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Navigating Fatphobia and Gender Embodiment: An Interpretative Phenomenological Analysis Of Women Undergoing Weight Loss Surgery in Lebanon

By
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Navigating Fatphobia and Gender Embodiment: An Interpretative Phenomenological Analysis Of Women Undergoing Weight Loss Surgery in Lebanon

Fatima Antar

ABSTRACT

Drawing on post-structuralist feminist theory about the body and health, this thesis critically deconstructs the experiences of Lebanese women who have undergone bariatric weight loss surgery and their reasons for undergoing it. Using Interpretative phenomenological analysis (IPA), this research explored the intersecting reasons that drove seven women to undergo weight loss surgery. The analysis uncovered five overarching themes central to the participants' experiences: (1) Socialization as Fat women, (2) The consequence of being socialized as fat women, (3) Navigating Uncertainty and Change throughout the weight loss surgery journey, (4) Navigating the body in its relational context throughout weight loss surgery journey, and (5) The effects of socioeconomic status and environment. This study contributes to the literature on fatness and gender, anti-fat bias, and the sociocultural and psychological aspects of being a weight loss surgery recipient, which is otherwise unexplored in Lebanon.

Keywords*:* Fat Women, Weight Loss Surgery, Anti-fat Bias, Interpretative Phenomenology Analysis**,** Lebanon

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CHAPTER ONE

INTRODUCTION

Prologue

In March 2022, my aunt underwent spinal fusion surgery in a hospital in Beirut. When I visited her after post-procedure, I conversed with the patient in the bed adjacent to hers. She was a fifteen-year-old girl. After inquiring about how she was doing, she replied that she was in a lot of pain; my mother asked her what type of surgery she had undergone, and she replied, "gastric sleeve." This response garnered the attention of everyone in the room: first, everyone assessed her weight, and one of my family members immediately interjected: "but you are not that fat!". Her mother jumped in to explain that she had tried every single diet, all unsuccessful, and that she insisted on getting the surgery. Then, someone asked if she was in school, and she said she was in the ninth grade and had taken a week off school to do the surgery under the pretense that she was traveling. When asked why she didn't wait a few more months until the summer vacation, she laughed dryly and replied, "I am tired."

I was intrigued: The look of exhaustion on her face and the frustrated laugh she let out when she said she was tired were jarring. I had several questions for her, but she was fresh out of surgery, and they all felt too invasive and personal at the time. What had caused her this much exhaustion at such a young age that she decided she needed surgical intervention? A question of autonomy surfaced: she is only fifteen; what does she know? *How* did she decide to undergo surgery? Did *she* make this decision? I glanced at her (thin) mother; I wondered what role she played in this since she was the one to answer my mother's question. I started wondering about the criteria

used that made someone eligible for weight loss surgery in Lebanon; I wondered if they are required to undergo counseling sessions, psychological evaluations, and a series of workshops like their counterparts in other countries, such as the United States (Tyrol, 2018).

Elsewhere, I had already noticed a disproportionately higher number of women than men I knew had undergone weight loss surgery. Of course, I understood the challenge of having a nonconforming body in a society where thinness is valued (Zeeni 2013). However, I was unaware that it was so accessible that a 15-year-old could decide to do it and end up doing it.

Background

The term "Weight loss surgery" encompasses a range of procedures that were initiated when surgeons in the twentieth century noticed that their patients who had had parts of their small intestines or stomach removed because of cancer had experienced weight loss without making any other changes (Faria, 2017). This observation led to the development of various procedures aimed at reducing the size of the stomach and bypassing certain parts of the digestive tract. Ever since, a range of methods have been developed: gastric sleeve surgery, which entails the removal of a portion of the stomach; gastric bypass (also called Roux-en-Y), which involves detaching a part of the stomach and redirecting the site where it empties into the intestine, saline-filled balloons that occupy a significant portion of the stomach, intestinal liners that create a barrier to prevent digestion, pumps that directly remove stomach contents, and lap bands that wrap around the stomach to reduce its size.

Even though weight loss is discursively framed as a health issue due to the conceptualization of obesity as an epidemic (Boero, 2012), many people's desires to lose weight are primarily driven by societal beauty standards (Boero, 2012; Farrell, 2011; Gailey, 2014). Despite efforts from activists to normalize all body types, the diet

industry remains a multibillion-dollar one (Boero, 2012), and there has been a growing global trend in fat individuals electing to undergo weight loss surgery. This issue is especially pervasive for women, as over 80% of the people who undergo weight loss surgery in the United States are women (Pratt et al., 2020).

In Lebanon, an increasing number of people have been undergoing weight loss surgery (Jabbour et al., 2021). It has become highly normalized (Jabbour et al., 2021), yet it remains under-researched, specifically from the socio-cultural and psychological perspectives. While some sociocultural literature currently investigates the lived experiences of people who have undergone weight loss surgery (Boero, 2012; Murray, 2009, Newhook, 2015, Natvik et al., 2014), no such studies exist in Lebanon. The available research in Lebanon looks at weight loss surgery from a medical lens (Jabbour et al., 2021; Dakkour Aridi et al., 2016; Chelala et al., 2020). This body of research overlooks weight loss surgery's gendered nature and treats it as a gender-neutral surgical intervention; thus, weight loss is discursively positioned as a biomedical intervention and is stripped of its sociocultural meanings (Boero, 2012).

Consequently, this thesis provides an in-depth examination of the experiences of seven women who have undergone weight loss surgery in Lebanon. It uses Interpretative phenomenological Analysis (IPA) to offer insights into the lived experiences of these women. IPA is an in-depth qualitative research method that allows us to understand individuals' subjective experiences as people who have undergone weight loss surgery. IPA enables us to examine how individuals make sense of their experiences navigating their social and personal world pre- and post-surgery and the meaning they attach to these states.

Research Questions

The primary goal of this thesis is to address the following question: What are the intersecting reasons that drive women to seek weight loss surgery?

In exploring this goal, I address the following questions:

- Are these women undergoing weight loss surgery for health concerns or body image/aesthetic reasons?
- What were their lives like pre-surgery, during, and post-surgery? (Including experiences and relationships with fatphobia, food and dieting, Health, desirability, attractiveness, etc.)
- How are they adjusting, both physically and mentally, to life post-operation?
- Is weight loss surgery what they expected it to be?
- What changes, if any, have they noticed in their social interactions and daily life?

This research aims to deconstruct harmful beauty standards and question how we can influence changing social perceptions about beauty and bodies. It does not seek to demonize weight loss surgery but to offer a fair and balanced perspective on this intervention and try to understand the mediation needed in society to stop people from getting to the point where they think surgical intervention is the only answer for their body image issues.

Positionality

This research project employs a feminist post-modern approach that requires me to critically evaluate my role as a researcher and reject the notion of being impartial or objective. My life experiences as a fat woman are integral to my interest in this research. Since I hit puberty, there has been increasing pressure on me to fit into contemporary feminine beauty standards, from hair removal, makeup application, feminine fashion, and, most importantly, weight loss. After yo-yo dieting for years as a teenager, medical professionals started recommending weight loss surgery as an "easy shortcut" to control my weight after inquiring about failed weight loss attempts.

This concern over my weight was purely aesthetic; there were no health concerns to warrant surgical intervention.

Language and Terminology

Fat

This thesis approaches bodies from a sociocultural perspective, so I have chosen not to use terms like "overweight" and "obese," which stem from biomedical understandings of body size and can carry negative connotations that actively pathologize fatness (Wann, 2009)[1]. Throughout my interviews and subsequent analysis, I use the term "fat," which is preferred by academics and researchers in the field of Fat Studies. Stripped of its negative connotations, at its essence, fat is a purely descriptive, neutral term. Participants in this study were asked about the terminology they felt comfortable using throughout the interview, and none objected to using this term. It is possible that some participants did not object to the use of this term but felt uncomfortable with the colloquial Arabic equivalent of obese (*smeene*) and fat (nassha).

BMI

Medical professionals and academics use the Body Mass Index (BMI) to classify bodies as underweight, healthy, overweight, or obese. The usage of this index is complicated because it was initially developed by a mathematician as a population measure, not for individuals, even though it simplifies the notion and places bodies in discrete categories. Numerous academics have claimed that it fails to consider differences in gender and race (Strings, 2019; Müller et al., 2016), and the fact that it served as the justification for the twentieth-century eugenics movement is a substantial argument for discarding it.

[1] Despite being generally used in a derogatory manner, at its essence, fat is a term that is purely descriptive, so it has been reclaimed by scholars and activists. Mirroring the reclamation of queer in queer studies, fat studies scholars have reclaimed the word fat.

Medical professionals continue to utilize this index even though it has been debunked and derided. This classification system is almost arbitrary. For example, the National Institutes of Health in the USA modified the BMI categories in 1998, which caused millions of people to move from the "normal" range to the "overweight" range and from "overweight" to "obesity." (Stang, 2022). Despite this, the BMI remains the primary criterion qualifying you for weight loss surgery.

Healthism

Healthism is a term used to describe an ideology that places a high value on health and wellness and sees them as individual responsibilities (Crawford, 1980). It suggests that a person's overall health reflects their lifestyle choices and that individuals can attain good health by making healthy choices such as eating a balanced diet, engaging in regular exercise, and avoiding unhealthy habits such as smoking and excessive alcohol consumption. While prioritizing health and wellness is generally considered a positive approach, healthism can lead to stigmatization and discrimination against individuals who do not conform to specific health standards, leading to a moralization of health (Rose Spratt, 2023) and creating a perception that they are responsible for their health problems. Healthism is a "non-political conception of health promotion" (Jiménez-Loaisa et al., 2019, p. 412) and strips health issues of their intersectionality with matters of power, race, class, and gender.

Anti-fat Bias & Fatphobia

These two terms refer to individuals' negative assumptions, beliefs, and stereotypes toward people they perceive as fat. They manifest in different aspects of one's life, from education to healthcare, employment, and social life (Zacher & von Hippel, 2022; Nutter et al., 2019).

Theoretical Framework

Post-structural Feminism

The foundation of this thesis is a feminist post-structuralist theory that emphasizes the body's multiple socially constructed meanings. Instead of a fundamental inherent order of reality, these meanings reflect the common social ideas, practices, and traditions of a given location and time. Even though these meanings do not correspond to a natural order, they are confirmed because they have a significant, often conflicting impact on everyone's lives. The body is a "locus of knowledge production" under the post-structuralist paradigm, where bodies and identities are viewed as fluid and continually changing, allowing for the acknowledgment of numerous truths or facts. (Shildrick and Price, 2010)

Standpoint Theory

This research aims to center the standpoints of women who have undergone weight-loss surgery. Feminist standpoint theory strives to construct an epistemology around marginalized people's experiences and knowledge production (Sprague, 2016; Harding, 1987). Feminist standpoint theorists argue that those from marginalized groups within society have a more ample and distinctive perspective into the inner workings of society, as they are positioned outside dominant power structures that shape the mainstream discourse and knowledge (Hesse-Biber, 2012). Standpoint theory proves to be even more meaningful for researchers who belong to the groups they are researching (Sprague, 2016). According to Hesse-Biber (2012), feminist researchers consistently and repeatedly question their positions as both researchers and feminists as we explore the limits of our multiple identities and research goals through careful reflection.

Intersectionality

Intersectionality is a theoretical framework first conceptualized by Kimberlé Crenshaw that recognizes the ways in which different aspects of one's identity and forms of oppression intersect and interact with one another, leading to the creation of a complex system of privilege, power, and oppression (Crenshaw, 1989). Intersectionality recognizes that all individuals hold multiple identities that shape their position in society. Intersectionality requires a nuanced understanding of power dynamics and a commitment to addressing the complex ways different forms of oppression intersect and reinforce each other (Puar, 2007). This research will focus on the intersections between gender identity, class, and body size.

Drawing on the conceptualization of identity from social psychology, identity construction uses cultural knowledge of certain identities and involves both personal and social processes (Stets & Burke, 2003). Both to the individual and to those around them, one's identity conveys information about their social function, status, and group membership (Stets & Burke, 2003). In this sense, identities have an impact on a person's actions, emotions, and self-perception.

Fat Studies

This thesis is informed by Fat Studies, a multidisciplinary field of research that investigates fatness and the lived realities of fat people. It unpacks how fat bodies navigate the world, how they are molded by it, and how they can remake it (Wann, 2009). This field rejects the mainstream discourses that medicalize and pathologize fatness and theorizes fatness as socially constructed. It offers alternative discourses, critically assessing the marginalization of larger people in different contexts, from the media to education to medicine. It is a crucial area of research for examining bodies. It serves as a reminder that the aspirations, anxieties, and values of a particular period

or culture are imprinted onto the bodies of those existing within said culture. These aspects are often labeled "objective facts" within health and biology.

Despite the universality of the discourse on fatness due to the “obesity epidemic” (Boero, 2012), conversations around fatness, whether in the academic or popular sphere, are very Western and mainly North American. There are currently no bodies of literature in the MENA region informed by Fat Studies.

Queer Theory: Critical Queer Praxis

Many scholars in Fat Studies apply queer theoretical perspectives to challenge essentialized notions of body weight and gender embodiment. Their objective is to disrupt societal norms that discriminate against fat individuals, just as they do against queer individuals, and to reject the notion that certain body types are ideal (Taylor, 2021). Queer theory is used as a tool to question conventional notions of gender and to critically interrogate what is generally conceptualized as “normal” and “acceptable.”

Critical queer praxis emphasizes the messiness of social experiences, relationships, and dynamics. It also highlights the precariousness of the power dynamics and the presumed meanings that follow (Browne & Nash, 2010). To queer my research is to accept that the people I am researching are not homogenous and uniform but unpredictable and distinct, each interlocuter having a rich, unique social history and exchanges where all their stories would actively deconstruct body normativity. Critical queer praxis is grounded in intersectionality (Taylor, 2021).

Butler’s Performativity

This thesis builds on the seminal works of several queer theorists, especially Judith Butler’s theory of performativity. In their book *Gender Trouble (1990),* Butler argues that gender is performative and is enacted through culturally and socially assigned iterations of sexed bodies. They say that it is impossible to understand sexed

bodies without also understanding gendered bodies because sex is only visible through the functioning of gender; using this argument, it is also true that it is impossible to understand different body shapes and sizes without linking them to cultural construction. Body shape and size are performative and subject to questioning. We perform, reiterate, internalize, and construct and reconstruct cultural norms regarding our physical appearance, just as we do with gender and sex.

By recognizing that fatness is a social construct that is constantly produced and reproduced, we can work on challenging and disrupting fatphobic norms.

Adrienne Rich's Compulsory Heterosexuality

Adrienne Rich's essay 'Compulsory Heterosexuality and Lesbian Existence' (1980) is a groundbreaking work of feminist and queer theory. In it, Rich argues that heterosexuality is not only a sexual orientation but also a social and political construct imposed on individuals through cultural norms and institutions (Rich, 1980). She theorizes that heterosexuality is a political institution that regulates cultural, social, political, and economic life according to an asymmetrical gender binary system. Critiquing how this heteronormative framework ostracises lesbian existence, she argues that lesbianism inherently challenges and unsettles it. In the same manner that those that do not conform to heterosexuality are marginalized, people that do not conform to thinness are marginalized. Through its "management of consciousness" (Rich, 1980), the ideal body is not only cis-normative and heterosexual but also slim and does not occupy too much space.

CHAPTER TWO

LITERATURE REVIEW

This section examines the critical literature on fatness, its cultural and societal meanings, and its intersections with gender, (hetero)sexuality, and class. It also provides an overview of the available sociocultural literature on weight loss surgery and the gap in the literature in Lebanon.

Fatness and Gender

In the fat studies literature, theories of weight and embodiment are intertwined with theories of gender. Much of this literature emphasizes the role of gender in shaping embodiment. Women's embodiment is particularly salient due to the social construction of the category "woman," which requires a specific and idealized physical form that is both petite and attractive, leading to its internalization in individual women

(Bordo, 1993). Weight is closely tied to women's identities, and being a "normal" weight is considered an essential aspect of being a woman (Boero, 2012; Murray, 2008). Bartky posits that cultural expectations for women have shifted towards what they are allowed to look like rather than what they are allowed to do: "Normative femininity is coming more and more to be centered on woman's body—not its duties and obligations or even its capacity to bear children, but its sexuality, more precisely, its presumed heterosexuality and appearance" (Bartky, 1990, p. 78).

Brown also suggests that the ideal feminine body is a "manifestation of misogynist norms flowing from a culture where women are devalued and disempowered" (Brown, 1985, p. 131). She argues that because women are considered inferior to men, their bodies must demonstrate that inferiority. In a study by psychologist Jason Seacat, fifty fat women were asked to document every instance in which they felt judged or insulted due to their weight. The study found that, on average, the women reported experiencing three such incidents daily (Seacat, 2013).

Fatness and (Hetero)Sexuality

Fat women are concerned about being regarded as unfeminine, undesirable, lethargic, and lacking sexual appeal, which affects their confidence and, as a result, their dating life. Gailey (2012) unpacks this issue, saying, "Fat represents a challenge to the identification as sexual because weight is connected to the heteronormative system of meaning and value that constitutes what it means to be feminine or masculine." (p. 116). Most fat women are terrified of "putting themselves out there" because of the heightened fear of rejection and the plethora of discourses reminding them they are perceived as unattractive. If a man is romantically or sexually involved with a fat woman, he is perceived as "stooping" regardless of his physical appearance (Lee, 2014).

Fat women are continuously bombarded with messages that they are not good enough. A study of the portrayals of recurring fat women in particular television shows indicated that, generally, these characters were portrayed as having masculine personalities and that their sexualities were either completely ignored or disparaged (Giovanelli & Ostertag, 2009).

Boero (2012) posits that there are three facets of heteronormative weight loss, "consuming femininity, relearning heterosexuality, and becoming visible" (Boero, 2012, p. 105). Relearning heterosexuality is the process by which women who have recently lost weight implicitly accept the objectification of women in society. For example, some of Boero's interlocutors found catcalling flattering because they perceived it as an essentially "female" experience, one they did not relate to before (Boero, 2012).

The phenomenon of hyper(in)visibility of Fat

According to Gailey (2014), the issue of hyper(in)visibility has taken on new significance in relation to the experiences of fat women. The phenomenon of hyper(in)visibility refers to the simultaneous hypervisibility and hyper-invisibility of certain bodies. In the case of fat women, their physical bodies are hypervisible due to taking up more physical space. At the same time, their needs, desires, and lives are frequently overlooked, making them hyper-invisible. This hyper(in)visibility is perpetuated by media, medical establishments, and popular culture. It reinforces the marginalization and "Othering" of fat women, reinforcing stigma, mistreatment, and discrimination against them. Fat women suffer from social interactions infused with labeling, prejudice, and sizeism, further contributing to their marginalized status. It also serves as a mode of discipline, reminding them that they must "be responsible" and lose weight while, at the same time, their existence is erased and dismissed. The

paradox of hyper(in)visibility, as it pertains to fat women, represents a structural issue that affects their everyday experiences and their social position as "Other" (Gailey, 2014).

Fat as a Liminal State

In his work on the rite of passage, Arnold van Gennep first introduced the concept of liminality, which was later developed by Turner (1977). This concept is now used beyond this scope and can be used to describe any state that is perceived as unstable and temporary and examine experiences or social statuses that are difficult to measure or understand.

According to Turner (1977), being in a liminal space means being structurally invisible and, for the moment, beyond definition. The experience of fat women as hyper(in)visible, as Gailey (2014) has conceptualized, can be regarded as one manifestation of this liminal experience. Kyrola and Harjunen's (2017) participants did not identify as fat but saw their fatness as temporary.

Fatness is often regarded as a non-permanent state in contemporary Western societies. The belief that changes and transformation of the fat body is a normative expectation has resulted in the common perception that fatness is a "phase" one eventually leaves or should leave behind (Harjunen, 2009). This notion of non-permanence is normalized in biomedical discourse, which asserts that fatness is a "curable" and temporary condition. Kyrola and Harjunen's (2017) research revealed that fatness is constructed as a liminal position, and for many, living as a fat woman is a liminal experience.

The Body in Neoliberalism

The emergence of neoliberalism in society contributes to the regulation of individual bodies, and by extension, to the stigmatization of fatness. Neoliberal

ideologies prioritize individual freedom and privatization, aiming to govern citizens' personal choices and responsibilities (Rose Spratt, 2021). In a neoliberal system, individuals are expected to behave rationally and responsibly, particularly concerning their bodies. In a neoliberal state, everyone is responsible for being "healthy," and because fat is perceived as unhealthy, fat individuals are subjected to greater social control and surveillance (LeBesco, 2011; Harjunen, 2017). In a neoliberal environment, being fat is indicative of illness and laziness, leading to the perception of fat individuals as failing their community (Tischner & Malson, 2012).

Feminist scholars have argued that a postfeminist sensibility has emerged within the neoliberal state because women's agency and consumer freedoms are touted as women's empowerment (Gill, 2008). In other words, women are 'free'' to choose to be ''healthy'' (i.e., not fat) and engage in self-regulating and disciplinary practices to maintain a thin physique. As Riley, Evans, and Mackiewicz (2016) state, ''postfeminist sensibility intersects with neoliberal constructs so that the self is understood as a project requiring transformation, often through modes of consumption'' (p. 97). Fat women are compelled to feel guilty about their size and strive to lose weight to reduce the ''drain'' they place on society. The ''obesity epidemic'' discourse has led to a conflation of health and beauty, and because fat is considered unhealthy and unattractive, fat women are under pressure to ''fix'' both (Gailey, 2014; Tischner, 2013). Tischner's (2013) participants expressed tremendous scrutiny, surveillance, and pressure to lose weight to meet societal expectations (see also Tischner & Malson, 2008).

Fat Shaming

Sara Ahmed, a feminist scholar, has stated that shame is a process that involves mutual exchange and is entirely reliant on the opinions and assessments of others. She says:

“Shame as an emotion requires a witness: even if a subject feels shame when she or he is alone, it is the imagined view of the other that is taken on by a subject in relation to herself or himself ... In shame, I am the object as we; as the subject of the feeling. Such an argument crucially suggests that shame requires an identification with the other who, as a witness, returns the subject to itself. The view of this other is the view I have taken on in relation to myself; I see myself as if I were this other. My failure before this other hence is profoundly a failure of myself to myself. In shame, I expose myself that I am a failure through the gaze of an ideal other. (Ahmed, 2014: 105–106)”

Fat shaming is the act of intentionally stigmatizing fat individuals due to their body size (Rinaldi et al., 2019). Fat people are frequently held responsible for their condition and related health problems because they are thought to have brought them on themselves by making poor lifestyle choices (Garthwaite & Bambra, 2017).

People who engage in fat shaming assume that individuals have complete control over their choices, including the foods they consume and how much exercise they engage in daily. These people frequently use the concept of freedom of choice to justify their derogatory, dehumanizing comments, contending that consumers can select their food items from the supermarket and choose whether or not to exercise and are simply making poor choices (Lee & Pausé, 2016).

The belief that fat shaming can be a valuable tool to promote healthy weight loss is problematic. Firstly, not all individuals have equal access to healthy food options or exercise opportunities due to financial constraints and time limitations (Hill, 2016). Secondly, fat shaming can lead to behaviors that result in weight gain, such as stress eating (Meulman, 2019), propelling people into an endless cycle of weight fluctuation and shame. Despite the plethora of literature confirming that shame-centered approaches are harmful, people still believe that shame-centered interventions

will convince people to lose weight, even though it has been proven that it actively harms the well-being of fat individuals (Lewis et al., 2011).

Anti-fat bias

According to Puhl & Heuer (2010), fatphobia has progressively grown during the 21st century. In 2019, Harvard University published a study that used an online test to measure people's unconscious biases around various characteristics, including sexual orientation, race, gender, skin tone, body weight, and disability (Charlesworth & Banaji, 2019). The study, which measured the attitudes of 4.4 million people, found that people's implicit negative bias based on body weight increased over the years, with anti-fat bias rising by 40 percent. Negative Bias against larger bodies was the only attitude concerning the six measured ones that increased over time, with racial biases decreasing by 17% and sexuality ones by 33% (Charlesworth & Banaji, 2019).

Schafer & Ferraro (2011) contend that the links between fatness and morbidity are caused, at least in part, by social and economic marginalization. From an epidemiological perspective, these could be viewed as unresearched intervening and confounding factors in the relationship between body weight and morbidity. The discrimination fat people experience, especially from medical professionals, is linked to delays in seeking medical attention. Fatphobic attitudes and behaviors doctors and nurses display directly impact the standard and quality of treatment they deliver to fat patients (Schafer & Ferraro, 2011).

Internalization of fatphobia

Saguy and Ward (2011) compared the phenomenon of fatphobia to homophobia in that fatness is regarded with the same fear and hatred in contemporary society. Thin bodies are idealized as medically, aesthetically, and morally desirable, while fat bodies are stigmatized. This hatred of fat is so intense that people often go to extreme measures to try to eliminate it, such as through excessive dieting or fad diets.

The fear of becoming fat and the disgust towards fatness contribute to how people see themselves through the eyes of others who discriminate against them. Many women interviewed for the study saw themselves as inferior and deserving of mistreatment, which positioned them as the 'Other'; they also held similar attitudes toward other fat women (Saguy & Ward, 2011).

Fatphobia is so pervasive that in a survey conducted by Yale University's Rudd Center for Food Policy and Obesity, they found that nearly half of the respondents would instead give up a year of their lives than be fat. A significant percentage would instead give up their marriage and the possibility of having children, lose a limb, become depressed, or become an alcoholic than be fat (Runfola et al., 2013).

The Existing Sociocultural Literature on Weight Loss Surgery

Murray (2009) explains that bariatric treatments are typically characterized as straightforward operations with little risk and minimum scarring, thanks to the use of laparoscopy. She claims that this explanation underplays the significant (and ongoing) physiological, behavioral, social, and emotional implications of living in a post-operative bariatric body and instead stresses just the modest intervention at the time of surgery (Murray, 2009).

Boero (2012) conducted interviews with people who sought weight loss in multiple ways, including bariatric surgery, to trace the discrepancies between public health framings of obesity as an epidemic and fat individuals' lived experiences. She discovered that conventional views of gender, race, class, and sexuality could not be separated from their desire to lose weight. She also found that the desire for and pursuit of weight loss was motivated more by the goal of body normativity than by the desire for better health outcomes. She argued that women who undergo weight loss surgery

learn to “negotiate a world of normative gender and sexual expectations that they had previously been outside of by virtue of their fatness.” (Boero, 2012)

Groven et al. (2010) conducted interviews with five women who experienced chronic pain, feelings of shame and failure, and energy loss after undergoing weight loss surgery. These women’s motivations to undergo weight loss surgery were shaped by the social stigma around their fatness and worries about future illness, even though they had very few signs of disease before surgery. The biosociality of weight loss has been explored in depth by Throsby (2008a). Throsby’s research has revealed that weight loss surgery patients must work to maintain their post-surgical identity and often experience anxiety in hiding their surgeries from others (Throsby, 2008a). She highlights the challenges that bariatric patients face when dining with others, as they must frequently explain their eating behaviors and the consequences of their surgery (Throsby, 2008. See also Murray, 2009). Throsby’s interlocutors accept the medicalization of their fatness and believe, despite multiple failed diet attempts over the years, that future weight management interventions will lead to durable weight loss (Throsby, 2007).

Throsby (2012a) advocates for a critical approach to weight loss surgery that acknowledges the complexities and ambivalences of bariatric lived experiences. She suggests that an analytical space should be created to accommodate resistance and compliance (Throsby, 2012a). Throsby (2008) found that women who underwent weight loss surgery tended to view it as a complete transformation, allowing them to become a more authentic version of themselves. The “new me” that weight loss surgery promises is not just a slimmer body but a rebirth of the self as a responsible individual who can control their consumption and body. However, this discourse requires new techniques of disciplining the body. It places the blame for any potential

failure of weight loss surgery on the participants themselves, making it a slippery and contingent identity claim that comes at a cost.

Throsby's (2008, 2009, 2012) research suggests that the discourse surrounding "obesity" limits the personhood of fat individuals, leading to various discursive registers that resist these constructions. Weight loss surgery complicates questions of responsibility and accountability. Medical constructions identify high body weight as a medical condition outside of a patient's control but blame unsuccessful weight loss surgery recipients for non-compliance. While some fat activists oppose Weight loss surgery, others have undergone the procedure and navigated the contradictions by selectively taking up or rejecting biomedical labels and claiming agency. Increasing social approval for weight loss surgery and a neoliberal emphasis on individual choice illuminate why some may choose weight loss surgery over political stances in favor of fat rights and liberation. (Throsby, 2007, 2008, 2009, 2012)

Constructing a weight loss surgery patient involves discursive practices related to surgical qualification and preparation. In the USA, to be deemed suitable for such a surgery, patients must meet various requirements, such as demonstrating a history of lifestyle change and attending mandatory education sessions or counseling. These requirements work to define the type of person who needs and deserving of surgery (Drew, 2008). Following surgery, weight loss surgery recipients are subject to increased surveillance and regulation and are often blamed for any weight gain (Simpson, 2015). Even possible unpleasant symptoms of weight loss surgery can be a form of regulation. For example, bariatric surgeons often view nausea, vomiting, and diarrhea as evidence that the surgery works as a form of surgically enforced behavior modification (Throsby, 2008b).

Narvik et al. (2014) explored the experiences of people who underwent weight loss surgery and their struggles to maintain weight loss through healthy eating practices. For some, the fear of weight regain was so great that they clung to highly structured eating practices as the only strategy for maintenance. Others expressed ambivalence, refusing to give themselves entirely to the care of health professionals. The impact of weight loss surgery and changed eating practices involved existential questions for some participants, some of which remained unresolved (Natvik et al., 2014). For many, eating became a means to access nutrition and maintain weight loss, with an emphasis on restriction. Other meanings, such as enjoyment and socialization, were no longer there. Despite the desire for healthy eating, participants also faced societal pressure to conform to beauty standards prioritizing thinness (Natvik et al., 2014).

Trainer and Benjamin (2017) highlight the effects of weight-related stigma on younger women's motivations for undergoing bariatric surgery, specifically the stigma surrounding assumed laziness and lack of effort. The younger women who expressed a desire for weight loss to be skinnier also felt the need to cite medical concerns as part of their motivation for pursuing weight loss surgery.

Newhook et al. (2015) explored the gendered meanings of weight loss surgery in Canada. The article highlights how the biomedical field uses a gender-neutral chronic disease model in weight loss surgery research, even though the concept of "fat" has long been feminized. They argue that pursuing health in a neoliberal context is driven by an obsessive and conspicuous focus on individual choice, which conceals socio-structural inequities that shape people's lives and health. The study finds that gender matters in the lived experience of fatness and that being identified as fat is a spoiled identity that links the external appearance of bodies with individual character

(Newhook, 2015). The article also notes that fat is coded as feminine and that Western society associates nibbling, eating small portions, and dieting with femininity. Large, hearty appetites are coded as masculine.

Weight loss surgery in Lebanon: The (Scarce) Existing Literature

With a few notable exceptions, the experiences of people who undergo weight loss surgery have yet to be thoroughly investigated in the sociological literature. In Lebanon, however, medical research on weight loss surgery is scarce, but qualitative studies focusing on the lived experiences of people that have undergone this surgery are nonexistent.

Jabbour et al. (2021) conducted a cross-sectional study to evaluate Lebanese patients undergoing bariatric surgery for binge eating behaviors, food cravings, and the Healthy Eating Index (HEI). Around 85% of their participants were women. They found that HEI progress remained relatively low despite improvements in dietary variables, with most patients falling into the poor-quality index category. They also found that 40% of their sample regained weight and emphasized the importance of thorough preoperative dietary and psychosocial assessments for achieving short- and long-term care objectives.

Another study by Dakkour Aridi et al. (2016) evaluates the efficacy of weight loss surgery at least five years post-op. They concluded that weight-loss surgery results were satisfactory, with most patients maintaining weight loss. This paper also attests that 1 in 5 patients developed de novo acid reflux after surgery. The most frequent long-term side effect was cholelithiasis, which required surgical intervention to remove the gallbladder (cholecystectomy) (see also Dakkour Aridi et al., 2016 and Chelala et al., 2020). While rare, several patients developed long-term complications like hernias, most notably depression, necessitating admission. The development of

depression in some cases post-operation is interesting, and qualitative analysis of the lived experiences of these individuals would be insightful.

This gap in the literature necessitates further investigation into the lived experiences of women that have undergone weight loss surgery.

CHAPTER THREE

METHODOLOGY

This chapter describes the methodology for examining the lived experiences of women that have undergone weight loss surgery.

Interpretative Phenomenological Analysis - IPA

Interpretative phenomenological analysis (IPA) is a qualitative phenomenological approach concerned with how individuals experience a phenomenon that holds particular significance to them (Alase, 2017; Smith et al., 2009). It is an extension of traditional phenomenology that emphasizes existential meaning, the interaction between participants' experiences and context, and the historical, contextual, and social and political forces on participants' experiences and lives (Smith et al., 2009).

Rooted in psychology, IPA was developed as a technique to encapsulate personal experiences and the significance that participants attributed to these experiences, as understood by the researcher (Smith et al., 2009). It focuses on unpacking unique or unexplored phenomena important to the participants.

IPA was chosen over traditional phenomenological approaches for this study because of its idiographic and double-hermeneutic approach (Chan & Farmer, 2017), which allows for both similarities and differences in themes to be presented and positioned. The voice of each participant is positioned at the forefront while the researcher provides further contextualization of the participants' experiences within larger political, social, cultural, and historical contexts (Smith et al., 2009).

IPA draws from hermeneutics, which is the theory of interpretation (Smith et al., 2009). Hermeneutics acknowledges that the individual parts cannot be understood in isolation from the whole, referred to as the hermeneutic circle (Smith et al., 2009). Interpretation is contextual and varies with the circumstances of the event (Smith et al., 2009). Unlike a traditional linear analysis, the IPA analysis process is iterative, and researchers adjust their perspectives as they engage with the data (Smith et al., 2009). As creatures who make sense of their experiences, humans seek to derive meaning from them, and the information that participants decide to disclose determines access to these experiences (Smith et al., 2009). It is the researcher's responsibility to interpret the account provided by the participants to gain insight into it (Smith et al., 2009). Therefore, the IPA researcher engages in a double-hermeneutic, in which the researcher attempts to comprehend the participant's attempt to understand their experience (Smith et al., 2009). Interpretative research recognizes that the researcher holds preconceived biases and assumptions, which are an indispensable part of the research (Smith et al., 2009).

Both IPA and feminist standpoint theory emphasize the importance of individual perspectives and their claims of knowledge when a researcher aims to identify a community of interest (Cohen et al., 2022).

The Rationale

My objective for this thesis is to understand better the lived experiences of women who have undergone weight loss surgery.

This type of research is interpretative and inductive, aiming to highlight the complexity, context, and humanity of their experiences (Creswell, 2018).

A qualitative approach is well-suited to the research question. The aim is to thoroughly understand the various aspects of the participants' relationships with their bodies throughout their lives, unpacking the reasons that drove them to undergo weight loss surgery.

The decision to limit the sample to women is based on the significant impact of one's gender on their body and identity, as well as the research asserting the gendered dimension of fatphobia (Gailey, 2014; Tischner, 2013; Giovanelli & Ostertag, 2019) and the higher number of women undergoing weight loss surgery than men in the USA (Pratt et al., 2019). Including various gender identities would not have allowed for sufficient connection and comparison of themes between participants, as required for IPA.

Recruitment method

After securing approval from the Institutional Review Board (IRB[2]), selective (purposive) sampling and snowball sampling were used to recruit women who met the study's inclusion criteria. I used purposive sampling to recruit two acquaintances who had undergone weight loss surgery. I also asked these participants if they knew any other women who had undergone weight loss surgery and would be interested in being interviewed to recruit for the study with snowball sampling.

Interested participants contacted me or were contacted via text, email, or telephone. I provided them with a brief overview of the research project and the consent form.

[2] The reader should note that the original title under which IRB approval was sought was 'Womanhood and the Body in Lebanon: Case Studies on Weight Loss Surgery.' The title has been changed, but the content and scope of the research remain the same. ***IRB #:*** *LAU.SAS.CJ1.29/Nov/2022*

During the interview scheduling process, it was crucial to identify a safe and comfortable location and environment for the participant; consequently, the individual interviews for this thesis were conducted in various settings. Three interviews were conducted on the Lebanese American University campus, three were conducted in coffee shops per participants' preferences, and one was conducted over the phone due to the participant's tight schedule.

At the end of each interview, the participants were asked if they would be willing to provide further information or elaborate on a previously discussed topic. All participants consented to this request and provided their personal phone numbers and email addresses for future communication.

Participants

There were three primary inclusion criteria for this study: (1) The participant is over the age of 18; (2) The participant identified as a woman; (3) The participant has undergone weight loss surgery.

I aimed to recruit younger participants (between 18 and 25) for this study. However, this age group proved elusive, and I faced challenges in obtaining sufficient participants. Eight women who fit this criterion refused to participate in the study, citing discomfort with the topic under investigation and saying that discussing their bodies made them uncomfortable. Therefore, I decided to broaden my inclusion criteria.

This is noteworthy, as it is generally assumed that the younger generation is more accepting because of the recent online body positivity movement (Gelsinger, 2021). The four older participants echoed this sentiment. However, this assumption was only partially accurate in our case. As opposed to popular online discourses, it is

essential to consider that these issues remain sensitive and uncomfortable for many people.

Participants Profiles

To help put the findings and themes in context, a brief description of participants who took part in this study and overall impressions throughout the interviews are offered.

Daisy is a twenty-year-old Lebanese woman. She is a third-year university STEM major and works part-time as a secretary. She underwent gastric sleeve surgery when she was seventeen. Throughout the interview, Daisy was relaxed and comfortable answering my questions. She tended to engage in self-deprecating humor and laugh at her own expense, especially when discussing her pre-surgical life.

Jana is a 30-year-old Lebanese coordinator at an NGO. She has a Master's degree and feels very strongly about contemporary beauty standards. She underwent gastric plication in 2020. In our interview, she started out as calm and increasingly grew frustrated as she reflected on her experiences.

Reem is a 42-year-old Lebanese writer. Throughout our interview, she was very open and inquisitive, often asking me for answers about things she had experienced, and wanting to know if everyone I interviewed had similar experiences. She underwent gastric sleeve surgery in 2020.

Mona is a 37-year-old journalist and feminist. Throughout our interview, she was incredibly animated, laughed loudly, and carried herself confidently. She underwent gastric sleeve surgery at 34 but still identifies as a fat woman.

Hiba is a 43-year-old Lebanese corporate employee who lives in the Gulf. She was professional and seemed confident, yet tended to whisper when discussing her body pre-surgery, sometimes even mouthing certain words out of fear of being overheard. She underwent a partial sleeve gastrectomy in 2019.

Sophie is a 20-year-old Lebanese undergraduate student. She had undergone two different weight loss procedures: She had an intragastric balloon placement at 17 which did not lead to weight loss, and gastric sleeve surgery at 19, which helped her lose weight. She was very comfortable discussing her lived experiences.

Dana is a 24-year-old Lebanese master's student. She underwent gastric sleeve surgery when she was 22. She seemed uncomfortable throughout our interview, avoided eye contact, and often gave surface-level answers if not prodded.

All participants identified as heterosexual, cisgender women.

Data Collection

To gather data for my study, I utilized semi-structured interviews, following the method outlined by (Miller et al., 2018). Each participant was interviewed once for 60 to 90 minutes, using a semi-structured interview approach. The questions were derived from an interview guide tailored to this study's requirements (refer to Appendix). At the beginning of the interview, I enquired about participants' preferred terms related to their bodies, especially the pre-surgical one: whether they preferred larger, plus-sized, obese, or fat. None of the participants objected to the use of the word fat.

Each open-ended interview was recorded using the researcher's phone. Once completed, the audio recordings were immediately downloaded to the researcher's computer. To ensure confidentiality and anonymity, the audio files were labeled under pseudonyms. The researcher is the only person with access to any documents or codes linking participants' actual names with pseudonyms.

Transcriptions

The researcher transcribed the interviews verbatim to maintain the data's privacy and confidentiality. The audio tapes are stored securely in compliance with the

Lebanese American University's policy, which requires them to be kept for seven years after the completion of the project, with any identifying information held separately. Identifiable information has been removed from the transcripts to ensure anonymity.

Data Analysis

IPA does not have a strict set of instructions for researchers to follow but instead allows for flexibility in researchers developing their analytical methodology. Despite this flexibility, all IPA analyses share a process of starting with specific descriptions and moving toward interpretation. The approach in this analysis followed the guidance of Smith et al. (2009), which involves identifying experiential statements and personal experience themes or clusters of meanings in each transcript through a progressive interpretative process. The researcher started by analyzing one interview in detail, making notations and initial comments with initial coding taking place. Each transcript was coded independently, creating a thematic code list for each participant in a separate document. Once all seven transcripts were coded, a standard list of connections and clustering experiential statements incorporating all participants was written. The transcriptions were then re-read sequentially to ensure all codes were checked in all transcripts. This resulted in a series of cluster codes firmly grounded in the data, focusing on common themes and non-comparable examples.

CHAPTER FOUR

FINDINGS

Using Interpretative Phenomenological Analysis (IPA), five overarching themes central to participants' accounts of their experiences as women who have undergone weight loss surgery emerged: (1) Socialization as fat women, (2) The consequences of being socialized as fat women, (3) Navigating uncertainty and change throughout the weight loss surgery journey, (4) Navigating the body in its relational context throughout the weight loss surgery journey, and (5) The effects of socioeconomic status and environment.

These major themes were further broken down into 17 subthemes detailed below. Relevant quotes from the participants who were given pseudonyms such as Daisy, Jana, Dana, Reem, Mona, Hiba, and Sophie are included. All the themes were present in most accounts (i.e., at least four out of seven participants).

1. Socialization as Fat Women

The first major theme emerging from the responses of all participants is the socialization they experienced growing up as fat women. This major theme was made up of six distinct yet intersecting subthemes. (a) Fatphobic parents, (b) Fatness as not romantically desirable, (c) trouble with plus-size shopping, (d) fatphobia from medical professionals, (e) fatphobic peers, (f) fatphobia as a feature of Lebanese society.

A. Fatphobic Parents

Parents teach children the values and norms of their culture. Consequently, they

play a significant role in the socialization process. Six participants expressed some variety of their parents' attitudes and perceptions of their bodies and the impact they had on them. For example, Daisy said,

> My parents weren't evil or anything, but there were some things they did that made me feel like I wasn't normal. When my mother prepared food for my siblings and me, she gave me smaller portions even though I was way older than them! Was I not supposed to notice that?

Reem recalled a similar experience: "Everyone at home was skinny. My mom would make dinner and tell my sisters to come to have dinner, and she would say, Reem, you don't come, have a piece of fruit." Both Daisy and Reem discussed the compensatory behavior they felt they had to do to earn their parents' love, like being at the top of their class. Sophie reported her mother's extreme feelings towards her body, saying, "Before, she would look at me in a way of disgust. It used to be so triggering; now she looks at me in a way of admiration." This newfound admiration is because of her weight loss after undergoing weight loss surgery.

In addition to describing situations where they felt rejected by their parents because of their bodies, Daisy and Mona reported their fatness being treated as a cautionary tale. Daisy said, "Once, when my sister ate too much chocolate, my dad told her, be careful, or you will end up like your sister. I was at the top of my class and never got into trouble. How am I the worst-case scenario?". And when Mona's sister was diagnosed with anorexia, her parents blamed her for her sister's condition, believing that she had become anorexic because she was scared of becoming fat like her.

When asked why their parents had such an investment in their weight, all participants elaborated that it was for aesthetic reasons and not driven by health

concerns. For example, when recalling her last pre-surgical weight loss attempt, Sophie said: “Mom was like: This is enough. I want you to look pretty for your graduation.” To drive her point home, Mona showed how excited her parents were when she got a hypothyroidism diagnosis. “When we found out I had hypothyroidism when I was 20, my parents were relieved; they assumed if I did the (thyroid) surgery, I would finally lose weight.”

B. Fatness as Not Romantically Desirable

Five participants discussed how much their presurgical bodies affected their romantic lives. Of them, three participants expressed frustration with being perceived as “one of the boys” and not being seen as a romantic option. Daisy elaborated on her struggle with being seen as a romantic option as a fat woman by saying,

> In the 11th grade, I knew this guy liked me. He never said anything, but I could feel it, you know? I told my best friend that, and she laughed and said, “I don’t think you’re his type, don’t get your hopes up.” That winter, I lost twenty-five kilos. And guess what? He slid into my DMs [laughs]… At first, I felt victorious; then, I felt angry and embarrassed. I KNEW he liked me six months earlier, but he waited until I was thin to hit me up. That felt cruel. Then again, we all know how mean teenagers can be; maybe he did not want to get bullied by his friends for being with a fat girl. I never wanted to feel like that ever again.

Echoing Daisy’s case, Mona discussed how “Even if a man actually sees you as a woman and has feelings towards you, he would hesitate (because) this isn’t the girl he can bring home to his mother….” Mona felt that by being fat, she was not feminine and did not meet the societal expectations to be a good wife.

Jana shared, “Guys would make you feel as if you’re not up to their standards. They would be friends with you just to date your friends. I was never seen as a romantic option; I was always the “cute, friendly person” who is never attractive.”

While two participants said that their weight did not affect their romantic lives, throughout their interviews, they repeatedly measured their self-worth through men’s interest, even through incidents of sexual harassment. Hiba “Two days ago, I was out with my friend; his friend asked me if he could touch my butt; at my age and after you put in all that effort to lose weight, you stop thinking that this is harassment; you take it as a compliment.” Here, Hiba highlights the nuanced and borderline problematic ways fat people are made to feel about their bodies.

C. Trouble Plus-size Shopping

All participants in this study discussed their dissatisfaction with shopping for clothes, citing feelings of frustration and embarrassment. Sophie says, “I used to go to the fitting room. I used to cry. Nothing fits; nothing works.” Three participants encountered fatphobic salespeople who did not shy away from commenting on their weight. Dana recounted, “When I used to go shopping with my mom, I would be trying on clothes, and they’re not fitting. Once, I heard the saleswoman telling my mom, why is she that fat? This is not good for her; take her to the gym and have her do a diet”. Daisy recounted an instance where a salesperson physically violated her “One saleswoman straight up grabbed my stomach and jiggled it to emphasize how fat I was and laughed! She laughed at a paying customer! I was so embarrassed.” It was clear that all participants in this study wanted to lose weight to be able to wear certain things and look a certain way in them. Reem, for example, said, “If I lost weight, I would be able to wear certain clothes, like dresses, and look feminine and dainty.”

D. Medical Fatphobia

Five participants in this study encountered anti-fat stigma while seeking medical attention while they were fat at various stages of their life. Jana recalls an incident from her childhood that stuck with her, saying,

> When I was a kid, I was chubby, not overweight. A doctor told us that if I reach the age of 16 and haven't lost weight, I will become paralyzed and won't be able to walk. I have reached the age of 30, and I am not paralyzed. He made me feel like my life was doomed.

Reem recounts seeing a gynecologist when she was pregnant with her son. "When she saw me, she screamed, 'How are you this fat and pregnant?' She said I was definitely not having a natural birth because of my weight. I never went back, and I had a natural birth." Participants often hesitated to seek medical attention because they believed the doctors would focus on their weight instead. Hiba used to suffer from back pain when she was bigger, and when she would seek medical attention for her back, they would blame her weight. "I don't think the weight affected my back; it was my lifestyle because my back still hurts. I used to wear high heels for nine hours at work, so my back will definitely hurt."

Three participants mentioned being subjected to fatphobic comments from dentists. "Even dentists had something to say. When I was getting braces, he told my mom I would lose weight because the braces hurt so much at first you can't really eat well."

E. Fatphobic Peers

Peers also play a significant role in the socialization process. All participants reported feeling inferior to their friends and constantly being reminded of this inferiority. Mona remembers, "One of my girlfriends told me that fat girls like me are on the 10th tier (on a scale of 1 to 10 where 1 is the best) as if we're sheep". Sophie also discussed receiving backhanded compliments when she was bigger and her social life improving after weight loss surgery.

> Believe it or not, I discovered my true friends after I did it. For example, I had a best friend of 17 years. Apparently, she told people after I did my surgery, 'So what? Does she think that if she loses weight, she will become prettier? Do you think she will be presentable? Give her six months, and she will regain them'. And she was my best friend for 16 years. I see this as her being envious. Because back then, when I was skinnier, she used to be overlooked. And I became fat. She gained attention.

Both Mona and Sophie highlight that there was an implicit ranking system and competition amongst women and that fat women are not viewed as a threat. Multiple participants also reported that their friends would never take pictures with them and that they were always the person behind the camera. Daisy explained, "I would rarely feel comfortable going out with them, but when I would actually do it, I would always feel bad after. They would always post the pictures that I wasn't in, and it's like, why don't you want to be publicly associated with me? Does my body ruin your pretty vibe and image?"

F. Fatphobia as Inherent to Lebanon

Five participants framed the fatphobia they encountered as a problem inherent to Lebanese society. Three participants compared societal beauty standards to those of

countries in the Arab Gulf. Sophie said, "If you notice this in Lebanon, there are no clothes. Last year I was shopping in UAE, they had big sizes, up to 52. Here, 42 is the biggest size. And like the shopkeepers make you feel judged. There, it is normal." Hiba, who lives in Qatar, also said, "My coworker tells me, 'You Lebanese women want to die skinny and wearing high heels,' and I reply to her, 'so true.' She explained that even when she was fatter there, she was still perceived as attractive by the community and that she gained weight when she did not come to Lebanon. In Lebanon, she feels surveilled. Mona repeatedly mentioned how she believed that Lebanon is extremely patriarchal, and women's bodies are constantly assessed by how "marriageable" they are. "In Lebanon, a certain pressure exists to be a 3arous (bride), even if you don't want to get married, especially when you live in the villages. They always ask, who will take such a bride? They don't even care if you want to get married."

2. The Consequences of Being Socialized as Fat Women

The second major theme present in all participants was the effects of being socialized as fat women on the participants' self-perception. This central theme was made up of four subthemes: (a) Fatness as a failure, (b) The shame and guilt of living in a fat body, (c) Fatness as Liminal, (d) Internalized Fatphobia.

A. Fatness as a Failure

All seven participants expressed some variation of this theme. In their accounts, participants explained how they believed their fatness affected other aspects of their life. For example, Jana reported,

> I have lost a lot of my life, and it even affected my life choices because I was so terrified of failing. My self-confidence, how I perceive myself at work, how

I talk to people, how I present myself, even my choices in the guy I am with… everything.

Reem expressed similar feelings about a general sense of failure:

> If I lost weight, so many things in my life would be better. I would want to go out more, wear certain clothes, feel lighter, and not feel guilty or like a failure. What is weird is that when you live success in other things, in your career…. It doesn't compensate for your frustration on this topic…. It robs you of your success; I feel like a failure.

Some participants' perceptions of themselves as failures were so pervasive that they found themselves in self-fulfilling prophecy narratives. For example, Mona said, "I was so convinced I was a failure that I would choose men that would not date me, that I knew were not attracted to me, some weren't even attracted to women at all! [laughs]" The way Mona was socialized to believe that her body is not desirable impacted her behavior and propelled her into a cycle of failure.

Most participants engaged in compensatory behavior to compensate for feeling like failures. Daisy says, "I was at the top of my class. I made sure there were no perceivable flaws in me that I couldn't control: I was a good student, a well-behaved daughter, and a funny and supportive friend. I was everything except skinny, and they still made me feel like I wasn't successful." Mona, Reem, Jana, and Hiba echoed similar sentiments.

B. Shame and Guilt

All participants expressed complex feelings of shame and guilt existing in their fat bodies, ranging from embarrassment going out to guilt eating food. For example, Dana said, "I used to go out with my friends to the pool. I was too ashamed to wear a two-piece. I always felt like I was going to be laughed at." Similarly, Mona said, "Being

fat made me introverted and made me stay at home; not having clothing options used to really embarrass me. I was also ashamed of going to a restaurant with my friends and finding out that the seats didn't fit me. I was living in a constant state of anxiety."

Daisy explained, "I felt like I was embarrassing the people I would be hanging out with. And it is very weird because most teenagers have insecurities, right? But usually, it's something you can cover up, like acne with makeup or shaving hairy arms. But being fat can't be hidden like that."

The way these participants were socialized contributed to their feelings of guilt eating, their issues with moralizing food, and, by extension, creating unhealthy relationships with food. For example, Hiba said, "If I overate and do bad things, like eat a lot of chocolate, my mom would yell at me, and I would feel guilty" Hiba's usage of the word "bad" to describe eating points to the fact that she has issues with moralizing food.

Jana also used to compare her portions to her smaller peers, saying, "I always ate clean and healthy. I never ate fries, and I never ate a full Man'oushe, but my skinny friends would eat a full one with a chocolate bar after, while I would eat half Man'oushe. I would live with the guilt."

Mona, Dana, and Sophie said they had a "snacking *problem*." Reem, Jana, and Daisy reported that they had an "emotional eating problem," and Hiba noted, "Food is an addiction." These participants openly acknowledge that despite their physical weight loss, their approach to food and eating, especially eating in response to stressors, continues to exist.

Hiba's use of the term "addiction" to describe food captures a pathologized view of herself, her body, and food.

C. Fatness as Liminal

The subtheme of fatness as liminal, temporary, and inherently fixable was present in all seven participants. Dana compared her fatness to the skin of a snake, saying, “I wanted to be like a snake because a snake is able to shed its skin, so I wanted to shed my body aside.” Most participants said they felt like their life was on hold and that it would not truly start until they lost weight.

Jana communicated this by saying, “All my life, I felt like I wasn’t living and that someday I will, someday I will get there, someday it will happen. My life will start when I lose weight as if you’re going to die and be reborn in a new body and life.” Daisy communicated a similar experience.

“I would always imagine future me as skinny, the girl that gets to go to her dream university and live in her dream house and marry her dream man? Yeah, she was skinny. Like the “real me” in my head wasn’t fat.”

D. Internalized Fatphobia

The subtheme of internalizing fatphobia and therefore harboring misconceptions about fatness and projecting fatphobia on others was present in all participants. Most participants explained that they project fatphobic ideas on other fat people. Reem said, “I project on people as if they’re me, that they are unable to control this issue and are unhappy about it.” Similarly, Sophie said, “I know how hard they’re trying; they must be suffering, I wish I could tell them they can do the sleeve surgery, and it’ll go away.”

Daisy discussed how much she used to project her insecurities on others:

> Man, I used to hate fat people. I used to feel so excited when someone fatter than me was in the room. I would walk into a room and assess every single person praying to God I would not be the fattest girl. I kind of still do it sometimes, like I forget that I look different now. I know it’s bad, but I can’t help it.

Some participants believed that they did not harbor such sentiments, but some things they said reflected otherwise. For example, Hiba said, “I am very jealous of super fat women that are confident.” However, she did express implicitly fatphobic attitudes when she described her friend’s body before weight loss surgery as “very fat, not a nice look.” Other statements were more subtle; for example, when discussing when she believes someone should get the surgery, Jana said, “Deal with your emotions, solve the issues related to emotional eating, and then if you want to do it, do it.” This statement includes misconceptions about fatness being inherently caused by emotional eating.

3. Navigating Uncertainty and Change Throughout the Weight Loss Surgery Journey

A. Aesthetically Driven Reasons to Undergo Weight Loss Surgery

Six of seven participants cited being driven by a desire to lose weight for aesthetic reasons. The younger participants, Daisy, Dana, and Sophie, were encouraged by their parents. As Daisy explains,

> When I turned 16, my father asked me if I wanted to do the sleeve surgery. He said he wanted me to look great during my graduation and didn’t want me to be ugly in college. I cried myself to sleep that night. But then I tried dieting my senior year, and nothing worked, and I had been yo-yo dieting for almost seven years. I didn’t want that to be the rest of my life. I was starting a new chapter. I wanted to do it as my best self.

Dana explained that she partly did the surgery to please her mother “I am someone who is very much a people pleaser, which is partly why I went with it, and partly because I wanted my body type to change. I wanted to put on something and for it to fit perfectly, not to feel like I am fat.”

Sophie's mother's insistence that she undergoes weight loss surgery was the reason she had an Intragastric balloon placed. Still, after this surgery "failed," and she gained more weight a year later, she decided to undergo gastric sleeve surgery. "I used to be big, from my waist down, never in my belly. But then, when I started university, I started having a bigger belly. This was my, my biggest, "No, no, no." I went back to the surgeon, we had the money now, and I did the sleeve."

Jana and Reem were tired of yo-yo dieting and were surrounded by multiple people who had undergone weight loss surgery and lost weight. Jana explains, "I was desperate to lose weight. I was sick of this yo-yo my entire life, and I thought if I did it, I would reach the "until" life. I also saw my cousin's successful weight loss with the sleeve, so I was convinced."

Only one participant underwent surgery because of health concerns, and she was conflicted and hesitant to do it. She explained her hesitation and said, "I started getting high blood pressure. I felt conflicted: I didn't want to do the surgery to please other people, but I wasn't happy being 170 kgs and having high blood pressure at 34; I felt like I wasn't being fair to myself. And the health scare was serious, and it wasn't getting solved. I also developed insulin resistance and was developing a chronic case of polycystic ovarian syndrome. My ob-gyn told me, you will reach 200 kgs, and your health will get worse."

When asked about what type of research they did before committing to the surgery, most participants said they didn't do much. Two participants, Dana and Daisy, watched YouTube videos of people who had undergone gastric sleeve surgery. Reem and Jana relied on word of mouth from the people they knew who had undergone weight loss surgery. Hiba and Sophie did in-depth online research. However, Sophie seemed misinformed about certain concepts. For example, she said,

> I did a lot of research and knew the risks. At first, I didn't want to do the gastric sleeve. I wanted to do the bypass, but I didn't do it because, for women, it has a lot of side effects that are dangerous. There's a huge possibility you wouldn't be able to bear children, or you could bear children and have trouble during labor, which is a big no-no to me because I want to be a mother. Bypass is trickier than sleeve because you have to take supplements for your whole life, while when you do the sleeve, you only have to take them the first year.

None of the statements she made are supported by evidence in the literature reviewed, but she seemed to believe them, which makes the type of research she conducted questionable.

None of these participants underwent any psychological evaluations, counseling, or educational and informative sessions pre-operation. They were given the post-operation diet plan and told they needed to change their lifestyle to lose weight. Dana's account echoes those of five other participants: "They told me to follow a diet plan and take my vitamins, but they didn't really tell me why. I think they expect you to just know this stuff, but it is their job."

B. Physical Changes

Weight loss surgery entails physical changes beyond weight loss, many of which most participants in this study were not aware of.

Two participants developed side effects that required surgical intervention. Mona needed a cholecystectomy, and Reem developed a hernia. Both expressed their frustration with not being informed of such possible developments. Reem said, "The pain was worse than the sleeve. I was very upset, and it really bothered me for almost a year." Three participants developed acid reflux, and three participants regularly experienced pain eating. "I've been having pain in my right side, in my abdomen, for

over three years. I might be lactose intolerant or something after the surgery. When I eat something that is full fat, I get pain." Jana and Daisy reported pain and bloating anytime they ate anything. Sophie, Jana, and Daisy reported their inability to digest oily food but viewed this as a satisfying outcome, as they didn't want to consume it anymore to keep off the weight. Daisy says, "The pain is a physical reminder that oily food should be avoided. It's like having an alarm in your stomach."

Five participants complained about loose skin after rapid weight loss. Hiba said, "I had to get my boobs done because I couldn't handle the saggy skin." While Daisy said, "I can't afford body contouring, so I am stuck with this body for now, but it is not as big of a problem. It's easier to hide."

Four participants complained about the existence of their surgical scars.

C. (Adjusting) Expectations

All seven participants expected drastic weight loss before their surgery and had to adjust their expectations. As Daisy puts it, "I was imagining an ugly duckling scenario. I thought my life would change overnight." Mona and Jana went into the surgery expecting to "become supermodels," while Reem expected to lose as much weight as the people who recommended the surgery to her. Reem expressed her frustration by saying, "I expected to lose 50 kgs like my sister-in-law and my friend. I've only lost 26-27 kgs. I didn't even reach the weight that I reached when I was just dieting two years before the surgery! My sister-in-law lives off chocolate! And she still hasn't gained weight."

Multiple participants believe that the reason they have not lost as much weight as they expected they would is that they had not been following the post-surgical diet plan given to them. Reem said, "Maybe it's my fault for not following the diet plan I

was given after the surgery, but like, if I wanted to follow a diet, I would've just dieted! So, the biggest help has been portion control."

Echoing Reem's sentiment, Jana said, "I didn't lose the weight I was told I would because I didn't eat as I was instructed; I wasn't eating chicken breast and broccoli. If I wanted to just eat chicken breast and broccoli, I would have simply dieted."

At first, Daisy employed the same argument to discuss her slow weight loss, but later in the interview, she shared the following:

> At first, I was not losing weight as fast as the people I saw online. They would say things like, "I lost 6 kgs in two weeks!" meanwhile, I was only losing two. I felt like a failure, but I was literally not eating anything, so what else was I supposed to do? I was so angry, and my surgeon asked me if I was cheating. How can I cheat when even drinking water hurts? He thought I was so addicted to eating that not even the surgery could stop me. This persisted for a while, I was losing weight but painfully slow, and I didn't know what to do anymore. Around six months after, I went to an endocrinologist, and she figured out that I had a metabolic disorder. And with treatment, I started losing weight faster. Sometimes I wonder if I knew this before, I would have lost the weight and not needed the surgery, maybe if I just did some blood tests eight months ago, but then I try to eat an entire burger, and my stomach screams, 'OUCH OUCH OUCH,' so I stop eating, and I am thankful for the surgery.

D. Relationship With Food

Participants had varying experiences with embodying eating post-surgery. Some participants were not able to adjust the amount of food they desired to the amount they could physically eat. For example, Jana said, "For a year: anytime I ate, I would throw

up because it (the surgery) doesn't control your mind, so you would eat too much and then throw up."

Other participants' relationship with food improved for some time, but after regaining some weight, they felt like they were back to thinking about food obsessively. Reem said, "Around one year after surgery, I felt like my relationship with food improved because I started eating less and was no longer constantly thinking about food, which was the case for my entire life. Recently, after I gained 6 kgs, I am back to the same problem. I obsessively think about food every day. Every day I think to myself that I don't want to gain weight again. What am I going to do?" Like Reem, Hiba obsessively thinks about food, saying, "I am a very good patient, I see a dietician, and I follow my diet plan. I totally believe that the key to the stomach is one bite. When you take the first bite, you lose control. So, I have to convince myself not to eat."

Daisy explained that while she still enjoys food, the socialization aspect of it is no longer comfortable for her. "It's a bit embarrassing to eat out with friends; I would rather go out for coffee or something; I don't want people to notice my portions! The other day we went out for lunch, and when I only had two slices of pizza, when my friends started saying I didn't eat enough, I had to lie and say I ate at home. [sighs]."

Mona's relationship with food improved after weight loss surgery. She said, "The surgery was a tool; it helped me learn, for example, what food I like and what I dislike. When people make you feel like you are the wrong person, the pressure of being in the wrong body, you don't know how to perceive yourself. I am now learning my food and eating preferences."

4. Navigating the Body in its Relational Context throughout the Weight Loss Surgery Journey

A. Weight Loss (Surgery) As a Responsibility

All seven participants viewed undergoing their respective surgeries as a personal responsibility. Jana said she "felt responsible because I wanted to fit in, and so people take me more seriously, they listen to you more…" Sophie said. "It was my responsibility to lose weight because my mom really affects my mental health. So, whenever she used to nag nag nag, I used to eat eat eat. Then when I lose weight, she stops nagging, and we were always stuck in this circle." Sophie believed gastric sleeve surgery would break this cycle. Daisy explained that despite knowing that her weight was not entirely her fault, she needed to do whatever it took. "I felt like I owed it to myself to lose weight. I know it's partly genetic, but I wanted to have a good life, so I was responsible for making it happen, whatever it takes."

B. Changes in Social Life

Six participants experienced positive changes in their social lives. Mona explains, "People's perception of me has changed; they look at me now and see a lady. There is more respect now, which is cruel [sighs], but thank God. I feel feminine; I can wear dresses now."

Sophie says, "Now I'm not just visible as a friend. I'm more visible as a lady, as a girl, and as a woman. Before, it was like, okay, she's one of the boys. Now, I'm more of one of the girls. I do feel more seen and heard."

Jana expressed her frustration with this shift: "When you do the surgery and lose weight and see how everyone's attitude shifts towards you, you will be disappointed in them." Daisy constantly fluctuated between feelings of satisfaction and anger, "I like that people are nicer now, but it makes me angry because sometimes I forget that I have physically changed like my mind has not caught up, so I am still the same person, right? But they treat me so differently, even though only my body has changed. Like how shallow are you?" Some participants' families explicitly stated that by losing

weight, they were now “marriage material.” Daisy reported her mother saying, “You are so beautiful now. I can finally imagine you in the white dress.” Dana said that her grandmother told her sister, “I’m glad she lost weight, or no one would have married her.”

Conversely, Reem, who did not lose as much weight as was expected, has encountered extra surveillance and judgment from her family and friends. She said, “No one is satisfied with the results. The people around me will say look at her. She lost 45-50 kgs, and you only lost this amount? So, your surgery failed.” Four participants discussed feeling a constant sense of surveillance from the people who do know about the surgery. “My family and people that know closely monitor my weight. Even if they don’t say it, I feel it,” explains Dana.

Five of the seven participants do not disclose having undergone weight loss surgery because of fear of being judged. As Jana puts it,

> I felt like I didn’t want to be pointed at and judged anymore, and the fear of failure was there. It also feels very personal; I don’t want to open a discussion about my body. People feel like they have the authority, the right, to give their advice. Why didn’t you try this medication first? Why haven’t you tried this diet…

Other participants wanted to distance themselves from the fat identity, like Daisy, who said,

> I don’t want people to know I was fat, not that there’s anything wrong with being fat! I don’t want to be the fat friend again. I like being treated normally, you know. People are weird about the surgery. They want you to lose weight, but when you tell them it’s surgically, they act like you’ve done the most insane thing on the planet? You wanted me to lose the weight; I lost the weight.

Four participants disclosed that they lied about the surgery scars, saying they were from an appendectomy, ovarian cyst removal, or uterine fibroids.

C. Post-surgical Attitudes Towards Bodies

Participants in this study had varying views concerning their relationship with their bodies and their perception of fatness now. Daisy and Sophie seemed to harbor negative feelings toward fat individuals.

Daisy says, "I feel very conflicted about it. I know how hard it is to be a fat person, but I also feel angry when I look at them, like I feel like they aren't trying hard enough to be respected, even though I know that it is not fair! Like, I am not okay with bullying or anything. But I was able to do it. Stop being lazy."

Sophie felt strongly about people who undergo weight loss surgery and still end up gaining weight. She said, "I eat chocolate, I eat chips, I eat whatever I used to eat. It's just in smaller amounts. So, if you want to finish the whole bag of chips or the whole sandwich. Honestly, you're a hopeless case. This is very toxic, you did surgery, and it is painful to eat. If you don't want to have a better life for yourself, then it's your fault. The sleeve does work for everyone."

On the other hand, two participants made peace with their bigger body size post-surgery. As Dana puts it, "I'm happy with my decision, not fully happy, but I am happy with it. I'm still seeing progress but still regained a bit of weight; I realized my body type is like this. For example, I wear size Large now, so it's like this is my body type; it seems like my body is like this."

Similarly, Jana explains how the surgery helped her overcome the idea that her life would not truly start until she lost weight, but not how she thought it would.

> If I didn't do the surgery, I would've kept thinking that my "until" life won't happen until I did it, so I broke this barrier. You did it, nothing has changed,

and there is no more "until." I don't strive for a "perfect body" anymore, but I would like to be more comfortable in my skin; I would like to move more and not be bloated… I don't want to stop eating burgers or ice cream; I want to enjoy my life.

Reem explained that she now feels like a bigger failure than she did before. She says, "When I have stressors in my life, and I go to stress eat because I have done the sleeve, it causes more guilt. Look at you; you did the surgery and suffered; imagine if I gained weight. How would I see myself, and how would others see me? What will they say about me? Look at her. She is such a failure, and she really loves food."

On the other hand, Mona explains how even though people believe that her surgery failed because she is not thin, she feels good about her decision. "I am fat, and that is okay because I now recognize myself. I started taking pictures and recognizing myself. I exist in this body; I am taking care of this body. I don't care what weight I reach or how it looks. Weight loss surgery didn't turn me into a mannequin but made me live in my body, understand it, and love it more."

All participants discussed fear of weight regain to varying degrees. Throughout our interview, Hiba repeatedly emphasized that she is terrified of weight regain. "I am terrified of gaining weight; I would do the surgery over and over again until I die. I don't care how much money I have to spend; I will do it." She seemed aware that her approach was not healthy because she said, "I am not able to drag myself out of this vicious circle. I would rather stay in this vicious cycle and remain skinny." Even participants who have accepted their bodies as naturally bigger have a fear of weight gain to a certain extent.

4- The Effects of Socioeconomic Status and Environment

Throughout the interviews, it was revealed that most participants' socioeconomic status and environment had a substantial effect on their body weight and access to surgery.

Six participants discussed their struggle with eating healthy growing up because their environment did not allow it, despite constant pressure on them to do so. These participants were expected to lose weight but were not given the right tools to do so. For example, Daisy explained,

> Dieting was always hard, honestly. I was the only person following a diet at home, and my mom couldn't just cook two different lunches every day, you know? So, she would make fried chicken multiple times a week, and I would eat it. Then I would weigh myself, and I didn't lose weight. And I was the only fat person at home, so everyone thought I was the problem, not the food. So, I started skipping meals instead. Not that I blame my mother. She was a teacher and would have to come home and cook. I didn't expect her to cook twice.

Dana shared a similar experience: "I had mom always telling me, "You need to lose weight." She used to police us, my sister and me: don't eat at night, stop eating sugar… but there wasn't this healthy environment at home. The food wasn't healthy; the lifestyle wasn't healthy, so you can't expect the child to become healthy when everything around them is unhealthy. It's not fair."

After her hypothyroidism diagnosis, surgery, and the subsequent cancer scare, Mona experienced some financial difficulties. "I started working a lot. I was not doing well financially. I was working a lot, and I was sedentary; I never moved. And the whole time, I was punishing myself for not being the right woman. I gained around 60 kgs in a year." Then, she explained that a shift in her socioeconomic status allowed her to pursue weight loss surgery during Lebanon's economic collapse. "When I did the

surgery in 2020, I had a stable job with insurance which I didn't have before. The economic crisis was just starting, and I did not pay a single lira. Sometimes I think if a different lifestyle were available, maybe I would not have reached this weight, and my health wouldn't have been compromised." On the other hand, Jana regrets spending money on a surgery that did not give her satisfactory results during an economic crisis and pandemic. "I feel very guilty; I paid in fresh dollars," she says.

Financial issues even affected Sophie's surgery options. Because of the higher cost of gastric sleeve surgery, Sophie's mother convinced her to place the intragastric balloon instead. "So, we went to my first doctor; he told us a price. Back then, my mom did not have the full amount, so she was like, no, this is too much, so we ended up going to a different doctor and doing the balloon, which was way cheaper, but the side effects were really bad."

Some participants were able to find a way around the high cost of gastric sleeve surgery. Three participants were fat but not "obese enough" to qualify to do the surgery on social services and were advised by their surgeons to gain more weight before the surgery.

Daisy said, "When I decided to do the surgery, I was 11 kg below the weight I would need to be eligible to do it for free. We could not afford the surgery, so the surgeon told me that if I wanted to do it, I needed to gain some weight. The doctor told me to eat whatever I wanted; he told me to consider it a month-long cheat meal. And I did." When asked about the consultation process pre-operation, Dana said, "I went to the surgeon once, then they started feeding me to gain weight, to do it on social services."

Only one participant, Hiba, came from a wealthy background. Throughout the interview, she expressed that when she did the surgery, she was in a "first class, class A, hospital room," and said, "I would do the surgery again. Money is not a problem as

long as I look good." She is also the only participant that has performed other elective interventions, such as breast augmentation, because of the skin sagging post-operation and regularly does dermal fillers.

Daisy expressed her frustration with not being able to undergo operations to counter the sagging, like excess skin removal or breast augmentation, because she is unable to afford them.

> I want to get rid of the extra skin, but it's so expensive. And I am a university student, and I am working to pay my tuition, which is my priority, obviously. As soon as I save up some money, I am fixing this. When I complain about the loose skin, my mom tells me to join the gym. With what time? I finish my classes and go straight to work, then I go home and study until midnight. I don't have the time.

Ethical Considerations

Five participants expressed their frustration with how underinformed they were. As Dana said, "They tell you, 'You have to follow the diet plan and take your supplements,' but they don't tell you why. They just expect you to know these things." Mona and Reem were especially frustrated because their post-surgical complications necessitated surgical intervention. "If they told me this might happen, I don't know if I would have done the surgery," said Reem when asked about her hernia.

Three participants reported feeling judged by their surgeons. Jana elaborated, "It is so annoying because my BMI was around 30. I consulted a surgeon first, and he took one look at me and said *You? You definitely need the sleeve. Look at your body*. It felt like a slap to the face. They were like, what's wrong with you? How are you still alive?"

Daisy, on the other hand, shared the following, “It was the worst pain I’ve ever experienced in my life. When I saw my surgeon after the surgery, I asked him why he did not tell me it would be this painful. He laughed and said we cut your stomach off. What did you expect? [scoffs] Can you believe him?”

Hiba spoke highly of her surgeon’s skills, but her account brought some ethical concerns to light. “I talked to him over the phone when I was in Qatar and told him I wanted to do the surgery when I came to Lebanon. We agreed on that. Then when I came to do the surgery, he saw that I was not that fat. The surgeon told my mom that if he hadn’t promised me, he would not do the surgery. He said that if he had seen me before, he would not have agreed to do the surgery.” It is peculiar that the pre-surgical procedure was a simple phone call, and the fact that he agreed to perform the surgery despite his opinion that she did not need one.

Jana repeatedly criticized the pre-operational procedure, saying, “Weight loss surgery is being done in the wrong approach here. There is no right guidance. It is only commercial. A surgeon’s job is to do surgery; that is their job, to cut. I think the surgeons doing these surgeries should be working alongside other doctors… there should be a committee to make a proper assessment.”

CHAPTER FIVE

DISCUSSION

In this section, the findings of this study will be examined in light of the empirical and theoretical results and concepts discussed in the literature review, as well as other relevant material that can provide further context. Including additional material aligns with IPA, which recognizes that "it is in the nature of IPA that the interview and analysis will have taken you into new and unanticipated territory" (Smith et al., 2009: p.113).

Five main themes and many subthemes central to the experiences of the seven interviewed participants were unpacked in this analysis. These themes answered the research question: What are the intersecting reasons that drive women to seek weight loss surgery?

This research is an extension of the existing literature about fatness, gender, and sexuality.

Parents of Fat Children

A recurring theme throughout the interviews was the fatphobia participants experienced from their parents (1A). This might partly be caused by parents of fat children often being blamed for their children's fatness and being perceived as bad parents (Lee et al., 2021). Research shows that these parents, especially mothers, often encounter negative comments and have their parenting skills criticized, causing feelings of guilt and shame (Gorlick et al., 2021). While this might explain parents' pressure and subsequent behavior, it does not excuse it.

Fatness & Gender

The pre-surgical accounts of each participant unpacked a gendered aspect of their weight. Participants frequently described their reasons for wanting to lose weight using feminine language, such as their wish to be perceived as "beautiful" and "girly." They considered being thin an essential part of their gender embodiment (Boero, 2012; Murray, 2008), not feeling "woman" enough as a fat woman. Most participants complained about being perceived as "one of the boys." Participants were extremely bothered by this perception, feeling like they were being associated with masculinity, which none of them connected to. When analyzed through Butler's notion of gender performativity, where gender is socially constructed and performed through our social interactions and behaviors (Butler, 1990), because of the norms and expectations of our society, fat women are assigned inherently masculine traits, reinforcing the notion that fatness is not feminine.

All participants related to Gailey's (2014) phenomena of hyper(in)visibility as fat women. They felt hypervisible and othered because of their bigger body size, but their needs, personhood, and traits beyond their fatness were often disregarded, making them hyperinvisible. Several participants reported becoming more visible as women after undergoing weight loss surgery (4B). They discussed finally being perceived as women and shedding the "one of the boys" identity (4B). This reiterates Boero's (2012) findings, in which she contends that after their surgeries, bariatric patients experience second adolescence, allowing them to engage in flirting, dating, and sexuality in ways they were unable to do when they were fat. These women finally understand heterosexuality and femininity after having weight loss surgery.

Like Kyrola and Harjunen's (2017) participants, all participants in this study considered their fatness a "phase" they would eventually get out of. They perceived

their fatness as liminal, using terms like “shed my body aside” and the existence of a “real me” underneath their fat self.

Sexuality

When they were fat, participants felt stripped of their femininity and sexuality and felt like they were not perceived as romantic options (1B). Most of my participants discussed how their fatness affected their ability to navigate the heterosexual dating scene, from men waiting until they lost weight to express romantic interest in them to not being perceived as an appropriate marriage option. Participants expressed an array of experiences that affected their sexuality.

After weight loss surgery, several participants started “relearning heterosexuality.” (Boero, 2012, p. 105). Evoking Adrienne Rich’s (1980) concept of “compulsory heterosexuality,” these participants were becoming a viable romantic partners or proper brides after weight loss (3E) implies that these women have finally fulfilled the societal expectation that thinness is the ideal type for a woman for her to be desired by men. This social shift affected some participants drastically, to the point where some of them found instances of sexual harassment and catcalling flattering, echoing Boero’s (2012) findings.

Fatness & Fashion

All participants in this study discussed fashion and having trouble shopping as one of their main concerns as fat women (1C). Fashion and dressing are conceptualized as “situated bodily practices” (Entwistle, 2015), referring to the notion that how we dress is essential to the performance of our embodied identities and how our bodies are viewed within societal norms. Entwistle contends that clothing is a byproduct of culture and social forces that have an impact on how we traverse the world, contending that investigating the social and political influences that influence our clothing choices and how they impact our experiences in various places is crucial (Entwistle, 2015).

The fashion industry contributes to the stigma against larger bodies, especially fat women. In her study of fashion students' perceptions and beliefs surrounding fatness, Christel (2014) found that they had strong negative sentiments toward larger individuals. As future gatekeepers and designers, this partly explains participants' struggles to find fashionable, inclusive designs. The options available to fat women shoppers restrict their capacity to use clothing to represent their identity (Peters, 2017). After losing weight, participants were finally able to express their femininity through their clothing.

Participants' inability to find fashionable clothes in Lebanon appears to be the main reason they consider fatphobia as an inherently Lebanese thing and not present in other (Arab) countries (1F), where they were able to find plus-size clothing. Anti-fat stigma is actually prevalent in countries in the Arab Gulf, in the United Arab Emirates (O'Hara et al., 2016; Weaver, 2017), and in Qatar (O'Hara et al., 2021).

Anti-fat Bias and Fat Shaming

All participants in this study encountered fat shaming growing up from different sources, as shown throughout overarching theme 1. Several participants believed that the people engaging in this behavior were well-intentioned yet acknowledged the harm they did (Lewis et al., 2011). Mirroring the existing literature (Meulman, 2019), fat shaming propelled them into stress eating, throwing them into a cycle of shame and gain. This shame-based approach did not work, not only because some participants did not have access to healthy food options and exercise opportunities because of time limitations and financial constraints (Hill, 2016) but also because they were children when they started encountering shame-centered comments. As children, they were held responsible for their fatness and were encouraged to "fix" it through disordered manners, sometimes by their parents.

Experiencing fat shaming and anti-fat bias throughout their lives had varying effects on participants' sense of self, from feeling like failures (2A) to feeling guilty (2B) and internalizing fatphobia (2D). Their engagement with fat-phobic discourses reflects existing literature, which explains that fat women are aware of and continuously affected by fat-phobic stereotypes and anti-fat beliefs (Puhl & Heuer, 2010). Participants felt judged, scrutinized, and observed living in fat bodies. Most participants reported not feeling comfortable going to the beach, to the gym, or engaging in nightlife or social dining. Similarly, Lewis et al.'s (2011) participants explained that they often avoided certain physical activities or refrained from eating certain foods in front of others due to the fear of being judged.

Participants discussed the exhaustion they felt because of how they were socialized (2A, 2B, 2C, 2D, 2E). By internalizing anti-fat bias, participants experienced negative body image, anxiety, depression, and increased emotional and binge eating (Hilbert et al., 2013).

They often reported performing compensatory behaviors so that fatness would not be their defining trait. Multiple participants resorted to academic validation to distance themselves from it, while some participants would compare themselves to other fat women (2D). Asbury (2011) proposed that fat individuals tend to employ identity protective strategies, including distancing themselves from their larger body status or comparing themselves favorably to those with larger bodies (2D).

Anti-fat stigma significantly impacted the lives of all the participants, even after they lost weight (Lier et al., 2015). Participants who successfully lost weight and shed the fat identity reported changes in their social interactions (4B). Despite enjoying these changes, adjusting to the shift in their social standing took time. Participants often reflected on their pre-surgery social life, reporting feelings of resentment and

anger, which was the case for Natvik et al.'s (2013) participants. When participants who lost a significant amount of weight receive positive remarks from people, they feel like their former fat embodiment is being scrutinized. Despite undergoing weight loss surgery so their weight no longer affects their social life, weight remains a dominant conversation point.

The tensions described by the participants appear to reflect a gap between their past and present bodies, leading to a sort of "residual stigmatization" (Lier et al., 2015: p.5) that persisted despite feeling more accepted. On the other hand, participants who lost a significant amount of weight but not enough weight to shed the fat identity (3C, 4B) continue to be perceived as failures.

Healthism and its Consequences

Lee and Pause (2016) have argued that when health is viewed as primarily determined by an individual's behaviors, it leads to medicalizing every choice made throughout life. This view suggests that a person's bad health is their own responsibility, making them more susceptible to criticism and scorn. The notion of health becomes similar to religious morality, indicating personal character and value. This perspective can result in discrimination based on an individual's perceived or actual health status. It is limited in its definition of health, as it primarily focuses on physical appearance and body size as indicators of good health.

Not only did participants encounter healthism discourses in their social life, but they also encountered them from medical professionals (1D), further cementing weight loss as their personal responsibility (4A).

All participants reported yo-yo dieting for years before undergoing weight loss surgery, explaining that all attempts of non-surgical attempts were unsuccessful. Research shows that long-term weight loss surgery attempts are often ineffective

(Evert, 2017). People who try to lose weight give up and fail to achieve clinically significant or maintained weight loss (Evert, 2017; Gill et al., 2012). Some research suggests that this is because people are more prone to give up on their weight loss efforts when they have unrealistic expectations for weight loss (Grave et al., 2005). However, weight is more complex than just "calories in, calories out."

Body weight is not solely determined by behavior but is also impacted by genetics, social and economic environment, and physical environment (Bortz, 2005). A person's environment and lifestyle account for about half of their weight variance, with genetics accounting for the other half (Evert & Franz, 2017). Fifty-nine distinct forms of fatness have been identified, and 25 genes with strong effects on body size have been identified (Farooqi, 2016).

The social environment, often identified as the social determinant of health, is an understudied factor that affects body size (Braveman, Egerter, & Williams, 2011). An individual's body size is influenced by a variety of factors, including socioeconomic status, educational opportunity, neighborhood characteristics, employment opportunities, income, race, time, stress, and the health status of family members (Braveman et al., 2011; Marmot, 2005; Wilkinson & Marmot, 2003). When body size is portrayed as primarily determined by one's behavior, fatness is equated with a disease, and weight loss is conceptualized as attainable for everyone, and these crucial nuances are overlooked (Chrisler, 2012). Each variable has its own causes, effects, and contributing factors, yet weight loss is generally perceived as achievable and a one-size-fits-all issue.

Participants' fatness was often catastrophized, with family (1A) and medical professionals (1D), contributing to their misconceptions about fatness. For example, several participants viewed food as addiction and had various misconceptions about

body weight and health (1D, 2D), most of which were influenced by how they were socialized and the healthism discourses and stereotypes they were exposed to growing up.

All participants tended to moralize food, categorizing eating certain things as "bad" and others as "good" and "clean" (2B). Associating morality with food is rooted in anti-fat bias (Strings, 2019). These participants deal with even more heightened feelings of guilt and issues with moralizing food because they could not change their "lifestyle" as was required post-operation (4c, 5). Part of healthism is expecting weight loss surgery recipients to be good patients (3G). After weight loss surgery, they are expected to know how to and be able to change their lifestyles, take their medication and vitamins regularly, and monitor their weight. When patients do not engage in these behaviors, they are blamed for harming their health and are held responsible for the surgery's potential failure (Salant and Santry, 2006).

Despite weight loss surgery being discursively positioned as a health-concerned intervention (Salant and Santry, 2006), only one participant in this study was driven by health reasons to undergo weight loss surgery, while the majority of participants were driven by aesthetic reasons to be thin. All participants perceived weight loss surgery as personal responsibility and weight loss as self-care, like Throsby's (2008b) participants.

Participants felt like they did not know enough before undergoing weight loss surgery, and some had various misconceptions about the operation and its consequences. Some participants reported confusion at the lack of an in-depth assessment stage (3A, II) and feeling underprepared for their postoperative lives. They felt like the advice they were given was too generalized (3C). Participants, especially those who struggle with emotional and stress eating, felt there was a failure to address

their emotional and psychological needs post-operation. While the findings of this study align with multiple studies (Boero, 2012; Throsby, 2012), it is essential to acknowledge that weight loss surgery recipients in the United States and the United Kingdom who are interviewed in other studies received counseling and educational sessions and underwent psychological evaluations pre-operation and post-operation, which participants in this study did not, further widening the gap. The most frustrated participants were the ones who developed severe side effects which necessitated surgical intervention (3B, II).

Treating the Stomach as the Site of the "Problem" and its Consequences

According to Groven et al. (2012), while gastric bypass surgery causes irreversible physiological changes, eating habits and desires are infused with social, cultural, and personal values. They cannot be reduced to one organ. However, several participants underwent bariatric weight loss surgery, discursively treating the stomach and appetite as the site of the problem, despite portion sizes not being the main factor causing their fatness. Participants had a variety of elements influencing their weight, including genetics, metabolic disorders (3C), socioeconomic stressors (5), time constraints (5), and emotional stressors (1A, 2A). Most of these factors continued to exist after they underwent weight loss surgery, like emotional eating issues or metabolic disorders.

These participants deal with even more heightened guilt and issues with moralizing food because they could not change their "lifestyle" as was recommended. For example, Daisy's stomach was not the site of weight gain, but it was the site where a disciplinary measure was enacted, and she was blamed by her surgeon for her lack of rapid weight loss and was accused of being "addicted to food." Such narratives were unpacked by Salant and Santry (2006), who discovered that surgeons typically blame

patients' pre-surgical states of obesity on the ineffectiveness of non-surgical treatments, weight gain following surgery is generally explained in terms of patients' failure to adhere to prescribed diet and exercise regimens. As a result, weight loss surgery is presented to patients as both a special, necessary medical treatment and a simple surgical instrument that they must utilize correctly to prevent gaining weight back (Salant & Santry, 2006).

All participants reported a fear of weight regain after surgery. After weight loss surgery, the stigma, perception as failures, blame for weight gain, or lack of dramatic weight loss (3C, 3D, 4B) are heightened.

Several participants reported dissatisfaction with their post-surgical bodies, most of them complaining about the surgical scars and citing loose skin as their primary concern (3B). The participants' dissatisfaction with their bodies aligns with past research that has emphasized the negative effects of loose skin that many people suffer after having bariatric surgery (Boccieri et al., 2002; Groven et al., 2013; Warholm et al., 2014).

Daisy's assertion that sagging skin is easier to conceal than fatness is consistent with Groven et al.'s (2013) findings, where they highlight the contrast between the "public body," which was visible to others, and the "private body," which was only visible to the women in their study unpacking the experience of living with excess skin. In line with Smith and Farrants' (2012) study, which explores the experiences of people who receive plastic surgery after weight reduction surgery, participants in this study felt that some aspects of their bodies still need to be aligned, whether by exercise, severe dieting, or plastic surgery (3C, 5).

According to Murray (2009), bariatric treatments are typically characterized as being very straightforward operations with little risk and minimum scarring, thanks to the use of laparoscopy. She claims that this explanation underplays the "significant (and ongoing) physiological, behavioral, social, and emotional implications of living in a post-operative bariatric body and instead stresses just the modest intervention at the time of surgery" (Murray, 2009, p.158). All participants have had varying side effects after weight loss surgery, especially experiencing pain eating. Most participants perceive this stomach pain positively (3C, 3D), considering it something that helps them be more disciplined. As most participants did not change their eating habits post-operation, they relied solely on the altered size of their stomachs for portion control and monitoring through pain. Participants repeatedly complained about being required to resume the precise types of dieting habits they thought weight loss surgery would liberate them from (3C), like tracking their calories. Murray (2009) refers to this as the "biggest irony" of having a bariatric weight loss surgery.

After undergoing weight loss surgery, participants' relationships with their bodies and their perceptions of fatphobia shifted (4C). Participants who lost a lot of weight harbor negative feelings toward fat individuals, blaming them for their fatness. Participants who lost weight but not as much as they were expected and promised came to terms with their bodies being bigger, accepting that their body weight is not solely caused by their behavior but also by factors such as genetics (Evert & Franz, 2017). Because they viewed weight loss surgery as the most extreme thing one could do to achieve thinness, when they did not become thin, they accepted their bodies.

Ethical Considerations and Implications for Practice

Throughout the interviews and analysis, multiple ethical considerations were brought up.

First, none of this study's participants underwent psychological evaluations, counseling, or educational and informative sessions pre-operation. They were only given the post-operation diet plan and told they needed to change their lifestyle to lose weight.

Psychological evaluations are often a crucial part of the evaluation for weight loss surgery (NICE, 2014). For example, multiple participants discussed how psychological stressors and traumatic events fueled their eating habits. Therefore, their underlying reasons for weight gain might still exist post-operation. Patients may not be aware of the possible psychological and emotional issues they may experience following the operation, such as feelings of depression, anxiety, or body dysmorphia, without a complete psychiatric evaluation. A patient like Reem, who potentially has a binge eating disorder, still struggles despite her physical changes. Without a thorough psychological assessment pre-operation, undergoing weight loss surgery might not be the ideal course of action for people with underlying issues (Sogg and Friedman, 2015).

A psychological assessment would be crucial in cases where a person's decision to undergo surgery is driven by someone else (Torress et al., 2019), like the three participants in this study who underwent weight loss surgery as per their parents' insistence, two of whom were still teenagers at the time. Current guidelines emphasize the need for services to provide psychological support pre- and postoperatively (NICE, 2014).

Participants also repeatedly emphasized that they were unprepared for weight loss surgery. Before having weight reduction surgery, patients must have education

sessions that allow them to comprehend the process and have an in-depth understanding of the consequences and the necessary lifestyle modifications needed for long-term weight loss (Throsby, 2008). This would be an essential aspect of getting informed consent, as patients have the right to decide on their course of action in an informed manner.

Unprepared patients may not be able to follow the required post-operative care plan, which could result in unfavorable outcomes and complications, ranging from vitamin deficiencies to complications necessitating surgical interventions (Jabbour et al., 2021) (3c). From a theoretical perspective, it would be necessary for the education sessions to be given by people who have undergone weight loss surgery (Peaple, 2016). Weight loss surgery is often permanent, and navigating it is an everyday endeavor. The medical perspective of weight loss surgery does not encompass the lived, everyday experiences of people who have undergone weight loss surgery (Throsby, 2012; Murray, 2008)

The weight loss surgery medical team must include professionals beyond the surgical team (Tyrol, 2018). As discussed earlier, multiple factors, including hormones, contribute to a higher weight (5, Daisy). Potential weight loss surgery recipients should undergo an extensive medical evaluation, not just treat the stomach as the site of the "problem." Treating any pre-existing medical condition should be the focus, not the weight. The qualification criteria for weight loss surgery should be more rigorous than a high BMI and a history of failed weight loss attempts. As our participant Jana says, "… there should be a committee to make a proper assessment."

Finally, we cannot talk about health without talking about socioeconomic status and class (4). Participants discussed being told they would need to make lifestyle changes post-operations to maintain weight loss, but they were never asked if they

could. To maintain weight loss, a person's socioeconomic level can significantly impact their capacity to obtain and purchase nutritious food selections (Braveman et al., 2011). According to my respondents, patients who could not afford weight loss surgery were advised to gain weight, raise their BMI, and undergo weight loss surgery on social services. However, what about the costs beyond the surgery? Follow-ups with their surgeons and nutritionists, the price of supplements and vitamins, gym membership costs, excess skin removal surgery, and the high price of "healthy" food in a country in a state of constant economic crisis all must be considered before weight loss surgery.

Patient Respect and Surgeon Attitude

Despite the limited sample size of participants, their accounts of how their surgeons treated them throughout the medical interviews highlighted how unregulated weight loss surgery is in Lebanon. Some surgeons actively berated multiple participants and catastrophized their fatness (5); one agreed to perform surgery over the phone, and one laughed at a participant's question about the pain she was experiencing post-operation. Appraising patients' experiences and education with respect and sincerity is essential (Torress et al., 2019). Further research needs to be conducted to understand how the status of a medical doctor influences patients to the extent that they do not always feel the need to question their recommendations or the ethical standards that they may be misapplying.

Beyond weight loss surgery, it is essential to understand the multifaceted nature of fatness and the long-lasting effects fatphobic attitudes and biases have on people. We are collectively responsible for a socializing environment, and it was clear from participants' socialization as fat women that they encountered implicit and explicit fatphobia throughout their formative years.

Strengths and Limitations:

This research was designed to target the research questions concerning the lived experiences of women who have undergone weight loss surgery in Lebanon. This created several strengths but also some limitations.

This research is the first in Lebanon and the MENA region to explore fatness as socially constructed through the framework of Fat Studies. Contemporary discourses within this framework orbit the Anglo-American world, so this research was vital to avoid universalizing statements about fatness to different cultural contexts. This study's findings imply that the hegemonic discourse about fatness circulates internationally and remains a gendered experience as it transcends borders. This study is also the first qualitative research to explore bariatric weight loss surgery in Lebanon, investigating the lived experiences of people who have undergone weight loss surgery, not just through the binary medical "successes" and "failures" paradigm but through a nuanced sociocultural analysis.

Having participants who had undergone weight loss surgery at least a year before the interview allowed for a deeper understanding of their post-surgical lives because they had moved past the adjustment period experienced in the first few months post-operation.

While the small sample size might be perceived as a limitation, as it does not allow us to generalize the findings, choosing IPA allowed me to explore the lived experiences of my participants in great detail, providing a nuanced understanding of their lives. Limiting participants to women also allowed for a deeper understanding of their gender embodiment and their relationship with femininity. The fact that all participants identified as heterosexual was also a strength, as it allowed for a comparative exploration of their complex relationship with their sexualities.

Although consistent with IPA, the findings of this study are based on my interpretations of participants' accounts. This means that my findings are not necessarily generalizable or transferable. I sought to understand their lived experiences as women who have undergone weight loss surgery, which I believe this research has achieved.

Another limitation of this study was the challenges with participant selection (See Chapter 3: Methods). I was interested in interviewing women who had regained weight after weight loss surgery and exploring the failure discourses they continuously encounter, but this proved challenging. While several participants and some acquaintances (people who have not undergone weight loss surgery) discussed knowing such people, they either refused to participate in the study when contacted, or the informants did not feel comfortable reaching out to them because they believed they would be uncomfortable. The sample size of this study does not include individuals who have had entirely positive experiences with weight loss surgery. If the experiences of these individuals as women who have undergone weight loss surgery differ from my participants, then I might be missing some interesting perspectives.

Not limiting the type of surgery participants undergo might also be considered a limitation. However, the goal of this study orbits the sociocultural reality of participants' experiences, not the surgery itself.

While limiting my criteria to one gender (i.e., women) is consistent with IPA, the lived experiences of men and gender-diverse individuals who have undergone weight loss surgery remain unexplored. It would be interesting to explore the effects of hegemonic masculinity on their gender embodiment and how their experiences navigating society as fat differ and intersect with those of fat women.

Future Research

The findings of this research depict areas where further exploration is necessary.

The first area of note is conducting research about the lived experiences of fat people in Lebanon in general, not just those who have undergone weight loss surgery. There is much potential for significant and groundbreaking research to be conducted in Fat Studies as it is a new and burgeoning field. The experiences of fat people navigating education, employment, consuming media, sexuality, dating, exercise, healthcare, fashion, eating, dis/ability, and gender embodiment.

It is also essential to explore the intersections of weight, race, class, legal status, and access to healthcare. As Amy Farrell (2021) reminds us, "Intersectional feminist theory ... clarifies the ways that fatness as both an identity and as a category of discrimination and stigma must always be understood *in context* and *in relation to* other forms of identity and oppression" (p. 49).

Literature exploring such intersections exists in the USA (Harrison, 2021; Mxhalisa, 2021, Strings, 2020) but not in Lebanon, where the lived experiences of refugees and ethnic minorities under the Kafala system are rarely explored, especially in relation to their weight. Even within healthcare, there is much to be explored, from access to reproductive care (see LaMarre et al., 2020) to delay of cancer screenings (Aldrich & Hackley, 2010; Mitchell et al., 2008) and interactions with medical professionals.

It is also essential to have quantitative data measuring explicit and implicit anti-fat bias in Lebanon. Quantitative research can provide a clear picture of how pervasive and severe the stigma associated with fatness is in Lebanon. It can uncover disparities in anti-fat bias on racial, gender, age, and socioeconomic status. We can create solutions that are suited to the requirements of various communities by better understanding these differences. Such research can aid in developing focused

initiatives to reduce the stigma associated with fatness and advance inclusivity by legislators, healthcare professionals, and others.

CHAPTER SIX

CONCLUSION

Personal Reflections

As a feminist researcher, I knew going into this research that I could not separate myself from the research I was conducting.

My experiences being socialized as a fat woman are an integral part of why I did this research, and I could not conceal my body from my participants. On the one hand, I believe my being fat made my participants feel more comfortable discussing intimate details of their experiences with fatphobia and how it affected them. On the other hand, I felt incredibly uncomfortable in some interviews, specifically when some participants directed specific comments at me, which I felt were fatphobic. Of course, I have read and cited the literature about internalized fatphobia, and I personally have struggled with my own internalized fatphobia over the years. However, I was still unprepared for being casually accused of having a food addiction by one participant or another, implying that I had trouble dating and getting men's attention. Other comments were less direct but still made me self-aware, like when one participant discussed how bright colors do not look good on fat people while I was wearing a green shirt. As a feminist, I view the interviewing process as a back-and-forth one. Still, I hesitated to argue against these comments because I did not want to be perceived as defensive, fracturing participants' comfort and making them hesitant to continue sharing their experiences. By prioritizing these participants' comfort over mine, I grew fretful and overwhelmed concerning the analytical process and slightly demotivated. I became worried about the integrity of my research: Despite my engagement with the existing literature since the inception of this research project and my awareness of the

pervasive nature of fatphobia, I began to worry that I had been naval gazing this entire time, that maybe I should have chosen a less personal topic. The analytical process proved challenging because I oscillated between my desire for fat justice and my need to have my participants' narratives remain faithful to them.

While paralyzing at the time, I believe that this oscillation helped me reach a balanced analysis that was faithful to my research and participants' accounts.

Conclusion

This IPA study explored from a gendered and intersectional perspective the lived experiences of women who underwent weight loss surgery. It queried the intersecting reasons that drive women to seek weight loss surgery. Data was collected through desk research and seven interviews.

Participants described being ostracized by family, peers, potential romantic partners, the fashion industry, and medical professionals due to their weight. They revealed their perception that fatphobic attitudes were ingrained in Lebanese society, and they shared how this made them internalize guilt, shame, failure, and fatphobia. Participants opted to undergo weight loss surgery to shed the learned social identity of being fat. They discussed how they navigated uncertainty and change throughout their weight loss surgery journey, explicitly examining how they had to adjust their expectations of the surgery, how it has affected their body beyond weight loss, and how they were surprised by these changes. Participants also unpacked the ways in which they navigated their bodies in their relational context after weight loss surgery; some explored how their social life has improved after weight loss, while others explored how they felt more scrutinized because they did not lose enough weight and were still perceived as failures. Participants believed that undergoing weight loss surgery was their personal responsibility and had varying degrees of internalized

fatphobia. Throughout the interviews, the effect of participants' socioeconomic status and environment on their weight was apparent.

This research aimed to convey the social pressures that impacted participants and how weight loss surgery is used as a tool to cope with contemporary beauty standards and relieve the pressure of being ostracized, scrutinized, and dehumanized for being fat. Weight loss surgery and its recipients provide a unique lens through which we can understand the sociocultural and psychological issues related to body weight, image, and weight loss.

As discussed throughout the thesis, anti-fat bias and fatphobia are quite pervasive. The societal pressure to lose weight participants experienced growing up propelled them into years of yo-yo dieting, disordered eating, and negative self-perceptions, all of which not even achieving weight loss has fixed.

This research encourages readers to question everything they have learned about beauty and bodies, no matter how simple the reasoning is. Why is this the beauty standard? Is it classism, misogyny, colonialism, or neoliberalism? Think of everything society and medicine have stopped doing, things that were perceived as objective science and necessary medical interventions at the time: from performing transorbital lobotomies on mentally ill women in the 1900s, robbing them of their personhood to unsuccessful medically sanctioned conversion therapy attempts against queer people. Fatness is socially constructed, and we must strip back the cultural equation of fatness to negative attributes and bad health and critically assess why discourses that actively cause psychological harm to people are so normalized.

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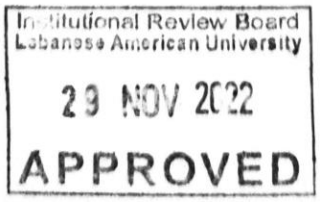
APPENDICES

APPENDIX A: Interview Questions

- Can you tell me what your life was like before weight loss surgery? (What were your experiences with fatphobia, food and dieting, and your body?)
- How did you make the decision to get weight loss surgery?
- How did the people around you react to your decision?
- What kind of research did you do before you underwent the procedure?
- Were you informed of the possible risks and long term effects of the procedure beyond weight loss?
- How are you adjusting, both physically and mentally, to life post-operation?
- Is weight loss surgery what you expected it to be?
- What are the changes you have noticed in yourself?
- What changes, if any, have you noticed in your social interactions and life?



APPENDIX B: IRB APPROVAL OF RESEARCH

LAU
الجامعة اللبنانية الأميركية
Lebanese American University
Institutional Review Board (IRB)

لجنة الأخلاقيات

NOTICE OF IRB APPROVAL

To: Dr. Cathia Jenainati Professor/Dean

School of Arts and Sciences Ms. Fatima Antar – Student

Date: November 29, 2022
RE: ***IRB #:*** *LAU.SAS.CJ1.29/Nov/2022*

APPROVAL ISSUED: 29 November 2022 **EXPIRATION DATE:** 29 November 2023 **REVIEW TYPE:** EXPEDITED – Initial

Protocol Title: *Womanhood and the Body in Lebanon: Case Studies on Weight Loss Surgery*

The above referenced research project has been approved by the Lebanese American University, Institutional Review Board (LAU IRB). This approval is limited to the activities described in the Approved Research Protocol and all submitted documents listed on page 2 of this letter. **Enclosed with this letter are the stamped approved documents that must be used.**

APPROVAL CONDITIONS FOR ALL LAU APPROVED HUMAN RESEARCH PROTOCOLS

LAU RESEARCH POLICIES & PROCEDURES: *All individuals engaged in the research project must adhere to the approved protocol and all applicable LAU IRB Research Policies & Procedures. PARTICIPANTS must NOT be involved in any research related activity prior to IRB approval date or after the expiration date.*

PROTOCOL EXPIRATION: *The LAU IRB approval expiry date is listed above. The IRB Office will send an email at least 45 days prior to protocol approval expiry - Request for Continuing Review - in order to avoid any temporary hold on the initial protocol approval. It is your responsibility to apply for continuing review and receive continuing approval for the duration of the research project. Failure to send Request for Continuation before the expiry date will result in suspension of the approval of this research project on the expiration date.*

MODIFICATIONS AND AMENDMENTS: *All protocol modifications must be approved by the IRB prior to implementation.*

NOTIFICATION OF PROJECT COMPLETION: *A notification of research project closure and a summary of findings must be sent to the IRB office upon completion. Study files must be retained for a period of 3 years from the date of notification of project completion.*

IN THE EVENT OF NON-COMPLIANCE WITH ABOVE CONDITIONS, THE PRINCIPAL INVESTIGATOR SHOULD MEET WITH THE IRB ADMINISTRATORS IN ORDER TO RESOLVE SUCH CONDITIONS. IRB APPROVAL CANNOT BE GRANTED UNTIL NON- COMPLIANT ISSUES HAVE BEEN RESOLVED.

If you have any questions concerning this information, please contact the IRB office by email at

irb@lau.edu.lb

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The IRB operates in compliance with the national regulations pertaining to research under the Lebanese Minister of Public Health's Decision No.141 dated 27/1/2016 under LAU IRB Authorization reference 2016/3708, the international guidelines for Good Clinical Practice, the US Office of Human Research Protection (45CFR46) and the Food and Drug Administration (21CFR56). LAU IRB U.S. Identifier as an international institution: FWA00014723 and IRB Registration # IRB00006954 LAUIRB#1

DOCUMENTS SUBMITTED:

LAU IRB Initial Protocol Application Proposal
Informed consent for interviews Interview questions

CITI Training – Cathia Jenainati CITI Training – Fatima Antar & CV

Dr. Joseph Stephan

Chair, Institutional Review Board

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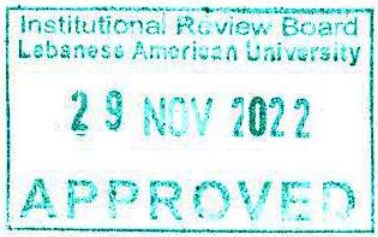
Institutional Review Board
Lebanese American University
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APPROVED