 women and 8 men) undergoing bariatric surgery participated in the present study. The mean age of the participants was 41 years, ranging from 18 to 58 years. All participants were clinically classified as obese, with a mean body mass index (BMI) of 46.2 kg/m² (range, 37.7–65 kg/m²). Of the participants, nine were operated on within the public healthcare system, while the remaining 14 were operated on within the private healthcare system. Participants were contacted through a surgeon who performed bariatric surgery and worked in both public and private healthcare in a city in southern Spain.

Data Collection Procedure

Before proceeding to the interviews, participants gave their consent by signing a document informing them of their rights and ethical issues of the study. This study was approved by the Research Ethics Committee of the first author's university. All interviews were conducted

by the second author using open-ended questions that allowed participants a starting point from which to relate their experiences of living in a fat body and the process of making the decision to seek surgery as a means of reducing their weight. Participants were invited to provide as much richness as they could in their stories, allowing complete freedom to highlight the events, issues, and words that they felt best brought those experiences to life. The interviews prioritized accounts of the subjective experiences of the events recounted, being interested in not only what had happened but also the elements surrounding the event (e.g., where, how, which individuals were involved, how it was resolved, or what consequences it had for them). In this way, the study sought to understand not only the objective details of the experiences but also the personal meanings that the events told had. Participants were interviewed before and after receiving bariatric surgery. Conducting different interviews allowed participants to recall moments in their lives more effectively while also clarifying some experiences previously recounted. All interviews were recorded and subsequently transcribed for analysis.

Analysis and Interpretation

The interview data were subjected to a reflexive thematic analysis (Braun and Clarke, 2022) based on a critical realist approach (Archer et al., 2008; Bhaskar, 2008). This approach assumes ontological realism and epistemological relativism. Although it recognizes the existence of an objective reality outside of ourselves, it rejects the correspondence theory of truth, which is why it is a transcendental realism that rejects a foundationalist position (Danermark et al., 2005). Individuals' knowledge of reality is socially constructed and situated within social and cultural structures (Bhaskar, 2008). This makes knowledge of reality determined by how the individual perceives the world from their experiences, which represents only a part of a deeper and larger reality than we can reach with our understanding (Archer and Elder-Vass, 2012; Fletcher, 2017). Far from aiming to make predictions, a critical realist approach proves relevant in the present

study to generate a better understanding of how stigma structures and mechanisms influence the decision to undergo bariatric surgery.

To become immersed in the data, the first two authors repeatedly read the transcripts to familiarize themselves with the content. After immersion in the data, these authors identified key features in the data and coded them through labels. The two authors then met to compare and contrast codes across participants, recording and describing patterns in the data. The patterns of shared meaning identified were linked to core concepts and ideas that allowed us to begin to generate meaningful themes across participants in relation to the research question (Braun and Clarke, 2022). Data related to each theme were grouped so that themes were reviewed, modified, and refined in consideration of the authors' theoretical frameworks. In this sense, weight stigma studies were used through analysis to increase the researchers' reflexivity, support assumptions, and allow for a more representative description of the participants' subjective reality. The themes were shared and discussed with other authors who acted as critical friends (Sparkes and Smith, 2014), encouraging reflection, exploration, and possible alternative explanations to the data and subsequent writing through a persuasive story that selected informative and vivid data extracts as evidence.

Results and Preliminary Discussion

Four themes were identified in the analysis: (i) exposed bodies, (ii) marginalized bodies, (iii) bodies deprived of opportunities, and (iv) damaged identities and the hope of surgery. Through the first three themes, we account for the process by which participants learned that their bodies were subject to social rejection and discrimination through their life experiences. The fourth theme shows how the slow process of internalization produced by the direct and indirect experience of living in a fat body ends up affecting the feelings and identity of the participants, to the point of considering bariatric surgery as an attempt to restore this damaged identity.

Exposed Bodies

A fat body conveys meanings that are inscribed socially and culturally. The constant association between fatness and disease that has been established in our societies means that the fat body carries meanings of loss of control and the breaking of established boundaries (Lupton, 2018). By virtue of the socio-cultural meanings attributed to fat bodies, Individuals make assumptions about the people who embody these bodies (Saguy, 2013). Fat bodies do not go unnoticed; they attract attention and are exposed to others' gaze because of the volume they occupy. The gaze on fat bodies, when it is made from the dominant meanings, tends to judge and moralize the individuals who occupy them. A fat body is perceived as abnormal, and anomalies produce repulsion because they threaten the established order and its principles (Kristeva, 1982). The experiences recounted by the participants in this study reflected their suffering not so much for having a sick body but for having an abnormal body.

Without exception, participants agreed that they perceived that their bodies were rejected because they did not meet a normal weight. Although the content of the stories may vary, all participants remembered events from an early age when their bodies were exposed to ridicule and derogatory comments. Juan recounted the nightmare he had to go through at school, to the extent that he had to change schools. Alba remarked how her classmates made derogatory comments to her, remembering those physical education classes where they told her that she was *"going to break the [gym] horse."* As in the case of Juan and Alba, some participants recounted how classmates created songs or nicknames that made clear reference to their fat bodies. *"Chubby," "fatty," "fatso," "tubby," "lardy," "pot-bellied," "whale," "cow," "hippopotamus," "pig," "meatball," "dumpling,"* and *"doughnut"* were just some of the nicknames that participants received during their school years.

Particularly critical was the period of adolescence for the women in the study. Some women came to perceive themselves as being perceived as more masculine, ugly, and unfeminine because they had a higher weight and, therefore, as having less sexual value in the

sight of others. Rosario recounted how she went to school with her sister, a “pretty” girl, who was always in the “cool” group at school. On the other hand, she was “a little bit more isolated,” witnessing the value that bodies had within social norms. Alba recalled that all her friends had boyfriends except her and explained that the reason was that she was fat. As she reported, when her friends asked boys if they did not like her, they often replied, “Alba? Alba is fat; where are you going with that fat girl?” Miriam recounted similar experiences, admitting that some boys bet on who would pick up the fat girl. However, she is quick to point out that her most traumatic experience with boys was when she was 14 years old. Social pressure in relation to her fat body was a determining factor in the fact that the relationship between her and a boy, who liked each other, could not succeed.

When I was a semi-adolescent—I was 14—I fell in love with a classmate of mine. We got on really well because we were also in religious [classes] together. So, I know that the boy liked me, right? And one day, I summoned up all the courage of my 14-year-old adolescence, which is complicated, and I proposed to him. I proposed to him. Because we played on the same basketball team. And then he told me that, of course, the problem was that I was fat, so how could he have a fat girlfriend? That his friends were going to laugh at him. Imagine that baby. Wow, what a shock! Of course, you say that you have no self-esteem. But how can I have self-esteem with these things? (Miriam)

Despite the attempt to immunize themselves from the prejudices aroused by their fat bodies, all participants acknowledged that they continued to be the subject of stares and comments in their adult lives. Elena acknowledged that she had developed a withdrawal strategy (Phelan et al., 2015) to adapt and survive in a hostile environment against fatness. In fact, she admitted that her current job as a bar cook was because she preferred working indoors to working at the bar counter, where she would be more exposed to others’ comments. As in Elena’s example, the interviews are replete with situations and events recounted by the

participants. As adults, they continued to perceive that their bodies are exposed to public scrutiny, and, in general, they considered that individuals' perception of people who are fat was negative. As Alberto stated, *"They see us as freaks." A person who is fat has no right to live. Once you're a little bit fat, you don't have the right to live.*"

Many participants were not hesitant to criticize many situations with health professionals where they had seen their bodies exposed to judgmental and moralizing surveillance. In her middle age, Alba was trying to get pregnant through assisted reproduction. During this process, she remembered several moments when she went to receive professional health services, which strongly wounded her identity.

Alba: What bothered me the most during this whole process was a nurse at [hospital name omitted]. The one who weighed me during assisted reproduction. Before I even stepped on the scales, she threw her hands on her head. I mean, I understand that I weigh 110 kg, but even if I had weighed 200 kg, I understand that it was not correct for a professional.

Interviewer: *And did she say anything, or did she just throw her hands on her head?*

Alba: She threw her hands on her head and said, What did she say? What did she say? She said that how had I brought that situation about? How had I left myself so much? Well, a gynecologist too. He was also very cruel to me.

Interviewer: *What happened?*

Alba: Well, he was the first gynecologist I visited. When I saw that I wasn't getting pregnant, we went to the gynecologist. Before he examined me, he told me, "You would be the first to die in a Nazi camp".

Interviewer: *You would what?*

Alba: In a Nazi camp, you'd be the first to die; you'd be the prey most... the easiest prey. He also told me how I had come to such extremes. Without looking at me, [he said], "You, polycystic ovaries?" As in saying, polycystic ovaries for fat. Very derogatory. That doctor and that nurse, bravo for them! That left a huge mark on me. Well, I dropped...I just got off [the scales], and I had two tears in my eyes.

Miriam also highlighted her discomfort with the strongly paternalistic nature of some professionals she had dealt with. She resisted health professionals telling her what to do when they saw her fat body. Without knowing her background, her general tendency was to advise her what to do for her own good, for her health. In her words, the attitude of the professionals *"really upset me."* As she said, *"I don't accept that they want to meddle in my life."*

Fatness made the participants feel as if they were wide open to society's stares and reproaches. As a clearly noticeable attribute, anyone could immediately judge them. However, fat bodies were not only exposed to stares and comments from others but were also marginalized within established boundaries and norms, as the participants themselves recounted.

Marginalized Bodies

The distribution of spaces is not neutral and benign and is strongly related to the cultural meanings attributed to the body and the attempt to classify and normalize it (Longhurst, 2001). Fat bodies are bodies that do not fit into either the space or norms made for other bodies. They are bodies outside the socially constructed norms and spaces of coexistence. A fat body defies and challenges the notions of space and, with it, the established symbolic property. The fat hangs and overflows the contour. It invades other individuals' space and breaks social rules. The world is not made for fat bodies. Society is made for normal bodies, and individuals with fat bodies soon realize that they do not fit into this world. This is why the participants' reported experiences

of occupying space and the interaction of their bodies with other bodies and objects did not offer pleasant experiences.

For the last year or two since the first interview, Javier admitted that he was always looking around to see if the place was suitable for his body. In one of the conversations, he said that before going to a bar to have tapas, he checked to see if he could sit down because, as he admitted, there are bars that have very small chairs and other bars where customers have to stand up. While waiting to undergo surgery and looking to the near future, Javier acknowledged that he hoped to have new memories soon. Like many other participants, he had to limit himself from going to many places because of his size, which triggered a depressive psychological state. His emotional state was palpable as he recounted other activities that he had had to stop doing due to space limitations.

Being overweight limits you from doing many things you enjoy doing.” In the end, I prefer not to do them, and not doing them significantly changes my mood. There are days when you are very irritable, you don’t want to talk to anyone, and everything is bothering you. It’s complicated because I think everyone likes to travel... But for many years, I’ve found it difficult to travel by plane because I’m also 183 [cm] tall. I’m very big. So, of course, the seats on these types of planes are very small (Javier).

As in Javier’s case, most participants reported difficulties in adapting to spaces designated for normal bodies. The difficulties in taking seats on public transport or in performance spaces such as cinemas or theaters were particularly mentioned. Problems were also mentioned when using seatbelts in cars or the risk of using stools or ladders that are too flimsy for such a heavy weight. Participants also showed difficulties in getting their bodies into some clothing or uniforms for work. All of these experiences were a glimpse of the emotional, and sometimes physical, pain experienced by the participants as they tried to squeeze their bodies into spaces designed for ‘normal’ bodies or fit into ill-fitting sizes.

Some participants' accounts showed the shame they felt about their fat bodies and the social humiliation to which they were often exposed by others. For example, Rosario recounted how she looked forward to being able to play with her children and not finding herself in embarrassing situations. Once, she went with her children to the fair to ride. The children wanted their mother to ride with them. However, Rosario had to tell them that the rides were going too fast for her. As Rosario admits, this little lie was to avoid the embarrassment of her children and the other individuals around them, seeing that she would be unable to fit in the seat. Situations like this were highlighted by the participants as key moments in deciding to lose weight definitively through surgery.

Bodies Deprived of Opportunities

Individuals with higher weight are continually subjected to moralistic assumptions about their life choices. A fat body is considered a diseased body because of neglect and lack of discipline on the part of the body's inhabitants. Fat bodies are represented as flabby, soft, and lacking strength (Lupton, 2018). Therefore, fat women are seen as unfeminine, while fat men are seen as lacking apparent virility, toughness, and sufficient strength (Saguy, 2013). These beliefs about individuals who are fat damage their identity because they determine what they can and cannot do, depriving them of the opportunities that others have (Nelson, 2001).

Although all participants perceived their fat bodies as judged and, at times, depriving them of opportunities to get jobs, they showed a clear resistance to the idea that a fat body is clumsy and less capable of performing public-facing jobs. Alba recalled one such moment:

The first job I had for a longer period was in an 'IR' [a chain of cosmetics shops], and I was hired because of my ability. I adapted very well. I did my job well with people. I did both the booth and the shop, and people came looking for me. Reports came out about my sales and those of my boss. At one point, I even caught up with her. And she told me that they weren't going to renew me because they had to make me permanent if they renewed

me, but if six months went by, they could give me another contract. But of course, [the boss told her], “If we call you back, you must promise me that you must lose weight.” That’s when I told him, “It seems to me that the kilos I weigh haven’t hindered me from working, because I’ve worked at the same level as they do, nor have they hindered me from selling.” So, don’t tell me it’s because it’s not... “Yeah, but we have diet products here.” [The boss replied,] “So? We also have nail polish, and we cannot wear painted nails because we must give massages” [Alba replied] (Alba).

Alberto, a chef by profession, recognized that the stigmatizing labels that individuals who are fat have deprive them of the same opportunities as others to find work. The attributions of lazy and being incapable to a person with a fat body were reflected by Alberto when he expressed that individuals consider that because they think you are fat and you are less able to function, “*you are not going to move, you are not going to be able to do your job, and you are going to have 50,000 problems.*” Based on these attributions, he had been deprived of employment experiences, and he hoped that weight reduction through bariatric surgery would give him back the options that others have.

Alberto: Yes, yes, it has affected me. If I’ve been rejected, they haven’t told you directly, but you realize that they don’t see you as qualified.

Interviewer: Where, what happened?

Alberto: I applied for a job in a cafeteria before I got my cooking diploma. Furthermore, you say they rejected you. They rejected you because of your weight. Now when I have an operation and I lose the weight I have to lose and lead a normal life, I will not have any problem finding a job anywhere. I am excellent at my job, but...

Interviewer: Why do you have experience?

Alberto: *Because I have experience, I know how to develop myself. I have been doing this all my life, and I know how to develop myself well. But until people see me working. "It is because of my appearance; they are not going to put me to work."*

Elena studied to be a teacher but ended up working in the catering industry after being passed over for a job in a children's playground despite being the only applicant with a degree. Her account reflected a clear experience of the invisibility of her fat body (Gailey, 2014), such that she was very critical and angry about the vetoes that individuals who are fat like her encounter for specific jobs. However, Elena does not believe that her experience was an exception, and she said that you only have to look at the person who appears on television to ask aloud, *"Do you see a fat presenter? Can't a fat person give you news on the news?" Why not? Don't they have a tongue? "Don't they have a head?"*

As a school cleaner, Carmen was also reluctant to consider that an individual who is fat with a higher weight cannot do the same job as everyone else. She admitted to reacting instantly to comments such as *"How can you be so fat and wiggle the way you wiggle?"* At these times, she forcefully replied, *"Because I'm fat and active, and you're thin and lazy!"*

Despite most participants' resistance to not being considered of lesser value just because of their weight, personal identities are complex narrative constructions that are not only shaped by the person's narrative but are also affected by other social narratives resulting from the continuous interaction of many narratives and fragments of stories that impact individuals' lives. Therefore, the participants' definition of themselves cannot completely escape the structures of shared meanings that constrain ways of thinking, feeling, and acting (Archer and Elder-Vass, 2012). These structures trapped participants to characterize them in a certain way, not only because of what others come to think but also because they can distort and poison a person's self-perception and self-beliefs (Nelson, 2001).

Damaged Identities and Hope of Surgery

A fat body can inspire negative emotional responses in others but, when sustained over time, ends up also inspiring negative responses in individuals themselves (Lupton, 2018; Saguy, 2013). Therefore, the participants' identification of themselves as fat people who are targets of these highly negative meanings and feelings ends up having implications for their identity. Some participants acknowledged that their weight had begun to affect them in daily activities, such as tying their shoes, showering, or dressing. Apart from these physical limitations, however, it was clear to all of the participants that having a fat body had brought them other problems that were not merely limited to physical functionality. Fatness began to affect their lives in other areas much earlier. Far from physical limitation, fatness took on a symbolic character, becoming the focus of dissatisfaction, embarrassment, or unhappiness. Participants were acutely aware of what this meant and how their bodies were perceived by others by identifying themselves as fat. In internalizing these meanings, they expressed feelings of self-loathing and shame about their bodies' size. Participants internalized the social values of the fat body and were aware that their bodies met these attributes.

Alba negatively assessed her body and made a comparison as if it were an assignment on an academic course, assuming that it was "*not even good enough for a pass.*" Carmen confessed that she turned off the light to have sex with her husband because she did not like herself from the waist down. Juan acknowledged that he was a fragile person who had always been affected by not only what individuals said about him but also how others saw him. As he said, he tried not to meet anyone in the middle of the day, especially on the hottest days, because he knew that he would sweat and not be comfortable with his body. He went so far as to describe his body as "*a disaster,*" although he made it clear that he was not referring to beauty but to the limitations he sets for himself. He hoped that the operation, insofar as it helps him lose weight, will help him to be more optimistic and cheerful. Similarly, Alberto indicated that the problem was not with

himself but with his body, and he hoped that the surgery could correct this by returning him to a certain normality.

Some participants more openly acknowledged that their weight affected them beyond the physical limitations of everyday life. Such was Luisa's case, who did not let anyone know how much she weighed. However, most participants wanted to show a less vulnerable face and went so far as to say that they were already more immune to what others might think or say. In any case, all the participants showed a hopeful attitude toward weight loss surgery. Before the operation, the patients' narratives in relation to the surgery were expressed as narratives of hope, in which they articulated a better and brighter future. A future where at a lower weight, they will feel more attractive, healthier, and accepted by others and themselves. Alba tried to describe the daily life of living in a fat body and what expectations she had about the possibility of surgery after a long period of waiting.

Let's see, I'm telling you. There are better days and worse days. Days when I look in the mirror and puff... For me, that is the day-to-day. It is true that there is a change in the way I perceive my weight since I decided to undergo the surgery. I see it as... Well, apart from the surgery, I've dreamt about having the surgery thousands of times. Moreover, I dreamt of being in the surgery room. Because it's something I'm really looking forward to, and I want it to happen now. It's something that I want it to be now, I want it to be now. Because I want to start changing my life as soon as possible. I want it to be as soon as possible. I'm very keen to have the operation. (Alba)

The surgery also activated in Carmen a possibility and a long-lost hope of regaining a body with less weight. As she said, *"I will be more at ease when I am thinner, because I will be more at ease with myself, my partner, and society."* After long unsuccessful efforts to lose weight and with a long history of suffering, all participants envisioned weight loss surgery as the path that would allow them to achieve the best version of themselves. Participants emphasized

that they did not aspire to a slim figure, simply to lose enough weight to become healthy.

However, the difference between being healthy and being sick maintained a fine line with the division between being normal and abnormal. For most participants, being healthy was akin to having a normal body. Therefore, although they avoided at all times that their decision could be understood as a matter of beauty, surgery became a legitimate way of restoring the body to a more acceptable weight. They did not expect the surgery to miraculously transform them into another person, but it did provide them with experiences of less shame and more self-acceptance.

None of the participants claimed to have taken the decision to undergo surgery in haste. All agreed that it was a decision they had been considering for a long time. Many of them acknowledged that fear of the possible risks had held them back for many years. However, they all reached a situation where their suffering was unbearable. Some had waited for years on the waiting list for public healthcare, while others acknowledged that they had not been able to wait and had decided to go to private healthcare. In all cases, the decision had been made, and they looked forward to the moment with great hope. Surgery was presented as the final step in a trajectory of suffering, an attempt to alleviate an unbearable problem.

General Discussion and Implications

This study examined how individuals considering bariatric surgery perceived their experiences of stigma and how these perceptions influenced their decision to undergo surgery. The findings showed significant suffering that occurred because participants experienced their bodies as different or abnormal. Their accounts detailed lifelong ridicule, humiliation, and the deprivation of opportunities due to their weight, which heavily impacted their sense of self. Our analysis reflected that the participants showed a stigmatized and damaged identity, situating the decision to have surgery as an opportunity to restore their damaged identity.

Social and institutional stigma was prominent in participants' narratives. They described societal views of fat individuals as lacking discipline, motivation, and effort to control their

weight. These perceptions led to feelings of marginalization and limited opportunities. Such experiences align with the negative fat culture (Murray, 2008), which pathologizes the fat body and advocates a fight against ‘obesity’ (Throsby, 2007). Within this culture, the fat body is considered a deviation, a product of abnormal behavior or the functioning of the person or the body itself (Lupton, 2018; Saguy, 2013), which made participants feel the paradox of hyper(in)visibility described by Gailey (2014). Their fat bodies did not go unnoticed and attracted attention because of their size (Longhurst, 2001). Simultaneously, they were attributed negative attributes that caused their desires, lived experiences, subjectivities, and needs to be ignored or devalued.

In addition, participants’ identities deteriorated as they expressed feelings of shame and rejection of their bodies because they internalized negative stereotypes of a fat body. The infiltration of derogatory messages about fat bodies on participants led to self-stigmatization (Nelson, 2001). These feelings translated into self-imposed limitations on doing things they had previously done, such as traveling by plane, shopping for clothes, or visiting healthcare system specialists more often. These behaviors should be understood as a product of the withdrawal strategies (Phelan et al., 2015) that participants imposed on themselves, producing indirect discrimination (Farrell et al., 2021; Lewis et al., 2011).

Although their lived experiences led them to devalue their fat bodies, the participants did not passively adopt a devalued sense of self. They resisted having their body define their self and refused to be defined solely by their weight, circumstances, and past. However, the situation must be viewed with some ambivalence, for although the participants presented clear accounts of resistance to the hegemony of stigmatizing narratives and questioned the status quo, they ended up adopting a strategy of dissociation of body and mind. In their attempt to actively struggle to find self-esteem, the participants marked a clear difference between who they were and their current body. Always justified on health grounds (Libeton et al., 2004; Pearl et al., 2019), the

participants ended up viewing weight loss surgery as a last resource to modify their body (Cohn et al., 2019; Griauzde et al., 2018; Lyons et al., 2014; Ogden et al., 2006; Wolff and Maydell, 2024) and therefore restore their damaged identity.

This study has two main implications. First, the results challenge the view that individuals undergoing surgery are cultural idiots and passive victims of medical discourse (Throsby, 2007). Instead, participants displayed resistance to stigmatizing narratives while actively seeking and struggling, within existing cultural and structural constraints, to find a solution to the physical and mental suffering they endure (Archer and Elder-Vass, 2012; Groven and Engelsrud, 2016). In this sense, the experiences recounted by the participants highlight what living in a fat body within a fat-hating culture means to them. Within this reality, the solution of undergoing weight loss surgery was recounted as a solution that allowed them to take back control of the situation and return to normal (Lyons et al., 2014; Wolff and Maydell, 2024). Surgery becomes an option to reverse the hyper(in)visibility paradox (Gailey, 2014), that is, an attempt to make their bodies more inconspicuous to the gaze of others, while at the same time their desires and needs begin to be more valued. Bariatric surgery can be seen as an intervention in identity, allowing individuals to renegotiate their relationship with their body and themselves, moving from an objectified body to an embodied subject.

Second, the decision to undergo surgery stemmed from a long history of suffering where the participants experienced their bodies as unacceptable, different, or abnormal. As Murphy (2015) points out, most individuals do not conceive of normality solely in physical terms, which in no way indicates irrationality but simply reflects a different order of values and commitments. Therefore, the decision to undergo bariatric surgery also involved issues of identity and agency, that is, existential questions of who they are and who they want to become, without denying the medical problems that participants presented with to a greater or lesser degree. Participants

sought not idealized beauty but ordinary bodies that allow for dignified development not only physically but also socially, cognitively, and emotionally.

Therefore, if bariatric surgery involves a process of altering identity, it has important implications for medical practice. Eligibility for surgery, typically based on physical health criteria such as BMI (Mechanick et al., 2020), may fail to capture the subjective experiences of individuals. It is not so much the external appearance of the body or the weight itself, but the subjective appearance that determines the private suffering that leads to the decision to undergo surgery. From the explanations offered by the participants in the present study, the health criteria by which the medical profession determines which bodies reflect an abnormality suitable for bariatric surgery appear very different from the subjectivities of the participants (Murphy, 2015). Objective indicators can offer little in terms of what makes one body ordinary and another not; that is, the subjective perception of what constitutes a ‘normal’ body. This highlights the need for practitioners to acknowledge the impact of relative weight and weight history on identity beyond objective health indicators.

References

- American Medical Association (2013) *Recognition of 'Obesity' as a Disease (Resolution 420-A-13)*.
- Archer M and Elder-Vass D (2012) Cultural system or norm circles? An exchange. *European Journal of Social Theory* 15(1): 93–115.
- Archer M, Bhaskar R, Collier A, et al. (2008) *Critical Realism: Essential Readings*. Taylor & Francis e-Library.
- Bacon L and Aphramor L (2014) *Body Respect*. Dallas, TX: Benbella Books, Inc.
- Bhaskar R (2008) *A Realist Theory of Science*. New York, NY: Routledge.
- Braun V and Clarke V (2022) *Thematic Analysis: A Practical Guide*. London: Sage.
- Bray GA, Kim KK and Wilding JPH (2017) Obesity: a chronic relapsing progressive disease process. A position statement of the World Obesity Federation. *Obesity Reviews* 18(7): 715–723.
- Cohn I, Raman J and Sui Z (2019) Patient motivations and expectations prior to bariatric surgery: A qualitative systematic review. *Obesity Reviews* 20(11): 1608–1618.
- Cooper C (2016) *Fat Activism. A Radical Social Movement*. Bristol, UK: HamerOn Press.
- Danermark B, Ekstrom M, Jakobsen L, et al. (2005) *Explaining Society: An Introduction to Critical Realism in the Social Sciences*. Taylor and Francis e-Library.
- Farrell E, Hollmann E, le Roux CW, et al. (2021) The lived experience of patients with obesity: A systematic review and qualitative synthesis. *Obesity Reviews* 22(12): e13334.
- Featherstone M (2010) Body, image and affect in consumer culture. *Body & Society* 16(1): 193–221.
- Fletcher AJ (2017) Applying critical realism in qualitative research: Methodology meets method. *International Journal of Social Research Methodology* 20(2): 181–194.
- Gailey JA (2014) *The Hyper(in)Visible Fat Woman: Weight and Gender Discourse in*

- Contemporary Society*. New York, NY: Palgrave Macmillan.
- Gard M, Powell D and Tenorio J (2022) *Routledge Handbook of Critical Obesity Studies*. London and New York: Routledge.
- Goffman E (1963) *Stigma: Notes on the Management of Spoiled Identity*. New York, NY: Prentice-Hall.
- Griauzde DH, Ibrahim AM, Fisher N, et al. (2018) Understanding the psychosocial impact of weight loss following bariatric surgery: A qualitative study. *BMC Obesity* 5(1): 38.
- Groven KS and Engelsrud G (2016) Negotiating options in weight-loss surgery. “‘Actually I didn’t have any other option’”. *Medicine, Health Care and Philosophy* 19(3): 361–370.
- Harjunen H (2021) Fatness and consequences of neoliberalism. In: Pausé C and Taylor SR (eds.) *The Routledge International Handbook of Fat Studies*. New York, NY: Routledge, pp. 68–77.
- Hill B, Bergmeier H, Incollingo Rodriguez AC, et al. (2021) Weight stigma and obesity-related policies: A systematic review of the state of the literature. *Obesity Reviews* 22(11): e13333.
- Homer CV, Tod AM, Thompson AR, et al. (2016) Expectations and patients’ experiences of obesity prior to bariatric surgery: A qualitative study. *BMJ Open* 6(2): e009389.
- Jiretorn L, Engström M, Laursen C, et al. (2024) ‘My goal was to become normal’—A qualitative investigation of coping with stigma, body image and self-esteem long-term after bariatric surgery. *Clinical Obesity* 14(3): e12657.
- Kim Y, Cubbin C and Oh S (2019) A systematic review of neighbourhood economic context on child obesity and obesity-related behaviours. *Obesity Reviews* 20(3): 420–431.
- Kristeva J (1982) *Powers of Horror: An Essay on Abjection*. New York, NY: Columbia University Press.
- Lewis S, Thomas SL, Blood RW, et al. (2011) How do obese individuals perceive and respond to the different types of obesity stigma that they encounter in their daily lives? A qualitative

- study. *Social Science & Medicine* 73(9): 1349–1356.
- Libeton M, Dixon JB, Laurie C, et al. (2004) Patient motivation for bariatric surgery: Characteristics and impact on outcomes. *Obesity Surgery* 14(3): 392–398.
- Longhurst R (2001) *Bodies: Exploring Fluid Boundaries*. London: Routledge.
- Lupton D (2018) *Fat*. 2nd ed. London and New York: Routledge.
- Lyons K, Meisner BA, Sockalingam S, et al. (2014) Body image after bariatric surgery: A qualitative study. *Bariatric Surgical Practice and Patient Care* 9(1): 41–49.
- Mechanick JI, Apovian C, Brethauer S, et al. (2020) Clinical practice guidelines for the perioperative nutrition, metabolic, and nonsurgical support of patients undergoing bariatric procedures – 2019 update: cosponsored by American Association of Clinical Endocrinologists/American College of Endocrinology. *Surgery for Obesity and Related Diseases* 16(2): 175–247.
- Murphy JW (2015) Primary health care and narrative medicine. *The Permanente Journal* 19(4): 90–94.
- Murray S (2008) *The “Fat” Female Body*. London: Palgrave Macmillan.
- Nelson HL (2001) *Damaged Identities, Narrative Repair*. Cornell University Press.
- Ogden J, Clementi C and Aylwin S (2006) The impact of obesity surgery and the paradox of control: A qualitative study. *Psychology & Health* 21(2): 273–293.
- Ogden J, Avenell S and Ellis G (2011) Negotiating control: Patients’ experiences of unsuccessful weight-loss surgery. *Psychology & Health* 26(7): 949–964.
- Pearl RL, Wadden TA, Walton K, et al. (2019) Health and appearance: Factors motivating the decision to seek bariatric surgery. *Surgery for Obesity and Related Diseases* 15(4): 636–642.
- Pfeil M, Pulford A, Mahon D, et al. (2013) The patient journey to gastric band surgery: A qualitative exploration. *Bariatric Surgical Practice and Patient Care* 8(2): 69–76.

- Phelan SM, Burgess DJ, Yeazel MW, et al. (2015) Impact of weight bias and stigma on quality of care and outcomes for patients with obesity. *Obesity Reviews* 16(4): 319–326.
- Puhl RM (2023) Weight stigma and barriers to effective obesity care. *Gastroenterology Clinics of North America* 52(2): 417–428.
- Saguy AC (2013) *What's Wrong with Fat?* New York, NY: Oxford University Press.
- Sicilia Á, Socías-Serrano M-L, Griffiths MD, et al. (2025) Narrative and obesity: Managing weight stigma associated with bariatric surgery. *Health* 29: 633-651.
- Sparkes A and Smith B (2014) *Qualitative Research Methods in Sport, Exercise and Health. From Process to Product*. London: Routledge.
- Throsby K (2007) “How could you let yourself get like that?”: Stories of the origins of obesity in accounts of weight loss surgery. *Social Science & Medicine* 65(8): 1561–1571.
- Throsby K (2012) Obesity surgery and the management of excess: exploring the body multiple. *Sociology of Health & Illness* 34(1): 1–15.
- Trainer S and Benjamin T (2017) Elective surgery to save my life: Rethinking the “choice” in bariatric surgery. *Journal of Advanced Nursing* 73(4): 894–904.
- Wann M (1998) *FAT!SO? Because You Don't Have to Apologize for Your Size!* Berkeley, CA: Ten Speed Press.
- Wolff S and Maydell E (2024) ‘Who am I now?’ The lived experiences and identity construction of individuals following bariatric surgery. *Communication Research and Practice* 10(4): 462–474.
- Wood K V. and Ogden J (2016) Patients’ long-term experiences following obesity surgery with a focus on eating behaviour: A qualitative study. *Journal of Health Psychology* 21(11): 2447–2456.
- Yumuk V, Tsigos C, Fried M, et al. (2015) European guidelines for obesity management in adults. *Obesity Facts* 8(6): 402–424.

