“How could you let yourself get like that?”: Stories of the origins of obesity in accounts of weight loss surgery

Karen Throsby*

University of Warwick, Coventry CV4 7AL, UK

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Abstract

In the context of the contemporary rhetoric of the "obesity epidemic", the fat body is easily labelled as lazy, self-indulgent and lacking in discipline. Those who become fat often find themselves needing to account for their size in order to refute the suggestion of moral failure that attaches itself easily to the fat body. Drawing on a series of interviews with 35 weight loss surgery patients in England and Scotland, this paper explores the discursive resources and strategies available to those who are, or who have been, very overweight in accounting for their size. The paper argues that the participants drew on three core discourses in order to resist the construction of their fatness as an individual moral failure: (1) the fat-prone body; (2) childhood weight gain; and (3) life events disrupting weight management efforts.

Keywords: UK; Obesity; Weight loss surgery; Gender; The body; Genetics

The opening quote in the title of this paper is taken from an interview with Anna, a 32-year-old social worker and committed Christian who had struggled for years with yo-yo dieting and incremental weight gain before eventually deciding to undergo a surgical procedure (described in more detail later in the paper) to restrict the amount that she could eat. The question was asked at a church social event by her vicar as he compared her to her tall, slim sister. His question signals the profoundly stigmatised status of the fat body in contemporary western society. Erving Goffman argues that "we tend to impute a wide range of imperfections on the basis of an original one" (Goffman, 1990, pp. 15–16) and this is particularly evident in the context of fatness, which "speaks of gluttony, lack of self-discipline, hedonism, self-indulgence, while a slim body signifies a high level of control, an ability to transcend the desires of the flesh" (Lupton, 1996, p. 16). This learned association of fatness with negative moral traits is deeply pervasive, with numerous studies showing that even young children express strong negative feelings towards fat children (Latner & Stunkard, 2003), and perceptions of fat people as lazy, incompetent and lacking in self-discipline have been shown to lead to significant discrimination in terms of accessing employment, health care and education opportunities (Puhl & Brownell, 2001). Australian feminist, Samantha Murray, suggests that the easy association of negative traits with the fat body reflects "a negative culture of collective ‘knowingness’ about fatness” (Murray, 2005, p. 154): "As members of Western society, we presume we know the histories of all fat bodies, particularly...

those of fat women; we believe we know their desires (which must be out of control) and their will (which must be weak). [...] We read a fat body on the street, and believe we ‘know’ its truth: just some of the characteristics we have come to assume define fatness are laziness, gluttony, poor personal hygiene and a lack of fortitude”. (Murray, 2005)

Fatness, therefore, is a spoiled identity, discredited, in Goffman’s terms, both via “abominations of the body” and “blemishes of individual character” (Goffman, 1990, p. 14). This discreditation underlies the pervasive social exclusion and discrimination that people who are noticeably fat experience.

Drawing on a series of interviews with people who have been (or still are) extremely overweight and who have undergone surgery in order to lose weight, this paper asks what stories can be told in this context about the origins of fatness in order to negotiate and resist the discreditation of the fat self. I argue that while the interviewees endorse many of the core assumptions of the “war on obesity” in the construction of the fat body as a problem to be solved, they simultaneously resist the attribution of moral failure to that body. I argue that this discursive work of resistance, whilst lacking the spectacular politics of size activism, nevertheless constitutes a challenge to the “war on obesity”, not least through its clear demonstration of the moral and ideological foundations of the “obesity epidemic”.

Accounting for fatness

Two key assumptions underpin the moral evaluation of the fat body in contemporary western society. The first of these is that obesity is a medical, financial and social problem, and that this problem threatens individual, national and global well-being (NAO, 2001; WHO, 2000). It is this perceived risk of future health problems that lies at the heart of the moral imperative at the level of the individual to take preventative action against obesity (Gard & Wright, 2005, chap. 9; Lupton, 1994, 1995; Throsby, 2006).

The second assumption underpinning the moral evaluation of the fat body is that obesity is a problem which is both preventable and treatable. The dominant representations of obesity reduce it to the simple physics of energy input and output, generating what David Ogilvie and Neil Hamlet describe as the “rational prescription” of reducing consumption and increasing levels of activity (Ogilvie & Hamlet, 2005). This prescription is made literal by Ogilvie and Hamlet in a paper published in the British Medical Journal, which includes a mocked up GP prescription for “Mr. E. Normous” to “eat less” and “exercise more” (Ogilvie & Hamlet, 2005, p. 1545). The presumed amenability of obesity to a “common sense cure” (Ebbeling, Pawlak, & Ludwig, 2002) of “lifestyle” interventions (Brownell & Horgen, 2004; Campbell, 2003; Ebbeling et al., 2002; House of Commons Health Committee, 2004; NAO, 2001; WHO, 2000) contrasts with the recognition of its complex multifactorial aetiology, and leaves those who are categorised as obese particularly vulnerable to the moral censure to which they are routinely subjected. This vulnerability is particularly salient for those having weight loss surgery (WLS), since they are (or have been), in general, at the more extreme end of the obesity scale, with their size rendering them literally more visible as the targets of ridicule and moral censure.

While the discourses of epidemic, crisis and individual moral responsibility in relation to obesity predominate, they have not gone unchallenged. Within the medical profession, debates about causation (and therefore, the degree of individual responsibility) are ongoing (see, for example, Keith et al., 2006). But there is also a growing body of critical obesity literature which poses a more fundamental challenge to the concept of the epidemic and its effects. This literature challenges the presumption that obesity is causative of ill-health (Campos, 2004; Gard & Wright, 2005), questions the validity of BMI as a measure of obesity/health (Burgard, 2005; Gard & Wright, 2005; Monaghan, 2007), and highlights the inefficacy and health- and esteem-damaging effects of anti-obesity interventions and campaigns (Aphramor, 2005; Campos, 2004; Evans, Rich, & Holroyd, 2004; Gard & Wright, 2005; Monaghan, 2005b; Oliver, 2006). From this perspective, the “obesity epidemic” emerges as a moral panic which is driven by ideology, and which is interpolated through the social relations of gender, class and race (Aphramor, 2005; Campos, 2004; Campos, Saguy, Ernsberger, Oliver, & Gaesser, 2006; Gard & Wright, 2005; Herndon, 2005; Monaghan, 2005a, 2005b).

This recent, but rapidly proliferating, body of critical literature on the “epidemic” intersects with the already well-established work from feminists...
and size acceptance activists who have critiqued ideals of slimness, and who have argued for the re-valuing of the fat body and the politicisation of body size (Bernell, 2000; Bovey, 2000; Braziel & LeBesco, 2001; Brown & Rothblum, 1989; Cooper, 1998; Shanker, 2004; Wann, 1998). Central to this critical writing, and in common with the more recent “moral panic” literature, is the claim that it is possible to be “fit and fat”, that the fat body can be desirable, and that diets not only do not work most of the time, but that they risk damaging health and self-esteem.

WLS can, in many ways, be seen as the apotheosis of the characteristics of the “war on obesity” against which these critiques are marshalled. WLS refers to a group of surgical interventions which aim to limit the body’s ability to consume and/or absorb food through the restriction of stomach capacity and/or the shortening of the intestine (see, for example, Flancbaum, 2003; Kurian, Thompson, & Davidson, 2005). It carries risks of a panoply of chronic side-effects and complications (varying across different surgeries), including infection, malnutrition, vomiting, diarrhoea, digestive and intestinal problems, and in a relatively few cases, death (Ackerman, 1999), and is premised on a risk calculation that relies upon the unacceptability of the fat body and the equation of fatness with mortally dangerous ill-health.

However, the categorical repudiation of WLS adopted by many size activists (see, for example, Wann, 1998) renders those who choose to engage with it as either active collaborators in anti-fat ideology, or as its victims: a model which overlooks the complexity of the embodied experience of obesity, and which equates resistance with refusal in ways which overlook the acts of resistance at the micro-level of everyday interaction. It is by looking at individual accounts that it becomes possible to observe the ways in which the participants strategically mobilise and resist the dominant discourses of the “war on obesity”, even while engaging with some of its most dramatic interventions.

In his interviews with sufferers of arthritis, Williams (1984) tells the story of Bill, who is severely disabled by the disease. Bill constantly asks himself: “How the hell have I come to be like this?”, adding, “because it’s not me” (Williams, 1984, p. 175). Those in my study can be understood as continually asking themselves a similar question in genuine bewilderment about what has happened to them (as opposed to the more accusatory question—“How could you let yourself get like that?”). My participants’ weight histories, therefore, can be understood as attempts to address this question, and can be seen as “narrative reconstructions” (to use Williams’ term) which aim to tell a story of the body which is coherent, and which resist assumptions of the fat body as lazy, undisciplined and out of control—a model which the participants did not recognise in themselves, even while they accepted their own fatness as problematic (as evidenced by the decision to have surgery). As such, while the participants’ narratives dip in and out of a range of different positions in complex and contradictory ways, the accounts offered by the participants in relation to the specific task of accounting for their size were predominantly what Scott and Lyman describe as “excuse accounts”—that is, “socially approved vocabularies for mitigating or relieving responsibility when conduct is questioned” (Scott & Lyman, 1968, p. 47)—as opposed to “justifications”, which aim to “assert [that conduct’s] positive value in the face of a claim to the contrary” (Scott & Lyman, 1968, p. 51; see also, Monaghan, 2006).

Methodology

This paper addresses these questions by drawing on data from a series of qualitative interviews, conducted in 2005–2006, with people who have either had, or were waiting to have, weight loss surgery (WLS). I conducted interviews across England and Scotland with 35 WLS patients (6 men and 29 women); in some cases, family members also joined the interviews. I also conducted one focus group at the beginning of the project with members of a WLS support group in the north of England. The majority of the participants were recruited through the website of an organisation that provides information and support for those seeking, undergoing and living with WLS, with an additional few recruited by word of mouth via friends and work colleagues. All of the interviews were transcribed and were analysed using discourse analysis (e.g. Gill, 1996, 2000). According to Michel Foucault, discourse “can be both an instrument and an effect of power, but also a hindrance, a stumbling-block, a point of resistance and a starting point for an opposing strategy” (1978, p. 101). It is this “tactical polyvalence” (1978, p. 100) that discourse analysis seeks out. The primary focus throughout the analysis presented...
here, therefore, is not what people say, but what that discursive act is intended to achieve in a given context, and how.

The analysis presented in the remainder of the paper draws specifically on the interview responses to my prompt question at the beginning of the interview to “tell me the history of your weight” and is divided into three sections. The first section focuses on discourses of the innately fat-prone body as constituting a fundamental disadvantage in the normatively prescribed work of “watching your weight”. The second section explores the ways in which the participants located the roots of their weight problems as adults in their childhoods. And the third section describes the ways that particular life events were mobilised as triggering weight gain through changes in activity patterns and eating habits. This sectional division is a structural device imposed by me onto the data, and none of these discursive strategies should be seen as mutually exclusive. Indeed, as the analysis will demonstrate, it is often only in combination that these can be fully effective.

The fat-prone body

All of the participants in my study experienced their bodies as innately fat-prone, and these biological accounts of fatness focused on two key sites: firstly, genetics; and secondly, metabolism. The identification of a genetic cause for fatness is the holy grail of obesity research (Shell, 2003), with any subsequent therapies promising enormous financial returns in a market hungry for new and sustainable weight loss technologies. However, with the exception of the identification of a small number of very rare genetic disorders known to cause obesity (Monaghan, 2006, pp. 136–137), the promise of obesity genetics, as with much biotechnology (Keller, 2000; Nightingale & Martin, 2004), lies in its imagined future. Nevertheless, within popular discourse, genes have taken on a culturally iconic status (Nelkin & Lindee, 1995), and the concept of the “gene for” has significant social currency in accounting for a wide range of traits and disorders (Peterson, 2001). The “fat gene”, therefore, has discursive potential in explaining the fat body, since, potentially at least, it frames fatness as a piece of implacable genetic “bad luck”, rather than a signifier of moral failure. This occurs in the interviews both in explicit references to the family “fat gene”, and also implicitly, through reference to familial and kinship networks of similarity and difference in body size.

Fiona, an office worker in her thirties, was one of the few participants to explicitly lay claim to what she described as the “big gene”:

Fiona: My dad was a big man and my mother’s mother, my grandmother, and my mother’s sisters were big. My great grand ... on my mother’s side, my mother was probably the one that didn’t get the big gene. On my father’s side, he got it, and my aunt ... she grew up a pretty normal size. But my sister and I got it in the very big, seriously kind of OTT [over the top] kind of way [...].

The random scattering of obesity across both sides of her family positions Fiona as a loser in the genetic lottery and mitigates against the easy attribution of individual moral failure for having become fat. Susan, a homemaker and mother in her thirties, offers a less explicit genetic account, but one which works to the same effect, and which receives extra endorsement through her alliance of her father’s American nationality with his “huge” body size:

Susan: I have a different dad to them [her slim siblings]. My dad is huge. He’s American and he’s huge. And he comes from a big family.

The construction of obesity as a fundamentally genetic problem is endorsed by many of those working in obesity medicine. Australian clinician and researcher, Joseph Proietto, for example, argues categorically that “obesity is the result of genetic mutations that alter appetite and that it is unreasonable to expect individuals with such mutations to exercise their free will to sustain hunger indefinitely in the presence of an abundance of food” (Proietto, 1999, p. 611). Significantly, however, even for such a strong advocate of genetic explanations as Proietto, a genetic propensity to fatness does not signify hopeless inevitability, but rather, signals the need for increased discipline and bodily surveillance within the medical domain—in this case, drug therapy:

[... the obese should not blame themselves for their excess weight; they should not pay money for weight loss therapies that are short term; society and the medical profession should view obesity as a chronic medical disorder; and we should accept the need for chronic drug therapy]
provided it is safe. (Emphasis added) (Proietto, 1999)

Writing on genetic screening for Huntington’s Disease, Carlos Novas and Nikolas Rose argue that “recataloguing illness and pathologies along a genetic axis does not generate fatalism. On the contrary, it creates an obligation to act in the present in relation to the potential futures that now come into view” (Novas & Rose, 2000, p. 486). The genetic explanation, therefore, does not render fatness inevitable, and there are no cases in the interviews where genetics was used to exempt the self from the responsibility of weight management. Fatness, therefore, can be rationalised and explained, but the “fat gene” discourse still holds in place fatness as a problem against which action must be taken by the individual themselves. Indeed, all of the participants gave detailed accounts of years of cyclical success and failure, highlighting their own determination to “do something” about their weight.

However, what the genetic explanation does offer is an account of why their attempts at sustainable weight loss have failed prior to surgery, with the genetic predisposition to weight gain constituting a fundamental disadvantage in the socially prescribed task of “watching your weight”. In the context of these interviews, this also constitutes a strong justification for having surgery, which is understood as circumventing genetic propensity by physically preventing the person from eating more than a small amount, effectively levelling the dieting playing field. Fiona, for example, went on to identify WLS specifically as enabling her to “diet like a normal person” (see, Throsby, 2006).

However, in spite of its dual discursive utility in both resisting moral responsibility for fatness and justifying the decision to undergo surgery, this is not without cost, since the “fat gene” discourse also pathologises the individual fat body to the exclusion of the broader social structures and conditions within which fat embodiment is experienced and negotiated, effectively precluding a more politicised perspective (see also, Aphramor, 2005). Furthermore, while the discourse of the innately fat-prone body can be mobilised in order to resist the attribution of moral failing to the fat body, this does not equate to a resistance to moral discourse per se in relation to body size; rather, it is the failure to “do something” about your weight that becomes the site of moral censure, which continues to hold in place the dominant discourse of the unacceptability of the fat body.

Metabolism is another central site of bodily difference between the participants and slim others in the accounts, as in this quote from Claire, an office worker in her forties:

I know I did have a good appetite [pre-surgery]. But even then, I’ve got friends who’ve got better appetites than I’ve got, they never put on an ounce, you know. [...] Where do they put it all? You know, I sort of ate half of that and thought I’d got a good appetite. They spin around and it’s gone. God, but you know, obviously, it’s metabolism or whatever, yeah. And you know, it’s no good thinking “Well, it’s not fair”, because that’s the way it is.

Just as the “fat gene” is seen as distributed unevenly and randomly across families, metabolism was equally represented as a matter of individual luck which advantages or disadvantages the individual in the surveillance and disciplining of the body in relation to weight—“that’s the way it is” (see also, Lupton, 1996, p. 148). However, there is considerable suspicion within obesity medicine of these readings of the body. Writing in the British Medical Journal, Prentice and Jebb (1995), in an article tellingly entitled: Obesity in Britain: Gluttony or Sloth, are dismissive of what they cynically describe as “the ‘Doctor, it’s my metabolism’ syndrome”, arguing instead that “it is clear that obese people tend to provide biased diet records and habitually eat more than they claim” (Prentice & Jebb, 1995, p. 437). This construction of obese people as fundamentally unreliable, and even deceitful, fails to take account of the shame and guilt which might inhibit full disclosure of consumption (see, for example, Heitman, Lissner, & Osler, 2000; Muhlheim, Allison, Heshka, & Heymsfield, 1998), but also discredits people’s lived experiences and beliefs of their own bodies as responding differently to food. Beth, for example, felt strongly that she had not eaten any more than her husband or friends, who she described collectively (including herself) as eating too much food of nutritionally low quality. In an echo of Bill’s question in Williams’ study, she asked frustratedly: “how could I possibly have got to that weight when people don’t?” Over-eating within these genetic and metabolic explanations of bodily difference is therefore translated into over-eating for my body—a body that is understood as responding to food in a
way that confounds the task of weight management to the point where surgery is deemed necessary.

**Childhood**

With only a small handful of exceptions, all of the participants in my study identified weight as a problem in childhood, although few described themselves as having been fat. Instead, they drew on a catalogue of familiar euphemisms—stocky, chubby, chunky, well-covered—which are understood as predicting future fatness in adulthood:

Karen: Is this your father? [looking at childhood photograph]
James: Yeah, he’s pretty stocky. Again [showing me another photo], that’s the same year. That’s me there, with some school friends. I don’t know if you can see, I was chubby there. I mean you might think if I showed you the photo and said “Which one’s going to grow up to have weight problems?” It might be me. I’m slightly rounder-faced.

Drawing on the discourse of the inherited propensity to weight gain, James, an IT worker and published crime writer in his mid-thirties, identifies his father as “stocky”, but his own fatness as an adult can literally, for James, be read off his own childhood body, not his father’s, with his “slightly rounder” schoolboy face signalling his body’s fat future. Drawing on the widely held conviction, central to the construction of the obesity epidemic, that an overweight child is destined to become an overweight adult, this effectively configures his weight problems as inevitable (rather than something that he “let” happen). It is this assumption that childhood obesity will continue into adulthood that underpins the contemporary raft of proposed measures in the UK designed to limit children’s access to junk food, increase physical activity and raise awareness of nutritional issues (Department of Health, 2004). However, these educational and environmental factors rarely figured in any of the participants’ weight histories. Instead, the participants relied on the biological explanations discussed previously, complemented by a much more explicitly adult-blaming discourse:

Charles: My father’s mother and my mother hated each other, and this is the 1950s—rationing, food is love—beef and dripping sandwiches, plum duff, spotted dick, lots of custard. You know—every carbohydrate in sight […] so basically, there were two people feeding me […] My gran was saying “Your mother’s not feeding you properly” and that was part of her propaganda. And my mother’s saying “Well, if you loved me, you’d eat this”. So there was an inevitability about me becoming a right porker at a very early age.

The food wars which Charles, a social worker in his fifties, became unwittingly caught up in as a child were unusual in the interviews, but the memory of being emotionally coerced into eating was not. Almost all of the participants recalled being pressured to eat everything on their plates, accompanied by guilt-inducing invocations to “Think of the starving children in Africa”, or reminders that the food had been prepared especially for them. These are not recollections that are confined to those who have subsequently become fat (see, for example, Counihan, 1999; Lupton, 1996), and it is precisely the easy intelligibility of this discourse that makes it so useful in accounting for weight gain when used in tandem with the discourse of the fat-prone body. As the primary providers of food for the family, and supervisors of children’s mealtimes, it is mothers that are cited as the prime movers in this guilt-induced eating. Working or absent parents, and particularly, mothers also featured centrally in the production of a learned association of food with love through the provision of treats in compensation for absence. Elizabeth, a medically retired office worker in her early fifties, for example, recalled the busy summer months when she would be left in the care of an au pair while her parents ran their pub:

And I think to a certain degree, my mum and dad probably felt a bit guilty about [leaving me]. So they’d come home from the lunchtime session, you know, with bags of crisps for me. Yeah, or they’d come home at night and bring a bar of chocolate or something like that. So you know, that became, it was like a kind of reward syndrome.

Elizabeth is unusual in that she shares the responsibility for this “reward syndrome” between both her parents, although elsewhere, she also describes her female au pairs as using food as a means of gaining her compliance. More commonly, however, it is working mothers who are recalled as providing compensatory treats. Fiona, for example,
described her “big gene” as being “fuelled” by her mother’s anxieties about being a good single parent, causing her to constantly bring home treats from the food hall of the large department store where she worked. Judith, a homemaker in her mid-fifties, also felt that her parents were too busy for her, although this shared responsibility is quickly shifted to her mother: “Working mother, nobody at home; food compensating for love”.

As an explanatory device for fatness, this explanation has significant social currency. This is firstly because it mobilises the highly intelligible discourse of food substituting for love that has become condensed into “common sense” knowledge from complex psychoanalytic and psychological theory. And secondly, the fact that it is primarily women who are seen as responsible for the provision of food and the management of family health means that blame for a disordered relationship with food attaches easily to those women. From a feminist perspective—that is, broadly speaking, from a perspective which places women at the centre of its analysis (see, for example, Throsby, 2004)—it is troubling that one of the most readily available and intelligible discourses in accounting for weight problems beginning in childhood is to hold women, and especially working women, responsible, since this effectively reproduces the very prejudices about women and work that the participants’ mothers themselves were struggling with. Scott and Lyman (1968) describe this form of accounting as “scapegoating”; however, this terminology does not adequately reflect the marked lack of recrimination expressed towards those onto whom responsibility was being placed. This lack of recrimination highlights the extent to which the mother-blaming discourse is simply one of a number of available resources for the consuming and immediate task of managing a highly stigmatised identity.

Life gets in the way

Although children are increasingly being encouraged and expected to take responsibility for their “lifestyle” and body weight (Evans, Evans, & Rich, 2003; Evans et al., 2004; Rich & Evans, 2005), they are, in general, still perceived as victims of the obesity epidemic rather than its perpetrators. However, as adults, the burden of responsibility is much more easily transferred to the individual—it is they who are deemed to have “let themselves get like that”. Biological disadvantage, and early weight gain, ameliorate this responsibility to some extent, but are insufficient in themselves to account for significant fatness as an adult. Consequently, in addition to these, the participants recounted key life events that were largely out of their control, but which constituted pivotal disruptions in their attempts to manage their weight. Writing about strategies of narrative resistance to stigma among overweight women, Cordell and Ronai (1991) categorise explanations which rely on either genetics, or on disruptive life events, as “loopholes” (Cordell & Ronai, 1991, p. 40) which ease the liability for a particular aspect of identity. But while it is certainly the case that these explanations seek to exempt the individuals from a degree of moral responsibility for having become fat, the term “loophole” implies a legalistic sleight of hand that holds culpability in place—an implication which risks overlooking the earnestness of the accounts, and the strong desire of the participants to get to the bottom of why they became as big as they did. These discursive strategies, therefore, are not simply “loopholes”, but can also be seen as faithful attempts to make sense of their weight histories through the socially and culturally intelligible resources available to them.

Illness or injury figured in a number of the interviews as a key turning point in their accounts of becoming fat, leading not only to a suspension of “normal” dieting attempts, but also to enforced inactivity, as in the case of Michael, an IT project manager in his mid-forties:

I’d always been overweight, until 13, 14, when I found rugby. I started playing a lot of rugby. I became very fit while playing rugby—played for several teams. Played squash, badminton, went running every day. All of that. I cycled everywhere. Erm … and then I had a neck injury when I was 18 [playing rugby]. […] I just tore the muscles from the back of my head, across my shoulder, and bruised the spine. I was paralysed for a little while, a couple of hours.

The prolonged period of rest following the injury, whilst still continuing to eat the quantities he was accustomed to, marked the beginning of Michael’s weight gain. Some years later, and significantly overweight, he started playing squash again, but in his words, “squash and knees and weight don’t really mix”. One of his knees subsequently “popped”, putting all exercise on hold and leading
to further weight gain. Michael felt strongly that he had inherited the family “fat gene”, but until these injuries, he had been able to keep its worst effects in check through exercise; without the exercise, the “fat gene” was able to express itself fully, and he subsequently gained weight to the point of almost total immobility. His rugby injury mediates against the attribution of blame for his weight gain, as well as locating himself within the normatively masculine realm of the contact team sports which his size has since precluded him from participating in (see also, Monaghan, 2006).

In addition to physically debilitating, life-changing, injuries, other life events such as divorce, bereavement, new parenthood, new relationships, moving house or leaving school all emerged in the interviews as pivotal moments in their weight histories. Within this model, life simply gets in the way sometimes and the exhausting, preoccupying and often soul-destroying task of weight management simply has to take a back seat. These life events then become “annexed to the body” (Skultans, 1999, p. 310) retrospectively in accounting for subsequent weight gain.

For several of the participants, and particularly among the men, a change in their working lives marked a significant change in eating and leisure habits (see also, Monaghan, 2006). For James, taking a sedentary office job in IT led to a dramatic reduction in his physical activity, which was reduced to “clicking a mouse”; his weight “just ballooned and ballooned” as a result. For others, a disruption in work patterns and stressful working lives triggered a period of chaotic eating and drinking. Charles, for example, took a sabbatical from his job as a social worker to become a union branch secretary—a demanding job which involved a lot of travelling:

I was always eating carbos—you know, it was Burger King, it was Pret a Manger, it was … whatever it was. And I wasn’t getting the time to get to the gym to keep it down.

For Paul, an IT worker in his mid-forties, it was the much more mundane transition from school to work that was seen as causing him to put on weight:

Yeah, at school, I was a fairly fit, good-looking lad. And I left school and started work, doing the apprenticeship … boys will be boys, beer, alcohol, call it what you want, the wrong type of foods … just carried on from there.

Beer, curries, chips and fast food, consumed in large quantities, emerged strongly among the male participants as appropriately masculine forms of consumption, especially in the context of the homosocial night out and the demanding life of the working man. By locating himself within a pattern of food consumption that is clearly coded as masculine—“boys will be boys”—Paul’s explanation of his weight gain smooths over the moral distinctions between fatness and thinness through his representation of himself as having behaved fundamentally no differently than any other men in response to his move into adulthood.

The women’s narratives function very differently in their mobilisation of life events, focusing primarily on the use of emotional eating to manage both negative and positive change, as opposed to the more mechanical energy-in/energy-out model of the body in the men’s accounts. Elizabeth, for example, was very explicit about her emotional use of food: “If I was happy, I ate cause I was happy. If I was sad, I ate cause I was sad”. Michelle, a retired engineer in her early forties, was born with a congenital hip deformity, the disabling effects of which had been exacerbated by the severing of a nerve during reconstructive surgery as an adult. She suffered chronic pain in her back, leg, shoulders and neck, eventually forcing her medical retirement. However, it is her use of food for emotional comfort that is central to her account, rather than her enforced physical inactivity:

I became inactive, and I’m very prone to putting on weight. But I was so depressed that I comfort ate. You know, people tend to … probably I would say about two thirds of people eat when they’re stressed, and about a third of people can’t eat because they’re stressed. But the majority of people do. And I ate my way through everything they [the doctors] did to me.

Michelle’s description of “comfort eating” as something that the “majority of people do” normalises emotional eating, and effectively minimises the presumed moral distinction between fatness and thinness in a very similar way to Paul’s account of boys being boys. She returns instead to the fact that she is “prone to put on weight” as the marker of difference between herself and thin others, rather than her use of food to cope with the stress and isolation of her illness. This discursive mobilisation of emotional eating in response to life events is reliant on the easy identification of women
with the emotional, as opposed to the rational, domain and although some of the men did recount moments of emotional eating and drinking, particularly in the context of depressive illness (see also, Monaghan, 2006), there are no cases in the study where men have defined themselves primarily as emotional or comfort eaters in the way that the female participants did.

But while the men’s accounts relied heavily on descriptions of the substantial over-consumption in a social setting of savoury fast food and alcohol, the “comfort eating” of women was described as occurring in private, often secretly, and primarily in terms of the “little and often” consumption of sugary foods such as chocolate, biscuits and sweets (see also, Lupton, 1996, p. 109). This pattern of eating is variously described by the women in the study as grazing, nibbling, snacking and picking—verbs that imply delicacy and constraint which hold in place the repudiation of prodigious appetite that is required by normative femininity and thereby offering a gender-appropriate form of (over-)consumption (Lupton, 1996, pp. 104–111).

In contrast to these examples of chronic, gender-appropriate “comfort eating”, Fiona recounted a more acute and chaotic period of emotional eating following the sudden and unexpected death of her mother. Unusually among the women, Fiona described herself as always having eaten “bucket loads of food”, although she made clear that she avoided sweet foods, and instead ate large portions of savoury foods more easily coded as healthy, such as “rice and stew”. However, after her mother’s death, the only way she could find to cope with her distress was to abandon completely the normatively prescribed vigilance in relation to food and the body:

Fiona: [My sister and I] never cooked, so we had takeaways every single night, and we drank like fishes, because we didn’t care […]. We didn’t care. We ate and we drank because it and we smoked cigarettes … because it was the only thing we could do to survive.

While takeaways and alcohol were used by Paul to signify normative masculinity, they are mobilised here by Fiona to signify having stepped outside of social norms of consumption. Furthermore, in a social and cultural context where the ongoing care of the self in relation to the body is normatively prescribed, particularly for women, the fact that she “didn’t care” is as transgressive as her chaotic and excessive consumption. This confession of uncontrolled consumption and a lack of care is risky since this could be read as precisely the kind of moral failure—“letting yourself get like that”—that her narrative is trying to resist. However, this can also be understood as a strategic appropriation of those stereotypes of fatness as part of the wider project of accounting for the decision to have surgery, since Fiona’s earlier description of herself as (over-) consuming foods generally coded as healthy establishes this period of chaotic and careless consumption as anomalous, brought on by her bereavement. This, in turn, provides a crisis point in the narrative which sets the stage for her decision to undergo surgery—an act of “taking control” whose impact is emphasised by the out-of-control low point which directly precedes it.

This is not to argue for a crude gendered division of consumption whereby the men in the study did not eat for comfort, or that women did not gain weight as a result of enforced physical inactivity; nor is it to suggest that the women did not eat takeaways and drink alcohol, and that the men did not snack on sweets. Instead, what this analysis shows is that in the context of the specific discursive task of narrating weight history, the normative gendering of food and consumption constrains the ways in which those stories can be effectively and convincingly told.

Conclusion

This paper has explored some of the ways in which those who have been (or still are) very overweight, and who have turned to surgery in order to lose weight, account for their size. In particular, I have argued that the participants accounted for their weight gain via the contradictory and complementary discourses of the fat-prone body, of childhood events and learned behaviours, and of disruptive life events. These accounts, I argue, enable the participants to distance themselves from the “negative culture of knowingness’ about fatness” (Murray, 2005, p. 154) that equates fatness with moral failure. The decision to undergo weight loss surgery signals an alignment with constructions of the fat body as a problem to be solved—a construction which runs counter to the critiques articulated by size activists, feminists, and within critical obesity studies. However, the participants’ accounts share with those critical positions a refusal to accept fatness as an embodied moral
failure, signalling a relationship of ambivalence towards the “war on obesity”, in spite of undergoing one of its most radical interventions.

In making these claims, the participants, in their accounts, are enacting a quiet, but significant, resistance towards the dominant discourses of the proclaimed “obesity epidemic”, and in particular, to the prevailing assumption that fatness is something that they have chosen to “let” happen to them through a lack of will and self-discipline. While this lacks the spectacular resistance of size activism, for example, the very need for this discursive work highlights the moral and ideological foundations of the “war on obesity” and can be seen as a “point of resistance and a starting point for an opposing strategy” (Foucault, 1978, p. 101).

However, it is important not to overstate this resistance. This is firstly because this explanatory work relies upon gendered discourses of maternal blame, emotionality and the denial of appetite that I, and many other feminists, would argue, are ultimately harmful to women; and secondly, because these accounts hold in place the fat body as a problem to be solved. This is not to place blame on the participants, who are already preoccupied with managing a deeply stigmatised social identity with whatever resources are to hand; indeed, I would want to argue that it is important not to shift the responsibility for challenging the problematic aspects of the “war on obesity” onto those who are already disadvantaged by being rendered its stigmatised objects. Rather, it is to bemoan the very limited vocabulary through which fatness can be intelligibly discussed and accounted for. More broadly, this points to the lack of availability of more overtly politicised understandings of fatness outside of the dominant discourses of individual responsibility within which it is framed.

And finally, it is also the case that while Anna was able to defend herself vigorously against her vicar’s fat-phobia to me in our interview, she did not feel able to do so directly to him. Consequently, while the interviews showed the participants to have thought with great care about how they had become fat, and had carefully constructed coherent narratives which accounted for that, the opportunities to voice those narratives safely remain very few and far between. This silencing can be seen as directly reflecting the entrenched nature of the “negative collective culture of ‘knowingness’ about fatness” (Murray, 2005, p. 154) against which the participants were struggling, and the pervasive marginalisation of the voices of those upon whom the “war on obesity” impacts most directly.

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