LEARNING A NEW SELF: ILEOGASTROSTOMY AND PERSPECTIVE TRANSFORMATION

by

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Abstract

Women who are morbidly obese have a well developed set of beliefs about themselves and their place in the world. Their beliefs grow out of and are shared by the society in which they live. Because obesity is viewed negatively, much of such women’s interaction with the world is associated with being the victim of stigmatization. Because of this and the well documented medical complications of such a condition, some women will accept surgical assistance, in the form of ileogastrostomy, to correct it.

After ileogastrostomy, women must adjust to a radically altered pattern of physical functioning, in the context of social upheaval related to and caused by their loss of weight. Such change is disturbing to the underlying beliefs they hold about themselves and the ‘givens’ of life. In education, profound and wide-ranging change in the fundamental structures of one’s belief systems, that is, in the way that one views the world, is perspective transformation. Perspective transformation is often associated with trauma or ‘massive change’ situations.

This study was undertaken with the assistance of eight women who had undergone ileogastrostomy procedures at St. Paul’s Hospital in Vancouver, British Columbia, Canada, in conjunction with a participant researcher. Following her own ileogastrostomy surgery, the researcher questioned whether her own experience was that of perspective transformation. Co-researchers were interviewed and the resultant narratives analysed across cases to investigate both the women’s experience and the learning moments and needs they identified.
Holistic perspective transformation was found to be associated with ileogastrostomy in three cases. Partial transformation, or perspective shifting, was found in all cases. Perspective transformation was strongly associated with a proactive stance closely following surgery, as well as a preoperative self-description of similar behavior.

All women identified learning strategies and learning moments crucial to effective progress through post-ileogastrostomy adjustment, particularly the need to be networked with others like themselves, the need to be kept informed of developments related to their procedure, and the need to feel supported, over the long term, by health care professionals.
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Introduction

The Researcher's Experience

After more than a decade of weight loss clubs, behavioral psychology and therapy programs designed to assist me in 'dealing with my issues', and, last but not least, repetitive (yo-yo) dieting, I gave up the struggle and sought surgical assistance with my obesity problem. I was not an uninformed patient, and this was not the 'Weight Loss Method of the Month.' I had known of bariatric procedures for more than twenty-five years before I undertook ileogastrostomy.

Like every other member of my culture, I had beliefs that pertained to who Women are, what Women do and, conversely what Women do not do. Whether I chose to accept or reject them, there was no question that I knew what these beliefs were. Because I was also an obese woman, I had beliefs about who Fat Women are and what they do. Again, whether I chose to accept and incorporate these beliefs or rebel against them, I still knew what they were. I knew how they applied to me. My taken-for-granted understandings about myself had shaped my life, as other cultural assumptions shaped others' lives.

I knew all the things that 'everybody knows.' Most of my decisions about myself and my life that were based on this infrastructure of belief took place far out of my conscious awareness, simply because day-to-day existence is so complex. It is far too complicated to be faced without employing at least some assumptions. One cannot be making a fresh decision about everything each time one encounters it, and to relieve some of this decision making stress, it is essential to have patterns from which to work.
These patterns, ways of seeing the world, give substance to our behaviour. The beliefs that create the patterns can call our perspectives, and the boundaries or outer limits of these, our perspective horizons.

When I underwent ilegastrostomy, I expect—in fact, I hoped—to experience changes in my ways of interacting in the world. I didn't expect great changes in my belief systems; rather, I expected that I would revert to what I considered my other self—my normal weight or preobesity self. I assumed I would, more or less, pick up from where I left off before Fatness had happened to me.

Ileogastrostomy did initiate change in my life, but not in a manner I was prepared for. I found that in spite of fourteen years in medically-related fields, my fluency in medicales and access to medical material, a conversance with learning theory, and a reasonable acquaintance with psychology, I was left asking myself, "What is going on around here? How come I don't seem to know anything?" Experiencing this degree of disorientation was in and of itself a very disconcerting experience. Worse was the discovery that my usual coping mechanisms were not adequate for this situation. I felt as though I had been hurled head-first into a small boat on a hurricane sea, and told to bring it safely to harbour—when I had never sailed before.

Because I happened at the time to be enrolled in a graduate program in education, and because I was searching for comprehension of my own plight, it seemed natural to me to look at my situation in the light of adult learning theory. I could see that change was taking place both within and across multiple venues in both belief and behaviour. I was re-experiencing or re-learning my body on a 'basic-functions' level. I
was trying to integrate that altered sense of my physical body with a constantly-evolving social milieu. As my social context changed in response to both my visible change (my diminishment in body mass) and, more subtly, in response to cues associated with my internal state, it affected my emotional state. My emotional state affected my physical functioning, which affected my social condition and my behaviour.

Very few of my old habits and familiar ways seemed suited to my new experiences. Many of my old ways were obviously inappropriate, but I knew no others. I had to recover from surgery and deal with the minutiae of daily living, while trying to establish a sense of self appropriate to my altered context, a context that was not what I had expected. I had not reverted to my 'before' persona as a normal weight woman. I was now an ileogastrostomy patient. Search as I might, there did not seem to be anything in my perspectives that suited my present situation precisely. It seemed that all my beliefs were being altered, and nothing seemed to fit. I began to question whether it was possible that I was undergoing perspective transformation.
Chapter One: Perspective Transformation

Some educators feel that as adults go through life, they will inevitably undergo some degree of perspective shifting. Some people will experience perspective transformation. The difference between the two is a matter of the degree of the change involved. In perspective shifting, one's beliefs are altered to conform to proofs gleaned from one's lived experience so that both can be accommodated.

However, when lived experience runs counter to beliefs, or lived experience falls outside the boundaries that belief can explain, the process becomes much more complex. Either experience must be repressed and/or denied, or a constellation of beliefs must be revised. When individuals make such changes, they see the world differently.

Perspective transformation, then, is a global or very nearly global alteration in the boundaries of what a particular individual views as the 'way the world is.' The process of perspective transformation is the when and the how of radical migration from one set of norms of thought to another set.

Perspective horizons and the worldview.

Abraham Lincoln said, "The horizon is that which we cannot see beyond", and we all have such limitations. We have things we must do, things we can do, and things we must never do. As members of our society, we do share an understanding of the typical. That is, we have commonly-held beliefs that "make it possible to account for experience, rendering things and occurrences recognizable" (Holstein & Gubrium, 1994). Beyond the recognizable, lie those things that we cannot recognize. McKenzie (1991)
calls the collective sum of our horizons our "worldview", which finds expression "in the
way people comport themselves in the world, in the action definitions they give to their
being-in-the-world." The worldview one holds is made visible by that which individuals
perceive themselves as being entitled to do or, in a negative sense, by those things they
are not privileged to do.

Cultural horizons encompass all aspects of what makes 'our' lives different from
'their' lives; what makes us be us and not them. Embedded within our cultural horizons
are the horizons that distinguish 'me' from 'you.' We may both know that we fit within
the broader horizons for our group--we do not eat insects--but I may consider domestic
animals 'food' while you do not. We both recognize that this is a horizon personal to
me, encompassed within a broader acceptable range of cultural beliefs for our society.
Both your and my beliefs and behaviours are typical for our culture. Eating insects is
not.

**Cultural horizons and deviance.**

If it should happen that one's cultural horizons clash with one's personal
horizons, it becomes important to either exclude the cultural belief (make it wrong) or
come to some accommodation with being, oneself, wrong. When we see ourselves in
opposition to a cultural belief system, the mirror image of this is, of course, the culture's
perspective toward us. Since it is likely that we are few and they are many, we are
labelled deviant. Deviance can, indeed, be a choice, such as that of the artist who
wishes to make a statement by flagrantly rejecting a cultural norm. Chosen deviance
can usually be electively discarded; imposed deviance status usually cannot, mainly because it is often allied to factors over which the deviant one has little control.

Involuntary deviance status also usually involves some type of cultural penalty. Cultural rejection most often takes the form of stigmatization of the deviant member(s). In the primate, a group of animals to which we tend to forget we belong (or a piece of knowledge we choose to exclude from our perspective horizons) ostracizism is a powerful societal control tool (Morris, 1994). Both human and primate young suffer developmental difficulties if they are ignored by those around them, and the need to be part of a group is intense for all primate species.

In humans, this need to feel oneself part of an understood world is so great that many victims of stigmatization will adopt the dictates of a social milieu harmful to them, rather than be left out of the social world entirely. They will live out the role of deviant, and will incorporate cultural perspectives detrimental to their own development into their cultural and personal perspective horizons, because these beliefs explain or excuse the treatment they receive and their deviant status.

The deviant worldview of the obese.

In most Caucasian cultures, if a girl has been obese since early childhood, her deviance status was imposed long before it could have become a choice. Because fatness is perceived as 'negative' deviance, the child's position in society is that of Outsider. By the time the child is able to interact effectively with others, at ages 3 or 4, it is already understood by her social group that she is inherently different from other children: she is a Fat Girl.
Because she is a Fat Girl, it is tacitly understood that she does not think like others, feel the same emotions as others, and is not likely to behave like others. Internalization of these beliefs into the child's worldview is an important element in the framework from which an obese child operates. Cultural reinforcement of this belief system will prove very strong. Although the child may have a personal belief that she is just the same as everyone else, experience will tell her otherwise. The majority of her social interactions will confirm the accuracy of the sociocultural worldview, not her own perceptions, as she will have many more experiences of being set apart than experiences of inclusion. She will find, over multiple experiences, that she is best accepted when she is acting as a Fat Girl.

Because the Fat Girl's deviance is closely related to her culture's experience of the body, much of her allowed role will relate to, or stem from, beliefs about the body. For all persons, a great deal of taken-for-granted knowledge stems from our relationship with our bodies—we cannot experience the world or ourselves except through them. Our understanding of, or knowing of our bodies has two components: our body image, which is a 'picture' of how our body looks to us, and a body schema. The body image is not strictly the image that a mirror reflects. Rather, we emphasize some aspects of our visual appearance over others. For example, we may 'see' our faces or our hair more than our feet.

The body schema is the physicality of our body and its presence spatially. Our body schema informs us of where we are now and how we must coordinate ourselves to get somewhere else. Because we are so accustomed to our body size and habitus,
this process is so subconscious that we are usually startled when we misperceive our distances and actually bump into something—even in our darkened bedrooms.

These subconscious givens are the earliest-established of our belief systems, and much else that we 'know' has been built on our sense of being in our bodies; experiencing our lived body. This knowledge has been developed through a lifetime of being acquainted with our personal body, how it works and how it responds (Moss, 1978). This sense of living in our bodies exists regardless of how acceptable or unacceptable our bodies may be perceived to be by our cultural norms, but if our bodies are the cause of our stigmatization, then this will inevitably be reflected in our perceptions of our experience of them. We still are our bodies, but we may not want to be.

When genetic, familial and societal environmental influences create a Fat Woman, she will become one who is not simply a woman of large body size, but will perceive herself to be deviant because of that. Because she understands, like other members of her culture, what her deviance stems from and consists of, she knows she is a Fat Woman. She acts—or reacts—in the world as a Fat Woman. It is just as likely that she may reject the social limitations that hem her in as it is that she will conform to them, regardless, the boundaries of 'what it means' to be a Fat Woman are understood.

However distasteful this state of being may be, it will be her baseline state. She will tend to remain in this stasis state unless and until significant changes occur that will make it necessary to revise her belief systems. Ileogastrostomy is intimately associated
with the creation of this magnitude of change. This disturbance of the stasis state is met with considerable resistance, particularly when events have been of a traumatic nature, and there has not been adequate time--perhaps even adequate desire--before the event to anticipate change. This could be because the capacity to examine one's inner state may be lacking at the time that events are under way. An uncomfortable state of disquiet occurs when one cannot avoid the realization that one's taken-for-granted understandings can no longer cope with one's observations and/or one's experiences.

There may be reluctance to bring to conscious awareness issues of deep personal magnitude when one feels one does not have a firm base or grounding from which to speak. It may be that in the state of disorientation that accompanies change, we simply are not able to separate the things that mean something to us from those that are trivial. We are not able, literally, to put things into perspective, since we don't have clear perspectives to place things into.

**Perspective transformation in common parlance.**

Whatever the case, one can be assured that perspective transformation does exist as a phenomenon. Everyday English gives us numerous descriptors of such change. Gossip, folklore and song celebrate greater and lesser transformations. The fact that people can, and do, change and seek change drives the marketplace, where transformations are promised, bought and sold with hundreds of products.

The language of interpersonal relationships abounds in new vantage points, those places in life's journey from which one sees things in a whole new way. The permanence of these shifts is confirmed by folk sayings that tell us that although we can
look behind, we cannot return from whence we came. Look Homeward, Angel, by Thomas Wolfe, is a classic modern novel that examines at length the painful transition period during which childhood perspective horizons are realized to have been lost, and they are replaced by those of the adult.

As adults, we do talk to one another about the transformational events of life; we acknowledge birth, love, death and loss to be significant experiences associated with learning and intrapersonal change. We speak of such events as landmarks, shaping our identities and changing our lives, altering as they do our very ways of seeing the world.

Perspective Transformation and Adult Education

An educator and researcher, therefore, may be reasonably confident in concluding that perspective transformation does play a significant role in the pattern of adult learning. Although the concept travels under different names in varied academic and professional fields, the assumptions underlying the process are similar.

In education and counselling psychology, emphasis is placed on intervention during, or provocation of, transformational events. Successful intervention is thought desirable when crucial social issues (such as racism) are involved, when intrapersonal difficulties are problematic for participants (such as in psychotherapeutic situations), or when perspective dysfunctions impede or preclude educational gains (such as adults who do not conceptualize themselves as 'successful learners').

Some educators, such as Friere (1972), Mezirow (1990), and McKenzie (1991) have devoted considerable discussion to the role of educators in change. Although it is a truism in counselling that change is not possible unless the individual wishes to
change, educators are somewhat more optimistic and feel that any change is best stimulated by the establishment of a learning climate that will allow or encourage initiation of such a process. If a learning focus were simple and singular, perhaps assistance strategies toward this end would also prove relatively straightforward. Unfortunately, this is seldom the case, since learning contexts most commonly related to perspective transformations are 'big issue', multiple realm venues. The more complex the interactions between venues, the more difficulties are encountered in knowing how and when to assist with learning strategies, and what strategies will be effective.

In Friere's (1972) experience with the illiterate in the slums of Brazil, for example, it was learned that it had to be the new readers who chose the material from which they learned. On the one hand, it was found that educators had so much difficulty escaping their own perspective horizons that they were not reliable in interpreting learner's needs.

On the other hand, it was found that learners, despite their limitations as readers, were those most aware of their learning 'openings.' They were capable of recognizing that which suited and that which did not. Learners were not necessarily able to do this in the moment, but were those best aware of 'learning moments' in retrospect, after reflection. Such post-experience integration of change, made visible to the conscious mind and allowing us to put the pieces together and suddenly get the picture, we call hindsight.

Mezirow's steps through perspective transformation.

Mezirow (1991) does indicate that awareness of perspective transformation is
frequently the product of hindsight. A shift becomes visible only through looking back to where one has been, and comparing that to one's current perspectives. Through this re-visioning process, judgments are made about the significance of events and interactions that have happened, and these are placed into what is considered their 'true' perspective. This process is, of course, moderated by these same newly-emplaced perspectives. Because this awareness is visible only in the context of recollection, there is debate about the connection between reflection, life events and change—which is the chicken and which the egg?

Mezirow (Taylor, 1989) has sketched out ten steps that he feels encompass the progression toward perspective transformation (see Appendix A). The first step is the "disorienting dilemma" (Mezirow, 1981). This state of cognitive dissonance, judiciously augmented with introspection ("critical reflection" [ibid]), he feels is the 'engine' that ultimately 'drives' an individual through to the ultimate end, perspective transformation.

Mezirow breaks the process of introspection into an internal and an external component, Step 2 is "self-examination", and Step 3, "sociocultural critical examination." His fourth step, "recognition by the experiencer that, although novel, their experience is not unique" reintegrates the experiencer into a wider realm of behaviour, where the remainder of his steps encompass recognition of learning needs, planning and organization of learning tasks, and role rehearsal. His final step is integration of new perspectives into one's life process, which is, of course, affected by the new perspectives one has adopted.
Taylor's revision of Mezirow's progression.

Mezirow does not elucidate on how it comes to be that the experiencer has arrived at Step 1, "awareness of a disorienting dilemma." Jane Taylor (1989), to address this question, reorganizes Mezirow's steps into three spheres, which she calls phases. Each phase encompasses a primary task felt to be essential to the completion of a perceptual shift, and collectively, the three phases encompass perspective transformation. Each of the phases is composed of one or more 'steps' (see Appendix B). Completion of the steps within a phase allows negotiation of the next phase.

Taylor's model also indicates that transformation events begin with a cognitive dissonance phase and end with an integration phase, but she calls her Phase I "Generation of consciousness", which is subtly different in implication, placing the inception of change slightly farther back. Taylor maintains that an event, called a "trigger event" brings into conscious awareness some disquiet within the experiencer. It is only after such an event is encountered that the experiencer follows by "Confronting reality", which closely parallels the self-examination and the social criticism steps in Mezirow's progression.

While it does seem self-evident that a disorienting dilemma or a state of discord must exist in order to compel movement from a comfortable stasis state into a disquieting transition state, how is it that one recognizes the trigger events? All lives are replete with events, certainly not all of which can qualify as 'significant.' Any event may look like nothing more than a detail in the moment of its occurrence, and yet ultimately prove to be profoundly significant. Significance may not be recognizable until
after a change in perspective has taken place, so one must question whether this was a trigger event, or is merely the experiencer imbuing an innocent occurrence with behindhand insight?

In a cyclical conundrum, it appears that if we do not know what belongs with a perspective that we do not yet know, we cannot recognize what is important, until we know what pertains. When we know what has influenced the new perspective, we can see what is importance. It seems very likely that the disorienting dilemma, represents as state in which we suspect that we do not know what is important. It seems likely that at least some preparatory ground must have been covered before we could have arrived at a conscious awareness of a dilemma. To recognize that we have a dilemma, we must see, however dimly, that there are two positions, those of our taken-for-granted outlook and some other position.

The involuntary disorienting dilemma.

We may have reached this stage of change voluntarily, as a result of some planned undertaking such as the birth of a first child, or as a result of hard work, in a therapeutic setting. Frequently, it is the case that perspective transformation is associated with events that are unplanned, involuntary and traumatic.

Because trauma situations do lie outside our normal patterns of behaviour, they violate our taken-for-granted beliefs about how the world works. Our habitual expectations are not met and, as a result, codes that we have developed to govern our being-in-the-world may fail to interpret our experiences. If this process fails, we are unable to comprehend what is going on around us. Since we may perceive that our
habitual perspectives are not providing a framework to think from, we may not know what to think. If we don't know what to think, then we don't know what to do.

When our behaviour patterns are disrupted, we suffer profound uneasiness; either the world has gone wrong—or we have. It is likely that we will try to continue with our established habits as best we can, but they will not yield the same comforting results, and we will struggle valiantly to either regain our old, comfortable horizons, or establish new ones.

Trauma can, of course, be 'good' (an obese person's rapid weight loss) or 'bad' (the aftermath of major surgery) or have mixed features of each (the loss of a known, but deviant, identity as a Fat Woman, and its replacement by another, as yet unformed identity). Good or bad, it is the sudden and overwhelming need to integrate a large body of changed expectations into one's comfortable worldview that marks the trauma experience as separate from a more subtle adult growth process, wherein a long-term evolution of one's perspectives can allow oscillation between old and new positions, perhaps over years. With trauma, little opportunity is present to allow retreat back into one's previous worldview and allow oneself breathing room. Trauma must be dealt with, in one way or another, in the moment, across multiple venues.

Opening perspective horizons to change.

Mezirow (1991) alleges that it is difficult for learners to recognize perspective transformation in process because of the magnitude of the learning involved and the immediacy of it. Learning tasks that seem, superficially, as though they ought to be
simple and straightforward are further complicated by the many shadings of emotion that imbue the conditions under which the learning is taking place.

The task seems simple enough: opening up the current perspective horizons to allow the possibility of other viewpoints, followed by allowing those viewpoints to influence habitual behaviours and thought patterns. Opening of one's horizons might seem the easier facet, but would be the more difficult. For example, in order to teach people who were color blind about 'redness' and 'greenness', one would literally need to open their eyes to something they cannot see and--never having seen--cannot conceptualize.

Furthermore, if the color blind lived in a society where everyone was color blind, introduction of the concepts of 'redness' and 'greenness' might easily be repudiated as an impossibility—a concept of inherent 'wrongness.' It would be important to the integrity of this society's image of itself to reject a worldview saying that an inability to see red and green is a deviance. Since color blindness would be the norm, it would be color vision that is deviant, regardless of how advantageous it might be to see in color. Such a culture would resist learning to identify their norm as abnormal and, by extension, themselves as lacking, by overturning their cultural perspective horizons.

This is not due simply to the amount of change, but also to the need to continue with day-to-day maintenance or survival tasks at the same time that one has been forced to critically examine the fundamentals of one's belief systems. Long periods of discord and confusion in the infrastructures of one's life are exhausting, mentally and physically.
Positioning and resistance to change.

Humans do like to live in relatively peaceful routines of thought and behaviour, and we do not particularly enjoy the state of cognitive discord that precedes change. Because "sets of habitual expectations constitute codes that govern the activities of perceiving, comprehending, and remembering" our worlds (Mezirow, 1991), we prefer that our sets of expectations do not change frequently. To initiate this movement, then, it seems necessary that an individual must be restless within their current horizons and aware, if only on a subconscious level, of some lack. One may not know where that lack lies or originates, or what is connected to it, but one needs to feel that something is amiss. This mental state is that which precedes the disorientating dilemma.

Cochran (1985), speaks of this mental preparation for change as "positioning" oneself toward the possibility (italics mine) of change. Entertaining the merest possibility of change implies a slight preliminary shifting in one's perspectives, as one cannot entertain the prospect of doing that which one cannot imagine existing. Further, Cochran describes placing oneself in a relationship to this tenuous concept, mentally, in such a way that change can begin, by envisioning what would likely occur should one allow one's perspectives to change, with the implications for being-in-the-world that accompany altered beliefs.

The Relationship Between Ileogastrostomy and Perspective Transformation

When we look at ileogastrostomy, we see, most obviously, a traumatic learning situation. There is trauma to the body; one might call this 'bad' trauma. Not only is the body recovering from an invasive procedure, but it is changed in fundamental
aspects, and a basic predictability long taken for granted is lost. As a result, many of the cues and sensations that have made up the lived-body experience are radically altered. Because body-related perceptions are the most familiar of our horizons, and operant at hidden, or taken-for-granted levels, the need to relearn these givens can be particularly distressing to an obese woman for whom conscious knowledge of the body has for many years been relegated to a category of secondary importance. Such a woman may have developed tremendous resistance to conscious acknowledgement of bodily cues, and being forced to consider these cues on a daily basis may be very difficult and emotionally distressing. Post ileogastrostomy, however, the body and its functioning cannot be ignored.

Concurrently, there is trauma to the social framework that may encompass both good and bad aspects. The changing body and related changing behaviours generate altered social cues. Altered cues provoke altered social responses, which provoke altered perceptions of experience. Although these changes may be both desirable and welcome, this state does represent the end of what has been a workable worldview for this woman.

Her identity, as a Fat Woman, is inexorably eroded and her taken-for-granted world is "turned upside down" (Moos & Schaefer, 1986). Any loss of identity, taken in isolation, would be traumatic; but the post-ileogastrostomy patient must also integrate feedback from the external world into her internal world, in a process of letting go of old and taking on new meanings for life experiences across multiple venues. Experience and reflection on experience provoke a continual reworking of the self-concept, in a
process of internal and external cycling from which there is no time out, as the body inexorably continues to change.

Within this process, the woman must also come to grips with the permanence of her situation: her old self is gone, and she must commit to the new. To cope with such a maelstrom of cognitive discord, the full spectrum of the woman's resources must be brought to bear. The patient's adjustment period optimally will bring beliefs, physical conditions, social interactions, and other varied and interactive elements into a state of equilibrium, wherein the woman can feel centered and stable.

Returning to the Researcher's Experience

It was into the center of this maelstrom of discord that I found myself placed, after ileogastrostomy. I had been a normal weight child, but whether I had been or not, I would have learned what Fatness was and what it meant. Certainly, when I became a Fat Woman, I knew exactly what that meant. I did not like it, but I knew what was 'allowed' and what was 'forbidden' to me. Throughout my life, I had dieted, so I knew what losing weight meant. I had been a normal-weight adult before my pregnancies, so I knew what that meant. And I had had surgery before, so I even knew what that meant.

But after I experienced ileogastrostomy, I found that I had no perspectives from which to view the world I was trying to live in. I was completely disoriented, and felt as though I didn't know what anything meant. I often pondered on whether this was an idiosyncratic reaction unique to me, or a feature associated with ileogastrostomy. I
wanted to ask other women to share their perceptions of their journey through ileogastrostomy adjustment, because I wanted to understand what their experience meant to them.

Perhaps the overlapping recovery from ileogastrostomy surgery and recovery from obesity was conducive to perspective transformation. If it were so, was that an important factor in recovery? The following study was undertaken to explore the meaning of the ileogastrostomy experience for women with these questions in mind.
Chapter Two: The Worldview of the Obese Woman

Before Ileogastrostomy

Cultural Perspectives About Obesity

Medically-Associated Perspectives

As far back in Western medical history as Hippocrates, morbid obesity is treated in such a way as to cast blame for the condition onto the victim of it (Bray, 1990). Galen, whose guidelines for medicine were employed for thirteen centuries, used language such as 'disobedient' to refer to obese individuals' disregard for natural laws (ibid). This trend has continued unabated up to and including the present with only a few modest dissenting voices attempting, over the centuries, to redefine the image of the obese individual.

Doctors studied by Maddox and Liderman (Allon, 1982) preferred not to have obese patients—in fact, many refused to do so. Collectively, the majority of physicians thought obese women were physically ugly and clumsy, and believed their obesity was evidence that they were out of control as personalities. Doctors, in fact, "evaluated the overweight even more harshly than the overweight evaluated themselves" (Allon, 1982).

In these and other studies, obese women were said to be ultimately responsible for creating their own problems. They created these problems not simply through a physical propensity toward endomorphology, or poor judgment, or even a combination of both; rather, obesity represented an outward manifestation of an inner, or moral, failure—a visible 'sin.' A deficiency of inner strength—lack of willpower—and a flawed
character combining to allow unabashed and uncontrollable gluttony was thought to be the root cause behind the obese person's offensively visible adipose tissue.

**Medical misconceptions about obesity.**

The formation of this belief may be due, in large part, to misconceptions about the etiology of obesity. Studies have shown significant correlations between morbid obesity and one's genetic heritage, between a tendency toward degrees of obesity and/or slenderness and one's basic morphological traits, and even between obesity and socioeconomic status (Cahnman, 1968), to say nothing of the very marked relationship between obesity and gender. Indeed, investigation has not yet been able to confirm that the obese do consistently eat more, on average, than normals (Allon, 1982).

At present, medical research into obesity has multiple foci, one of the more prominent being the hypothesis that body weight set points unique to each individual exist that both impel and compel weight gain and food-seeking behaviour (Greenstein et al, 1994). It is thought that these set points are coupled with genetic propensities toward super-efficient metabolism of particular types of nutrients and/or highly effective absorption and storage mechanisms in obese individuals (Smith & Gibbs, 1992; Tai, 1991). These and other reports have received little dissemination into the general public, in spite of the relevancy of their findings.

**The interaction between beliefs and obese patients' care.**

Although there appears to be an immensely complex infrastructure underlying obesity, the medical population, in concert with the general public, clings to the most simplistic scenario: the overweight are weak-willed gluttons who voraciously consume
huge quantities of food against their own best interests and often against their own best judgment, and are thus very obviously 'not okay.'

The New England Journal of Medicine (NEJM) editorialized that publication's concern with continued "folk beliefs" about the obese held by medical practitioners, and the resultant negative influence these beliefs have on patient/physician interactions (Bennett, 1995). Recent findings in genetic and metabolic research were discussed, and the "two fatal flaws" in the theory that overeating causes obesity were examined.

First, it was noted that the definition 'overweight' is in itself "logically vacant" and "circular", since only the fat are said to have been proven to have overeaten, and the inference that they have overeaten is also taken as the modus operandi behind their fatness. Second, "whenever the proposition has been redefined to have meaning, and then has been tested in a well-designed experiment, eating behaviour has appeared to be the dependent variable, rather than the independent variable" (ibid).

The NEJM reminded its medical audience that all evidence at present points toward a "complex, highly-sophisticated system for regulating [the body's] fat stores" as the true operant for weight gain, loss and maintenance; and emphasized that this regulatory system is not attuned to either aesthetics or morbidity statistics... [and although] many obese people would like to reduce their weight or would benefit considerably if they were able to do so, they [will] not be helped by relentless moralizing and easy solutions reflecting a theory of gluttony that does not stand up to the available evidence (ibid).

Sociocultural Acceptance of Medical Perceptions of the Obese

Unfortunately, because of the status position held by medical practitioners in North American culture, their opinions about obesity and the obese are of great
influence culturally, and are shared by many members of North American society (Price et al., 1987; Singh, 1994; Wadden & Stunkard, 1985).

**Fatness as evidence of 'badness.'**

Curiously enough, the morbidly obese ought to be concurrently pitied for their obesity as well as condemned for it. It is as though their body size is seen as a misfortune that onlookers are delighted to have escaped, regardless of any self-indulgent eating behaviour they may personally indulge in. Generally, it is a wide-spread belief that sensible eating behaviour requires that the majority of adults deny themselves sweet and fat-laden foods, unless they want to get fat. If that is the case, then the obese must not be obeying this law, which quite obviously they are not, because they are fat. Therefore, they must want to be fat.

This cyclical interpretation makes a simple equation: Persons too weak/self-willed/foolish/stupid to curb their eating behaviour will inevitably become fat/obese/morbidly obese, which is what they deserve because they are weak/self-willed/foolish/stupid. Those who break laws, even natural ones, must be punished, and the obese are punished more naturally than most--by their own bodies.

Surprisingly, it is not necessarily people who have little difficulty in either weight control or weight loss who are the most unquestioning of this. These beliefs are generalized even among those who have had trouble with weight control, and the connection is very highly evident in language associated with dieting, with its emphasis on 'guilt', 'self-indulgence', and 'getting away with' tempting foods and 'being good' and 'strong' and eating 'healthy' foods. When people talk about weight reduction, it is as
though they are saying they know that weight gain is caused by 'being bad', and accept
that the fault, as well as the cure, must lie within themselves. And if they, the
moderately overweight, are 'bad' to the extent of, say, twenty pounds over norm, how
'bad' must the morbidly obese be?

Fatness as evidence of poor mental health.

Sadly, in addition to the perception of the obese as a voracious eater, there is
also the idée fixe that the obese woman is an unstable, infantile personality who uses
food as a compensatory mechanism to avoid dealing with her 'real problems.' Many
support groups and therapies are founded on this belief, devoting much literature and
teaching to the conviction that if one faces one's 'intrapsychic issues' effectively, the
'need' to be overweight will disappear. Weight loss will thus ensue effortlessly as a
natural result of one's improved mental health.

The obverse of this belief is, of course, that continued fatness is evidence of a
state of psychological disturbance or neurosis. The obese are walking signboards
proclaiming their own emotional instability. The Catch-22 to this is that even though
the solution to obesity is seen to be obvious--simply 'getting control' over oneself--the
obese person is seen as an ineffectual personality far too impotent to be able to do any
such thing. Their continued state of obesity is seen as proof of this (Cahnman, 1968).

This belief about the interaction between the mental and the physical flies in
the face of obesity-related research findings. Leon and Roth (1977) found "evidence
strongly suggests that there are very few personality characteristics that obese persons
share that can be considered causative in the development of obesity." This was
followed by Leon's (1982) conclusion that

among the largest percentage of people who have earned the label 'obese' because of a deviation of their weight from the statistical norm, psychiatric disorders appear no more prevalent than they are in a comparable number of people of normal weight.

Studies on bariatric surgical patients in particular have been unable to sort out, in a "chicken-or-egg" conundrum, whether neurosis in the morbidly obese causes obesity or is caused by it (Digregorio & Moorehead, 1994; Kalucy & Crisp, 1974; Powers et al, 1992; Stunkard & Wadden, 1992; Wadden & Stunkard, 1985).

Furthermore, studies have also indicated spontaneous remission of apparent neuroses following bariatric surgery, with little or no displacement of neuroses seemingly centered on weight and body size into other realms (Castelnuovo-Tedesco & Schiebel, 1976; Crisp et al, 1977; Kral et al, 1992; Mills & Stunkard, 1976). One might conclude from this that bariatric procedures then pertain to that very small category of surgical interventions that are efficacious in treating psychiatric or psychologic disorders. It would seem more likely that the apparent disorder corrected with such surgery would stem from the psychic distress of being fat in a hostile environment, rather than some intrapersonal cause. Such distress would indeed remit spontaneously after surgery as a result of the social acceptance and amplified social involvement following weight reduction (Stunkard et al, 1986).

**Self-Esteem and Body Size in Women**

*Current perspectives on female body weight.*

Since the late 1950s, reaching its cultural zenith in the late 1970s to mid-1980s, there has been a polarization in societal body-acceptance norms toward extremes of
thinness. Media attention and public approval has focused toward the young, the slim, and the fit body. Casual discussion with women in gyms, in the workplace, and through online bulletin boards and forums indicated to the researcher that many women view their bodies with shame and embarrassment if they are only a few pounds over their self-selected 'ideal.' Very few of the women spoken with were aware that the ideal they prefer is very low, with an associated very low body-fat ratio—one that is more common to the athletes than to 'typical' women. Most women stated that they could "lose a few pounds" and that they would "look a lot better and feel better about themselves" if they could do this. Their feeling of being overweight did not particularly correlate with their current body size: even women who were at or below current norms felt they carried "a little extra."

Concurrently, there has spread a conviction that individuals do, or should, have complete control over their bodies—body size, shape and contour ought to be under the tight control of each individual. To be able to achieve control represents a personal victory and is, therefore, desirable. Conversely, lack of control is an indicator of amotivation and social failure. This belief has taken hold of the popular imagination to such a degree that, if perusal of a month's worth of the popular 'supermarket' magazine shelf is any indication, the majority of normal weight women suffer a sense of guilt about and express concern over their body size and image, and are deeply interested in strategies that promise more control over their bodies (Grunwald et al, 1995).
When the researcher introduced food into discussions with women in gyms, many showed great ambivalence about it. They would talk at length about food preparation and the sensual enjoyment of food, yet most refused a small piece of chocolate candy. Rarely could they refuse without needing to express a considerable amount of self-justification about doing so. Almost always, this would include a statement that they were "watching their weight" or they "couldn't handle" the calories. If women were coaxed to take the candy, they usually did but said they would regret their "weakness" and they would "pay" for their self-indulgence with weight gain and an accompanying diminishment in self-esteem.

This investment of self-esteem in body weight and body size prevalent among women close to ideal body weights is exaggerated in the obese. The obese are, of course, participating members of society and, as such, become imbued with the same societal messages as other women. A perception of oneself as 'ugly' or 'blemished', leading to a sense of revulsion from one's own body, cannot do other than create a negative self-image.

The language of revenge and remorse associated with eating also amplifies the judgment that one is out of control, which does little toward mitigating one's guilt and shame. A perception that one is not functioning well increases in correlation to the amount in excess of the norm that a woman perceives her weight to be. Sadly, to counteract such intensely negative perceptions, the obese would have to have highly sophisticated levels of insight in the context of acutely honed skills in social and cultural
criticism. Obese women are neither more nor less likely to have such social and psychological capacities than are any other members of society.

Weight reduction and weight loss failure.

Instead, the obese woman struggles with her challenges on a more prosaic, day-to-day basis. Those who perceive themselves to be overweight practice frequent dieting, with a goal of 'joining society' by making themselves 'normal.' Literally millions of dollars yearly are spent in this pursuit, yet according to Rodin (1982) less than 3-4% of women are able to maintain significant weight loss for more than a few months, regardless of whether they were initially morbidly obese, moderately obese, or only slightly overweight.

Even more discouraging, low-calorie regimes are extremely difficult to maintain over long periods of time, and dieting in the obese is usually a many-week to many-month project, during which low-calorie regimes can have long term food deprivation side effects on dieters. Such deprivation can provoke binge eating and food obsession, which only further reinforces the woman's notion that her relationship to food is disordered. It rarely occurs to the dieter that it may have been the dieting itself that encouraged binging (Cowen et al, 1995) rather than some mysterious neurotic compulsion in herself.

Long-term low-calorie intake can also be associated with depression and anxiety. This is interpreted by the obese, in accordance with wide spread cultural beliefs, as further confirmation of her neurotic relationship to food. However, the same result appeared in normal weight food-deprived persons in research studies done as long ago
as the 1940s. Normal young males who lost 25% of their body weight over six months through severe calorie restriction, under Keyes' experimental conditions, demonstrated a syndrome of anxiety, depression, and food-obsession (Rodin, 1982).

Perhaps even more discouraging for the obese dieter is a biologically-based tendency for the organism to try to return to the previous normative weight (however socially unacceptable and 'obese' that setpoint may be perceived to be) on resumption of normative eating patterns (Halpern et al, 1990; Kuczmarski, 1992; Rodin, 1982). A pattern of low levels of intake, followed by 'falling off the wagon' and regaining whatever weight becomes a repetitive one, called 'yo-yo dieting.'

Regain after initial loss usually somewhat surpasses the pre-diet weight and over time, it is thought that repeated bouts of low-calorie restriction can reduce basal metabolism rates by between 4% and 10%. Metabolic rates do not return to normal for many months after intake has been restored to pre-diet levels (The Ultra-Diets, Prevention Magazine, Feb. 1995). The eating habits of the woman post-diet likely will return to her pre-diet habits, but this intake will be as though she were eating an additional 4-10% more food, yielding a net regain surpassing her starting weight. The net result for months of weight loss effort? Increased obesity.

**How the Obese Woman Learns Her 'Place' in the World**

On proving to herself that she is worse than not effective at weight loss, the woman confirms that she is not okay. Sadly, because of the visibility of obesity and the folk beliefs around it, the obese woman is continually reminded of her condition. She learns to see herself at the extremes of the unacceptable--walking "worst case scenarios"
Whether an obese woman believes her social role is justified, fair or accurate is highly irrelevant. More important is that she must accept it, reject it, or deny it, because it does exist socially and is imposed upon her to the degree that it forms the typical constructs of her perceptions in a complex and interlocking grid between the social belief systems and her personal beliefs. Even those who reject social beliefs usually do so as 'rebels' who are well aware of what they are rejecting. They serve as a contra-punto to the prevailing note struck by society, rather than being truly outside of it.

Society tells her she is not okay. She may agree or disagree; regardless, she has internalized the social constructs. If she is in agreement, she may project her self-disgust not only against herself but also against other obese people (Ainlay et al, 1986). The net result is a woman with a sense of contempt and shame over her appearance, her body size, and what she perceives as her weakness.

Such self-contempt would be devastating to personal growth if it were to take place within the loving environment of a kind and gentle society. The obese woman does not receive such support. She shares the socially-based contempt for others like herself. She would like to prove herself the exception to the Rules of Fatness, (fat people are weak; fat people are ugly; fat people are stupid; etc.) but this is an uphill struggle.

The stigmatization associated with obesity in childhood.

If a woman has been obese since early childhood, she may have suffered outright persecution from a very young age. Even extremely young children have been culturally
conditioned to reject the obese unequivocally. Richardson et al (Cahnman, 1968) gave children six drawings showing other children with various body deviances, such as crippled or amputated limbs, or facial disfigurements. They asked the children to rank them in order from 'persons they would most like to have as friends' to 'persons they would least like to have as friends.' The drawing of an obese child was consistently ranked last.

More recently, researchers who asked parents in a shopping mall for photographs of children (to be used in a study not related to obesity) found that those with an obese child were unlikely to allow the child to be photographed. Some of the same parents would allow a non-obese sibling to be photographed while the obese child looked on. One can only speculate as how the obese child explained this behaviour to themselves, and how frequently such a child is subjected to similar treatment (Hill et al, 1994).

Perhaps the saddest and most difficult feature of obesity, is the tendency for the obese to also see the obese as individuals to be avoided, rather than likely to demonstrate solidarity and understanding. The obese child is no more likely than anyone else to rank the overweight as desirable friends and companions. This finding was not mitigated by the ages of those studied; similar results were seen among older children and adults, in varied social and work-related settings (Millman, 1980).

Cultural perspectives about the obese woman's sexuality.

Childhood is unquestionably a difficult period for the obese; but with the onset of puberty, burgeoning sexuality adds a further complication. Partners who might be attracted to an obese girl or woman are often reluctant to admit such social deviance.
In fact, they may be deeply ashamed of this 'unhealthy' desire (ibid) and those who do become involved with obese women may act out their own sense of shame by maltreating their partners. Even if this is not the case, the woman herself may create an abusive situation through her self-condemnatory stance. That is, she either believes that anyone who could desire her must be abnormal, or she simply cannot believe that they do desire her. Thus she places herself and her relationships in a downward spiral of low self-esteem reinforcing dysfunctional behaviour and beliefs (ibid). It would indeed be an affectionate--and strong-willed--person who can consistently respond with loving reassurance to an obese woman making negative statements about her ugliness and undesirability, particularly when these negative images are socially reinforced.

In the media, popular electronic entertainment in particular, the idea that an obese woman might have the same interest in and desire for a sexual partner as a nonobese woman is the stuff of low comedy. It is seldom that an obese woman's desire for a sexual partner is treated with dignity, respect or even acceptance. The obese woman rarely sees herself shown as a positive, interactive or stimulating companion. She is most often portrayed as dysfunctional, shrill, and/or pathetic.

Her body and its grossness are often 'punishment' reserved for the male villain, particularly if he is a pathetic villain. An ineffectual male 'deserves' to have a fat woman throw herself at him--he can't 'do any better'--and neither can she. But he can demonstrate his own self-esteem: he reacts with horror, and he runs. He's not so desperate that he will welcome her repulsive advances, and certainly not so depraved that he could be sexually attracted to her!
Discovering 'appropriate' roles.

If the obese female is treated in a more humane manner, it is often to be considered 'harmless.' The obese woman is the all-compassionate confidante who knows just when to fade out of sight. She is the buddy who is always there for other people's problems, but who has no life of her own. If she does achieve center stage, the role she plays may well make her body size the issue, and a successful weight loss regime to be 'the answer' to all her problems. It is implied that if the obese woman will prove herself worthy by make eating/not eating the focus of her life, she will be rewarded. She must 'pay her dues' and 'get a grip' so life can 'happen to her.'

It is very exceptional that a strong and confident image of the obese is seen, wherein a woman deals competently and effectively with the more significant of life's issues without making weight or weight loss a concurrent issue. The number of obese women in the public eye can be counted on the fingers of one hand, and media attention does attempt to make their weight at least a portion of the focus of attention on them. Unfortunately, some of these women do reinforce the myths about obesity by allowing their bouts of weight loss or gain to be emphasized, rather than encouraging more attention to be paid toward their other significant accomplishments. They contribute to the negative stereotype of the fat lady and her all-consuming weight problem.

This negative stereotype is present in work and work preparation/education as well. The New England School Study, carried out by Channing and Mayer in 1966, indicated that an obese girl was less than half as likely to be admitted to college than
a nonobese girl. The subtle effects of this socialization appear in the headline associated with that study in the New York Times: "College Admissions Hint: Lose Weight." Thus, "insult is added to injury" (Cahnman, 1968).

In the work force, the same pattern prevails. A court decision in the state of California upheld the right of a store to refuse to hire a qualified obese woman because her weight would be bad for the store's image, and is in accord with findings in Larkin & Pines' study (Allon, 1982) that found significant stereotyping and negative treatment, both in the hiring process and in evaluation...Discriminatory hiring bias occurred despite equivalent performance on task-related selection tests, both physical and mental. It was not the case that performance was misperceived or misrecalled. Overweight persons were less likely to be hired even though they were perceived to be equally competent.

The Robert Half Association study found "not only that overweight workers made less money than their slimmer counterparts, but also they were less likely to get top spots when promotions came around" and employers stated that weight considerations played a role in hiring and promotion, where the public could "form an impression of the company by the employees on display." It was thought that obese employees were best placed in low-profile positions, positions from which promotion would be unlikely (ibid).

**Social isolation associated with obesity.**

Knowing that one is not fit to be seen contributes to the isolation of the morbidly obese. The distancing of the obese by normals of both sexes, in context with limitations in employment and educational opportunities, leaves such women with a markedly constrained range of options socially and culturally (Kuskowska-Wolk & Rossner, 1990). The obese, rather than fight this prejudice, will frequently concur with it. This may be
for self protection, or may be to try to insure that significant others do not suffer "obesity by contagion" (Cahnman, 1968). To this end, the obese woman is both subtly and actively assisted by others. Indeed,

not only will a 'normal' person feel contaminated by association with an obese person, but so will the entire gathering to which that person is introduced. The obese person may feel indecely 'invaded' by the covert stares of onlookers [and] are deprived of their right to be judged according to their personalities...but will be considered by all and sundry as 'fat' and nothing else (ibid).

If the obese woman finds herself marginalized, as well as invaded by the staring and comments of others, she may prefer simply to remove herself. Like other members of society, she is very aware of how 'ugly' she is. She will particularly avoid activities or locales in which the physical limitations of obesity will be made most obvious (eg: sports) or situations in which the body is displayed (eg: dancing, clothes-shopping).

**Building defense mechanisms.**

Although the obese woman may not be versed in social stigma theory or psychological interpretation, she is certainly will be very aware of the effect that her sheer body mass has on others. If every venture into public provokes hastily diverted stares, whispered comments, and even rude remarks, the woman will need to have strong defenses. Some develop an affective shell to deflect the impact of such treatment; they 'ignore' it. Some become more than a little aggressive in their own defense. Some learn to make the fat jokes themselves before others do, and become the stereotypical jolly fat woman.

For many, a large proportion of their protective armament consists of denial of the reality of their experience. Rand & McGregor (1990) found that obese people were
only able to acknowledge the full extent of their pain and anger about their social condition after obesity surgery. The pain and abuse they had suffered was minimized, reinterpreted, or forgotten in the moment.

**Stigmatization of obese women's significant others.**

However well defended an obese woman might be with reference to her own treatment, few are prepared to cope with the overflow of hostility that can be directed toward a woman's significant others. Children are teased about their mother's size. Predictions are made that they, too, will grow up fat--either as teasing remarks or well intended advice from counsellors and friends. Spouses are made objects of sympathy for having to 'put up with' an obese mate. The easiest and most obvious solution to this spillover prejudice is for the obese to take themselves out of the picture. The obese woman thus enters into a form of "role imprisonment" which narrows the circle of possibilities from which she can choose to a smaller and smaller compass.

**The 'mind-body' split.**

Ideally, everyone should have a strong and healthy ego state from which to draw reserves of self-esteem to meet such challenges. Yet even in the young and the beautiful, self-esteem issues are deeply troubling ones for many women (Steinem, 1992). In the obese woman, against whom such forces of social and moral condemnation have been marshalled, the struggle to maintain a functional sense of self-esteem is unremitting.

In order to be able to cope, obese women may 'split' themselves away from their rejected bodies and focus their self-esteem issues and values around 'head knowledge.'
This is called "the mind-body split" (Moss, 1978). This protective mechanism allows a woman to maintain sufficient ego strength to carry on in the face of both external and internalized repression, by denying the negative relationship she feels to her body and its obesity.

The cost of maintaining this relationship is high. To be alienated from one's physical being to maintain one's mental health cannot be less than stressful. According to Cahnman (1968), the obese woman who responds this way will exhibit behavioral and characterological traits remarkably similar to those of persons "exposed to an atmosphere of discrimination on account of race, color, or ethnic origin." Such a pattern cannot help but "impair the individual's overall effectiveness" (ibid) in social interaction.

**Obesity, Morbidity, and Surgery**

The obese woman thus looks back at a blighted past and forward toward a difficult future in which the unlikely prospect of significant, permanent weight loss seems to be her only hope for a complete, fulfilling life. For many women, this dismal picture of social isolation, restricted and prejudicial employment and educational interactions, and intrapersonal distress is worsened by physical problems related to large body size. There is no question in medical circles that severe obesity is, in and of itself, a physical health concern (Ashwell, 1994; Bray, 1992; Colditz, 1992; Debruy, 1978; Masek et al, 1978; Pi-Sunyer, 1991; Sjostrom, 1992a, 1992b). Excessive weight and body size are restrictive to muscle movement and place great demands on bodily organs to service
large amounts of tissues that are unessential and which can impede optimal physiological functioning.

When such conditions develop and the patient's likely prognosis is placed into context with the social and psychological difficulties associated with the condition, medical practitioners may recommend surgical intervention, particularly when the seemingly ineffective nature of reducing-diet strategies in the control of morbid obesity is factored in.

**Ileogastrostomy surgery.**

At St. Paul's Hospital, Vancouver, ileogastrostomy is one surgical option provided by the Bariatric Clinic. This surgery was developed from jejunoileal bypass surgery (Gourlay and Cleator, 1988). This procedure was developed to enhance control over the development of blind loop syndrome (infections caused by overgrowth of bacteria in the still-living but defunctioned section of the small intestine), a prevalent complication of jejunoileal bypass causing considerable post-surgical morbidity (Butler et al, 1980; Venturi et al, 1994).

The surgery is a major undertaking and, like any surgery in an obese patient, a risky one. Typical, expected effects (especially during the initial recovery phase) are diarrhea with restrictions in the types of foods that can be eaten, fatigue, hair loss, bloating, gaseousness and flatulence, and hydration difficulties. There can be more sinister long-term effects ranging from the development of stones in kidneys or gallbladder to metabolic disorders threatening to life (Cleator & Gourlay, 1988; Dingee et al, 1990; Gourlay & Cleator, 1988; Pappas, 1992). This surgery does induce rapid,
profound weight loss and because of this, it is not surprising that centers that do
perform this and similar surgeries have a steady stream of candidates willing to undergo
this rather controversial procedure. Patients agree to undergo this procedure and its
aftermath in order to get a shot at a 'normal' life.

The normal life that such patients are pursuing is, of course, one that they
imagine to be bounded by horizons that they have learned or imagined. They wish to
escape the perspectives that apply to them as Fat Women, and fully expect to move
easily into perspectives that apply to normal-weight women. Unknown to most patients,
an unexpected 'learning contract' accompanies ileogastrostomy surgery. Patients will,
indeed, experience profound alteration in basic tenets of their lives. Whether they wish
to do so or not, they will be confronted by bodily change. They will not, however, move
'obese' to 'normal', but rather from obese to 'post ileogastrostomy.' Women after such
surgery must learn to think of themselves as inherently different, and then learn to act
from that thinking, if they wish to achieve maximal adjustment post surgery. Reaching
this stasis situation describes the 'end' of their process of adjustment to their new state.
Chapter Three: The Research Method

The Cross-Case Interview Study

It was thought that an interview study, conducted from the perspective of a phenomenological approach was most apt for illumination of the interlocking complexity inherent in the post-ileogastrostomy experience.

As we research the possible meaning structures of our lived experiences, we come to a fuller grasp of what it means to be in the world as a man, a woman, a child, taking into account the sociocultural and the historical traditions that have given meaning to our ways of being in the world...so when we analyze a phenomenon, we are trying to determine what the themes are, the experiential structures that make up that experience (Van Manen, 1992).

It appeared appropriate, then, to search for meaning within the particulars of individual women's experience, within and across cases.

By concentrating upon a single phenomenon or entity (the case), this approach seeks to uncover the interplay of significant factors...characteristic of the phenomenon. The case study seeks holistic description and interpretation (Merriam & Simpson, 1984), yet the case study is not a methodology per se. It is, rather, "a choice of object to be studied...defined by interest in individual cases" (Stake, 1994).

Such research does not assign meaning prior to investigation; instead, participants are allowed in their own words to explore and define their issues and experiences in conjunction with a researcher. Overly specific questioning may inadvertently exclude exactly the meaning that is being sought, by implying the 'field' in which the participant is allowed to work and excluding tangential or related themes. 'Fields of inquiry' are preferred. (For fields of inquiry associated with this research, see Appendix C).
Although researcher and co-researchers are seen as partners in a shared search for comprehension, the researcher brings a specialized training to the setting and a curiosity concerning the question, and the co-researcher brings that which they 'know.'

The researcher's role.

In this study, the researcher was named 'researcher' throughout because of essential differences between her role with respect to the data and that of the co-researchers. First, the researcher was the one member of the group who met and spoke with all others; each of the others spoke only with the researcher. Therefore the researcher was the sole member of the research group to be privy to more than one case.

Second, although co-researchers did play an important validation role in data analysis (with their reading and discussion of "Kay's Experience", See Appendix D), but the remainder of data analysis devolved upon the researcher alone, which was again a significant difference in role.

The co-researchers' role.

Co-researchers are generally called 'co-researcher'. As they often played somewhat different roles in medically-related settings, they were occasionally called 'patients' when acting in those settings. Co-researchers were referred to as "the women" or "the women in this study" periodically, as a reminder to readers. "Co-researcher", a genderless, almost nonhuman identification, is conceptually far removed from "woman" or "women".
Those involved with this research went through their experiences as women, not as members of a research team. The meaning of their experience, then, unfolds within one realm of some women's lives, far more than it represents as part of a research experience. Recall of their inherent status as women was considered important, as a reminder that formerly obese women underwent these procedures. If this had not been the case, the knowledge they brought to this research would not have existed. It is as co-researchers that these women generously shared their knowledge of both obesity and ileogastrostomy, through narrative, as obtained by means of interviews, and created the data for this study.

Their narrative was a distillation of the entire phenomenon as they understood and interpreted it, a condensed and self-selected outline of that which the co-researcher deemed the essential nature of the event(s) or experience(s) she had undergone. The meaning of the experience is encapsulated within the narrative's themes. "Phenomenological themes may be understood as the structures of experience" (Van Manen, 1990). The results of the research interviews, contain that which the co-researcher identifies as the 'typical' or essential meaning of the experience. Because human beings often lead unexamined lives, meaning likely is 'hidden' within the storyline of the narrative—that is, framed within pre-reflective language. This is not to say that co-researchers 'don't know what they mean', it is that they may not be able to verbally conceptualize meaning.

Interpretation of this 'knowing without knowing' is the task inherent in phenomenology. It is done through analysis of the interview narrative. By reading and
rereading the interview transcripts, the researcher enters into the realms of significance indicated by the co-researcher in pre-reflective language. The researcher can reflect on that language and move it from an amorphous state toward a more solid one.

In a collective case study, the researcher is privy not only to each case's narrative, but to the elements of the collective narrative. Meaning shared among co-researchers will become evident to the researcher because of this unique position. It does not mean that co-researchers cannot recognize conjunction with or dissonance from their own experience, nor that they cannot identify the accuracy of categories or interpretations extrapolated from that by the researcher's reflective process.

Indeed, because co-researchers are able to confirm accuracy of meaning—how 'close to the mark' the researcher has come—they are asked to assess the products of the process during the research period. Their input is an important check on validity, as well as a cross-check on the researcher's interpretation. What the researcher may wish to 'read into' co-researchers expressed meaning is quickly 'read out' again by the co-researchers' refusal to accept meaning alien to their experience.

The researcher undertakes to assist in the dialogue of reflection between co-researchers and their world. The co-researcher is not 'under study', but is sharing a unique vision. The researcher's concern is to organize the uninterpreted meanings of lived experience into a whole that is organized within a discipline. Through reflection on co-researchers' purposeful revelations, and with mirroring of apparent expressed meanings back to co-researchers for confirmation, negation, elucidation and expansion, the researcher undertakes to articulate meaning on the co-researchers' behalf.
The co-researcher, who has lived the phenomenon, often welcomes the opportunity to critically examine experience. Human beings apparently have an innate drive not only toward understanding their own experience, but also toward comparison of the meaning they derive from life with the meanings derived by others in like situations (Leitner & Dunnett, 1993). The research question and the researcher serve as a guide to the examination of experience and, in fact, may serve as an 'excuse' for that examination.

Issues in participant research.

Because the researcher had had ileogastrostomy, she was a participant interviewer, and had her own process of recovery from ileogastrostomy running concurrently with data collection. Because of this, she chose to keep a second, personal journal, besides the one used for field notes and research data to assist with issues related to her participant status.

One such problem was a perception on the part of the interviewee that she and interviewer had an almost intuitive understanding of their shared experiences as obese women and as ileogastrostomy patients. Because of this, interviewees sometimes did not verbalize their experiences completely, and spoke in partial statements, giving only 'clues', or ending sentences with 'you know'.

The greatest challenge to the researcher was striking a balance between interacting and interviewing. This process was made more difficult by the fact that many of the women interviewed had had no contact at any time with another woman who had undergone ileogastrostomy and were enthusiastic about the opportunity to talk
about their experiences and were eager to compare their own experience with the researcher's. It was difficult, at times, to keep the researcher's experience from becoming the subject of the interview.

Initially, the researcher believed she should confine her role to being as 'neutral' or 'anonymous' as possible. It quickly became evident, that such a stance was neither well received by interviewees nor was it a valid one. What the researcher did not reveal about herself and her experience became as much a part of the interviews as anything that was said. The absence of information appeared to preoccupy interviewees and, thus, made itself an unwelcome presence during interviews.

The researcher discussed this with more experienced graduate students and other researchers, and reflected on her own role as researcher, patient and participant. She then decided that she would provide a brief outline of her 'path' to ileogastrostomy and her reasons for deciding on this research, as well as some details of her personal life, during interviews. She further decided to employ an anecdotal method to check her understanding of what was meant by particular statements. This strategy allowed interviews to develop a reflexive and conversational tone, and appeared to encourage detailed reflections.

When interviews became interactive and reflective, the researcher then found that the intimacy of the situation was such that she found it important to use a personal journal (as previously described) to 'debrief' herself. Later in the process of interviewing, she decided to employ some counselling to separate her own unresolved
issues with ileogastrostomy from the interviewees', in order to maintain a balance between appropriate engagement and becoming enmeshed with co-researchers.

Since much of the material divulged by co-researchers was painful, primarily to them, but also secondarily to the interviewer, the process of interviewing did raise a number of issues that required third-party diffusion. The knowledge that one has introduced oneself into co-researchers' lives, asked of them recollections of experiences and circumstances that provoked tears and evidence of strong emotion, then has left the scene with nothing to offer beyond suggestions as to how the co-researcher could seek support in her own community, was problematic. A feeling of having caused, or contributed to, co-researchers' pain was difficult to place into perspective.

During the researcher's personal counselling, focus was held to issues related to obesity, body image and self-image, as well as to issues related to the process of entering into another person's life in an intimate, yet limited, manner, as is the case in counselling or interviewing of this nature. No discussion of interviewees, their lives, or any data from the study was done.

Interestingly, themes raised by the researcher in her journal and counselling sessions sometimes emerged as pertinent issues for interviewees as well, although the researcher took pains not to introduce these topics. However, the role played by nonverbal communication remains a controversial one, and could be fertile ground for future research.
Inception of This Study

In discussion with the researcher, Bariatric Clinic physicians, Drs. C. Laird Birmingham and Dr. Iain G.M. Cleator, had noted that physiological adjustment to surgery occurred in the majority of patients by eighteen months. Additionally, in the surgeon's opinion, patients were by that time "like new people" (Cleator, private discussion, Nov. 18, 1993). It would seem likely, then, that if perspective transformation is a part of the post-surgical recovery phenomenon, the minimum time period for occurrence will have been between surgery and eighteen months.

Dr. Cleator was also interested in a holistic comprehension of the post-surgical ileogastrostomy experience. He noted that through his research assistant, Andrew Rae, a Quality of Life Assessment had been carried out that had produced findings he felt were significant, but that it was difficult to place these findings into context for new patients. Common learning tasks apparently associated with the recovery period were also discussed in general on more than one occasion.

Dr. Cleator was of the opinion that a study of this kind would be useful to patients and of interest to him. As the researcher was, at that time, experiencing an equal interest in the post-ileogastrostomy experience, a proposal was written and submitted for his consideration, after which he offered to sponsor this study through the Bariatric Surgery Clinic, and assist the researcher in access to ileogastrostomy patients from his clinic list. The researcher then undertook to propose and carry out the present research.
Criteria for Case Selection

After background readings on obesity, the researcher came to the conclusion that there are significant differences between the male and female experience as obese persons. As well, there is some suggestion that there may be physiological and biochemical differences between male and female post-ileogastrostomy events. Furthermore, since the ratio of patients undergoing ileogastrostomy is heavily weighted toward women, it was decided to restrict this study to women.

A minimal time bracket post-ileogastrostomy of eighteen months was selected, for reasons cited above. A maximal bracket of eight years was chosen as representative of the inception of the procedure as performed by Dr. Cleator, at St. Paul's Hospital. A three-hour commute radius from Vancouver was decided on geographically, which included the Lower Mainland as far as Hope on the east, Sechelt on the north, the United State border on the south and Vancouver Island on the West.

Twenty-eight women fell within these criteria. Through Dr. Cleator's research assistant, Andrew Rae, a letter of introduction was sent to these women, describing the nature of the study and requesting participation. A postage-paid return mail card addressed to St. Paul's Hospital Gastroenterology Research Lab was included.

Of the letters sent out, nine were returned by the post office as undeliverable. No attempt was made to trace these patients, as this would have been in violation of patient privacy. Nine women did not respond in any way, nor were letters returned; these were considered 'passive refusals.' One patient refused to participate.
Eight accepted and were included in the study. A final respondent also accepted, but returned the postage-paid card only a few days before the termination of the study period and so was not included. The eight 'yes' cards were passed from Andrew Rae to the researcher.

Approaching subjects.

Telephone contact was made with each woman by the researcher. Assessment was made during the call as to whether the woman was articulate in the English language and understood the nature and intent of the proposed interviews, and that they would be recorded and transcribed. No interviewing was done over the telephone at this time. A site and time for a first interview was arranged, according to the co-researcher's wishes. Interview locations ranged from public places (restaurants, libraries) to co-researchers' homes to hospital offices.

Data Collection

Data were collected by in-depth one-to-one interviews. All eight co-researchers were interviewed face-to-face for the first interview. Seven were interviewed face-to-face for their second interviews; one was interviewed by telephone. All eight had a third interview held by telephone to discuss the narrative document, called "Kay's Experience" (see Appendix D).

First interviews and single-case analysis.

Brief notes were made tying nonverbal cues to taped material. Notes were made of documents, photographs or other artifacts brought. Nothing of this nature had been requested, but several co-researchers chose to bring items, particularly photographs.
During the first interview, a simple time line of 'what happened when', which usually began with 'when I was heavy' or 'just before surgery' was established. These frameworks were usually expanded both backward into the distant childhood past and into a projected future during the process of the interviews.

Consistent fields of questioning were used in all interviews, because "in both uses of the conversational interview it is important to realize that the interview process needs to be disciplined by the fundamental question that prompted the need for the interview in the first place" (Van Manen, 1990).

Each woman was asked about the age of and circumstances surrounding her becoming obese, and what that experience had been like for her.

She was asked about how she had discovered, been selected for, and decided upon having this particular surgery, and about her recall of the events surrounding surgery itself.

The process of recovery was explored with reference to the immediate postoperative period, any medical or surgical complications, and the process of long-term physiological and psychological adaptation.

Women were asked to summarize their present experience as post-ileogastrostomy patients, and to reflect on what strategies might assist another in making post-surgical adjustment.

Finally, they were asked if they would 'do it all again' knowing what they now knew, and if they would recommend that such surgery be performed on someone they knew.
Interviews were a minimum of two and a half hours' in duration; the longest extended to five hours. Interviews were held as close to three hours at one time as possible, to avoidfatiguing interviewees.

As soon after the interview as possible, the researcher expanded her minimal field notes. It was noted in early interviews that 'writing things down' at the same time as taping was somewhat troubling to co-researchers, so note taking was held to a minimum. A code of marks and signs was worked up (eg: 280-apct-i, would indicate 'answered phone, changed topic-interviewee' at 280 feet of tape) to allow expansion of field notes post-interview.

Second interviews.

A minimum of twenty-four hours' time was allowed to lapse between first and second interviews, to give co-researchers a cooling-off period and time to reflect on what they might choose to revoke, say differently, or amplify upon. Because of time constraints and a particularly virulent flu season during the study period, it became necessary to conduct second interviews with some subjects before first interviews were held with others. All first interviews were transcribed before second interviews were held with that woman.

The early part of the second interview addressed concerns raised for both co-researcher and researcher from the co-researcher's previous interview. The researcher also used second interviews to clarify points that had been raised but not fully elucidated during first interviews that she had noted as she transcribed them. In an attempt to avoid influencing later interviews, formal cross-case analysis was not
undertaken at this stage, though as the researcher was the data gatherer as well as transcriptionist, 'inadvertent' analysis and speculation was not entirely avoidable.

Six of the eight women were interviewed in person a second time. Illness prevented a personal interview in the eighth case, so the second interview was held by telephone and was not taped. In another case, although a second interview was held in person, equipment failure resulted in a blank tape at transcription. The interview subject was not interested in re-interviewing, so a summary of this interview was made from field notes and memory. This material was not used as verbatim material for encoding, but rather as 'support' or 'contra' evidence for themes.

Third interviews: validation of understanding.

After all first and second interviews had been transcribed, a composite picture of the 'typical woman's' post ileogastrostomy experience began to emerge. This 'case' was written up and a copy of it was sent by mail to co-researchers, to validate the researcher's understanding of the experience as they had expressed it (see Appendix D). After a week to ten days, a telephone interview was held with all but one co-researcher; this subject was unreachable by telephone and was contacted by mail.

The consensus of opinion was that although details did vary from woman to woman, the picture presented by Kay's Experience was a "true story". None of the women felt there should be major changes in the narrative, which was felt to represent an accurate portrayal. It was agreed that, if this summary had been read before women had undergone ileogastrostomy, it would have given them a good sense of what to
expect from their experience. The researcher then continued with cross-case analysis in the light of this affirmation.

**Analysis**

**Transcription as part of the analysis process.**

As mentioned, the researcher personally transcribed all tapes. A system of encoding was used to indicate pauses, laughter, and other sounds with the verbatim material from the tapes, including all helper words such as 'um, ah' and so forth. Linguistic stresses were indicated by multiple punctuation devices (eg: ??!) or italics, to indicate particularly emphasized phrases or words.

Transcription was found to be a 'rehearing' process for the researcher, one in which careful attention had to be paid to the precise inflection and phrasing chosen by co-researchers, in order that meaning not be lost with the translation of the inflected verbal narrative into print. In this manner, it could be said that analysis began within each case, in the transcription of each narrative.

**Organizing data and extracting themes.**

Data from this transcription process initiated the process of organization of the meaning behind the words in each case. Each narrative was read repeatedly after transcription, until the researcher felt she had a grasp of the overall picture in each case, and a beginning sense of the shared meaning across cases. This data was organized tentatively and statements of meaning were extracted from within cases, and written on 4x6" file cards for ease of sorting and classification.
According to Merriam and Simpson (1984), the researcher may then begin aggregating, organizing, and classifying the data into manageable units. Data can be organized chronologically, categorically, or placed within typology. Aggregation is a process of abstracting generalities from particulars, of looking for patterns characteristic of most of the pieces of the data.

Thus phrases about learning to live with ileogastrostomy were extracted, then sorted and resorted according to the meaning, with similar meanings grouped and regrouped, after Van Manen (1990) by
determining the universal or essential quality of a theme...to discover aspects or qualities that make a phenomenon what it is and without which the phenomenon could not be what it is.

Phrases that encompassed multiple meanings had several cards made, so that they could be included with more than one group. Categories of similar meaning were identified first within cases, then compared across cases. Again, after Van Manen (1990), as we study the lived-experience descriptions and discern the themes that begin to emerge, we may note that certain experiential themes recur as commonalities or possible commonalities in the various descriptions we have gathered. The task is to hold on to these themes by lifting appropriate phrases, or by capturing in singular statements, the main thrust of the meaning of the theme.

Meanings were reconsidered and reorganized until 'umbrella' meanings--themes--emerged that could encompass a shared meaning across cases.

After extraction of meaningful phrases, cards numbered in the hundreds. Many hours' time was spent sorting cards into groups that seemed thematically related. Each grouping was given tentative meaning statements that apparently summed up the intent of the quotations within a group.

For example, one early theme was 'letting go of my obesity problem'. This shifted over time to 'letting someone else deal with my obesity problem'. Ultimately,
it was collapsed with 'letting experts handle their job' until a combined theme of 'letting experts take over my obesity problem' emerged. Umbrella concepts were re-referred to the original data, and the data themselves were read and re-read to be sure that the extracted material on the cards was not being 'revised to suit' the theme the researcher hoped to find emergent, rather than the theme being revised to reflect the co-researcher's meaning.

This process of contemplation and comparison occupied much of the analysis period. When themes failed to be readily apparent, the researcher sought fields of reference that would elucidate issues expressed in the meanings. It was through this process that the researcher looked at readings on self-esteem issues, socialization of primate species, the psychology of eating and drinking, and stigmatization behaviour, among others. With a further grounding in an area of meaning under discussion, the researcher would then re-sort and reconsider the meanings within categories, reorganizing, regrouping, and revising themes.
Chapter Four: Findings

The Co-Researchers

Co-researchers fell into three categories of experience; those 'born fat'; ie: Infancy onset (Ivy, Irene-Teresa, Ingrid-Tova); those gaining substantial amounts of weight at or near Puberty (Penny, Paula, Patricia); and those gaining weight as Adults, usually with pregnancy (Anna, Alicia-Tammy). The three women who self-identified perspective Transformation resulting from their experience were given an hyphenated name.

The Creation of an Obese Woman's Worldview

Those who had infancy onset obesity had learned to think of themselves as essentially fat people, with spells (usually short-lived) of thinness. They had made perhaps the best preoperative adjustment to being obese. As Ivy stated, "What else did I know? That was my life."

Those who experienced the onset of severe weight gain in the early teens (the puberty-onset group) were perhaps the most damaged by the experience. They had learned the early childhood social contempt for fat people, without having had to challenge those impressions against their own knowledge of themselves as valuable individuals. The infancy-onset group, had had time to carve out an identity for themselves as a Fat Girl. The role of Fat Girl was not necessarily a comfortable one, but it had become a well-established identity by the time infancy-onset group had to struggle with the issues of puberty.
The puberty-onset group struggled with the more usual adolescent stressors in the context of a body that was unexpectedly 'against them', much more so than is the usual case in adolescence. Much distress was focused into a contempt for the body. As Paula stated, "I would look at myself and just barf. I got undressed in the dark and I never, ever looked at my body."

Both groups of girls frequently put themselves on severely reduced diets during the teen years and sometimes lost substantial amounts of weight, but never 'successfully.' That is, being thin was a 'passing phase' and obesity always returned. Women who had followed this pattern reported substantially disordered eating patterns, usually semistarvation (dieting by skipping meals) followed by gorging at a night meal or secret night eating.

Women for whom obesity became an insurmountable problem in adulthood also had had what they had considered a 'weight problem' throughout their teen and early adulthood years. In photographs shown to the researcher, this belief was not objectively supported. Oddly enough, this picture of eating behaviour was not restricted to obese women during this era (1970s, early 1980s), but was a not uncommon pattern for women in general. Sadly, there were more than mere echoes of similar concerns expressed by present-day women in conversation with the researcher.

As social norms had been focused at extremes of thinness at the time, coresearchers felt that they had probably misperceived their weight, by which they meant that they saw their bodies as too substantial to comply with the social ideal, rather than that their bodies actually were obese. As a result, adult onset women had focused much
attention on domination of their problem by almost continual calorie restriction and frequent bouts of intense exercise.

It should be noted that all co-researchers in this study, regardless of age of obesity onset, had dieted at least once, and were far more likely to have done so many times. They had almost always been successful, in that they were able to remain on restricted calorie/food regimes sometimes for months at a stretch; but they were equally unsuccessful. As Anna said of herself, "I'm a great dieter... always on one...and still fat."

No matter how skilled adult onset women had become at weight control, the cultural environment of marriage, the hormonal climate of pregnancy, and the postpartum period sent carefully managed systems off the tracks. Adult onset women experienced themselves as inexplicably 'losing control' over previously well-behaved, though rebellious, bodies. Tactics that had worked previously no longer yielded results. This failure was internalized as a belief that they were "somehow, someway, doing something wrong" (Alicia-Tammy) and if they could only figure out whatever it was, it could be fixed.

Of the three groups, these women applied the most heavily punitive cultural standards to themselves and expressed the strongest beliefs about the obese woman as one who had 'let herself go.' They were very self-condemnatory about this aspect of their lives, but were the most adept at separating the "Real Self" from the "Weight Problem."

This could perhaps be due to their experience as socially-accepted individuals previous to weight gain. This group of women did have the most clearly delineated
parallel set of perspective horizons: those they lived from while fat and those they felt would govern thinness, if and when it should be recaptured. Because of these dual perspectives, they seemed particularly sensitive to the effects of their obesity on significant others. They had often gone to great lengths to shield others from the subjective pain associated with their obese condition, as well as from the social repercussions they perceived were related to their obesity.

Alicia-Tammy, for example, sometimes "forced herself" to take part in family activities, but secretly felt it was "easier all round" if she did not do so. Instead, she would encourage her family to go out and enjoy themselves without her, leaving her behind at home. Anna felt that she had "done her [child] a favor" by staying in the background as much as she possibly could.

Although a great deal of the co-researchers' social limitations were self-selected and self-imposed, they reflected reactions to both perceptions and experiences of anti-obese stigmatization. Co-researchers told of strangers approaching them in grocery stores or in restaurants to criticize their food choices. All but one had strangers attempt to victimize them with varied weight loss methods. Nine out of nine (eight co-researchers, one researcher) had well-meaning friends, relatives and strangers offer unsolicited advice on dieting.

All had been publicly humiliated by the business of ordinary life. An airline had expected one co-researcher to pay a double fare--although the plane was not fully booked and the seat beside her was taken up by her own small child. People on public transport expected co-researchers to stand up rather than "take up more than my share"
(Paula) of a bus seat—and felt free to point this out. Turnstiles routinely captured large bodies, and no other entrances would be available. Adjustable automobile seats adjusted to upper limits of normal that did not include these women. Movies couldn't be watched in theaters, because no seats would accommodate them. Restaurants simply did not provide chairs suited to the obese body—one co-researcher had to leave her own surprise birthday party when it was discovered that no chair could be found. Taunts, fat jokes, being 'left out' of discussions of sexuality, food and fashion were common elements of everyday life. Frank staring was part of any public exposure.

**Co-researcher's beliefs about their 'place.'**

Co-researchers all believed society in general felt they should have a strong sense of guilt or personal failure for not being able to get a grip on their continuing obesity. They believed that the average person-on-the-street condemned them for, if nothing else, stupidity or laziness because they couldn't figure out the 'answer' to such a simple problem. Irene-Teresa spoke for all when she said:

> Look, I don't know why people would think that fat people stay the way they are because they want to, or something, or because they're so stupid and don't know about dieting...I never figured that out. If I could have done something about it, I would never have ended up here [in this clinic] because I would have done whatever it was, years ago!

The sense of being 'gross' or 'deformed' by obesity played the most significant role in co-researchers' struggles with self esteem. They cited occasions when public remarks, laughter, and "sneaky looks" (Ivy) had played a role in their decision to not become involved in activities or outings. Alicia-Tammy recalled vividly the parameters
of her allowed universe, as she perceived it:

Ride a bicycle? Are you kidding? With my big, fat...behind? No, I would never, ever have done anything like that before [when I was fat]. I would have been too embarrassed. Perhaps I shouldn't have been so sensitive, but people looked, you know? They would really stare and I wasn't even on a bicycle. (Alicia-Tammy)

This sense of being constantly and critically observed and judged wanting was a major focus of emotional pain in the women's experience. They chose to react to it in either passive ways, like Alicia-Tammy when she chose not to ride a bicycle; or they become reactively aggressive. As Irene-Teresa said,

My hardest task after losing my weight was remembering not to bite people's heads off. If they were looking at me now, it couldn't be for the same reasons they were looking at me before, so I had to give them a break. But it was a bad habit...hard to break.

Co-researchers agreed that their preoperative experience as an obese woman was one of believing it was entirely appropriate that they feel ashamed and be embarrassed about themselves. They accepted that it was a fact of life that they were displaced from a world that found them grotesque, did not value them, and continually told them so. They cited as evidence for this belief abundant observations indicating that the social world was obviously not made to be shared by persons of their size. Further, since it was agreed in both folklore and by medical persons that their problem was of their own making, co-researchers 'understood' that they were not entitled to any particular considerations, nor had they much right to be offended by this prevailing attitude.

Choosing change.

Indeed, co-researchers ultimately found themselves in an untenable situation; they could no longer tolerate living with obesity, nor could they succeed at weight loss.
They felt they had pursued—with a vengeance—all possible variations on weight loss methods over the years, but "nothing worked for me" (Irene-Teresa). They were puzzled as to the exact mechanism underlying their personal inability to make progress, but they knew that they were failures.

Co-researchers were not sure whether the 'disease' lay within themselves, as the individual obese person; or within a society that would not accept them and labelled them the perpetrators of their own victimization; or within some combination of not-yet-understood genetics and biology. This was of little concern to them, and most did not wish to speculate much about it. "It makes me angry to think about it," said Ivy. They stated bluntly that surgery had offered them a viable alternative to the fruitless pursuit of weight reduction and the misery of life as an obese woman.

When surgery was placed in the context of the daily lived experience of discrimination, isolation and other-intrusiveness women underwent, it was seen as a 'healing' modality for a serious and debilitating disease process. It was believed by the women that healing would extend far beyond the physical 'morbidity' symptoms associated with obesity that were the prime indicators for surgery. However radical the method might seem, the women were willing to accept it.

Transfer of responsibility to 'experts.'

No co-researcher knew much about the procedure prior to surgery. They spoke of a desire to "leave it in the doctors' hands." This process was accompanied by a great feeling of relief, as though a burden had been lifted off their shoulders. A proportion of abdicating responsibility was a desire to not know anything that might interfere with
minds already made up, and require the patient to re-think her situation:

   Whatever they said, I said, 'Yes, yes. I understand.' I saw that as their job and
that I didn't really need to know the details. And I thought I did understand
pretty much what they were talking about, enough anyway. Because I really
wanted it [ileogastrostomy].

Ingrid-Tova stated bluntly that she gave over responsibility for her condition to the
physicians right at the beginning of her consultation process:

   Whatever they wanted to do, I told them to go for it. I figured, 'They've done
this before, they know more about it than me so, good, let them take care of it.'
After all, I mean, it's their job, isn't it?

Most felt they had not inquired sufficiently even about what to expect during the
immediate postoperative recovery phase. There was some ambivalence about this, as
co-researchers felt (in hindsight) that they would not have known what to ask.

So now I know what I should have asked then...but then I didn't have a clue. So
I just went along and said, 'Okay, yeah, uh-huh'(Anna).

A belief that each had finally given her all--paid her dues--and could admit 'final defeat'
in her diet wars, left many of the women with an bittersweet feeling of both failure and
hope. Ingrid-Tova responded to her ambivalence by becoming involved in yet another
weight loss program during the surgical wait-list period, thinking:

   I can't stand it, if I have to live another two years like this...and that drove me
to try [a commercial weight-loss program]. I was thinking, 'Maybe I can get
some weight off before I go in for surgery', or 'Maybe I'll really be successful this
time and I won't even have to go through with [ileogastrostomy] at all.' Because
I still felt bad that I couldn't do it myself.

Although she followed the extremely low-calorie program religiously for more than
thirty days, she failed, as previously, to lose a significant amount of weight. When the
program counsellor, whom Ingrid-Tova described as "as big around as my finger" hinted
that she must be "cheating", she quit the program in disgust, both with it and with herself:

That cemented my decision about having this done...that experience was a good example of what I had done all my life. I used to be thinking 'failure, failure' all the time... 'I tried and I failed'... but this time I just looked at it like 'I can't. I really can not do it.' So what am I left with? And that was [ileogastrostomy] surgery. So my mind was completely made up after that.

She felt, with this decision, a "sense of relief." Alicia-Tammy also noted particularly her "sense of relief, like it was all over at last."

**Avoiding critical reflection prior to surgery.**

Very little thought and energy was invested in learning about the surgical procedure before surgery. Co-researchers admitted that they went so far as to avoid thinking about and talking about the surgery, partly to not scare themselves before hand and perhaps 'chicken out'; and partly because they felt they had no-one to talk to about it. They felt that if others had not understood the obesity experience, they certainly would not comprehend this drastic solution to it.

One could understand such an inability to comprehend on the part of normal-weight people, but one would think obese friends would be different. Since co-researchers did not admit to having close friends who were obese, the procedure could not be discussed with anyone who would possibly understand the motivation to seek it. Two co-researchers did have obese siblings, whom they considered both relatives and friends; but these two did not discuss the procedure in more detail with their obese siblings than others did with nonobese siblings. The possibility of the siblings being
'jealous' and 'upset' by the ileogastrostomy patient's escape from obesity was given as the reason.

It seems more likely that the co-researchers did not discuss their procedures with anyone at this time, because they preferred to direct their attentions toward more nebulous speculations. Co-researchers recalled, "How much am I going to lose", as the question uppermost in their minds at this time, and they spent a good deal of time fantasizing and daydreaming about their future.

Nevertheless, their admitted hopes for their future were surprisingly modest: most co-researchers named 'not being stared at', 'being able to go out in public', and 'dressing nice' as their three highest ambitions after weight loss. Two mentioned, somewhat wistfully, that they "hoped to turn out pretty" (Paula, Ivy). 'Being able to forget about weight' was an important expectation, and 'being able get a handle on the one thing I have always failed at' was postulated as the most valuable outcome of surgery. Co-researchers also were optimistic that their weight-related 'success' would filter through into aspects of their lives that they felt were not particularly successful before surgery due to obesity-related causes, such as 'finding a relationship' or 'getting a better job.'

The Proactive and Reactive Stances

Co-researchers who saw themselves as central to, and at least somewhat in control of their experience were proactive in their stance and 'positively-oriented' (eg: a small hernia, no big problem, a few troubles) in their word choices. These women were likely to seek out information about their condition, likely to guide (or believed
they guided) interactions between themselves and physicians, and likely to 'experiment' with their condition and feel that their experiments had yielded valuable information.

The proactive were likely to claim that their preoperative expectations had been exceeded, if anything, by their post-operative experiences: "I feel like now I can do anything, absolutely anything!" Ingrid-Tova said. She was quick to qualify this, indicating that she felt capable of succeeding at what she tried and that she was interested in trying new things, not that she felt omnipotent, but her choice of language was typical. Opposed to proactivity was a stance wherein a co-researcher waited until something happened, or someone else took the initiative, and then reacting to that. For this reason, this pattern of interaction was called 'reactive.' This stance was associated with 'negative' language usage (a horrible shock, a hideous scar, sick as a dog). Among reactive co-researchers, for example, postoperative recall of their ambitions and hopes before surgery was couched in either frankly negative or negative-humorous terms: "I was expecting a miracle" (Patricia) or "I've gotten about half of what I hoped for--but which half?" (Anna). Strongly associated with this stance was an expressed desire to continue in the other-dependent mode that all co-researchers associated with the earliest stages of the ileogastrostomy learning process, one that co-researchers described as "letting go" of their problem, allowing the experts to deal with it.

It should be noted that not all reactive women were other-dependent at all times; nor were proactive women never other-dependent. All shared qualities of both in varying degrees, often behaving in one manner concerning certain issues (such as medically-oriented ones) and another manner at different times (such as social issues).
Overall, individuals did tend to choose a 'coping style' that fell toward either a proactive constellation of interaction, or toward one that was reactive.

**Repossessing the problem.**

For some women, an inkling that giving over total responsibility to others was not going to work for long became apparent even during the earliest moments of the hospital admission. It was also during the hospital admission that many women became aware that 'outsiders' (persons not having experienced ileogastrostomy, regardless of whether these were medical or lay persons), could not be thoroughly trusted to act in the patient's best interests. For example, all patients received milk and milk products with early-stage diet trays--items strongly 'not recommended' by bariatrics dieticians and physicians. They were faced with deciding whether to trust their own judgment or the 'professionals' who had provided the trays.

Such 'clues' that the ileogastrostomy patient would be required to take a great deal of responsibility for self care were noted more, and given more importance, in retrospect than they had received in the moment. These events were placed into context with the benefit of later understanding of what 'ought to have been.' In the moment of the experience, co-researchers tended to yield control to health-care providers.

Well, I thought it was a little strange, but there were so many people around and not all of them could know everything about everything, I guess. (Paula)

At the same time, some co-researchers chose to assign blame to particular, ineffective
individuals for oversights,

I mean, those people in dietetics--what kind of an idiot would send somebody with a stomach operation a glass of grapefruit juice (Anna), thus making it possible to continue to believe that everyone else could and should be given control over the patient's care.

**Early postoperative bodily change issues.**

Early stage recovery was difficult for everyone, no matter how medically aware or well-assisted the co-researcher was. A dilemma evolved for co-researchers in which the woman's presurgery functioning, the unknown nature of the present state of functioning (which was not at all predictable) and her projected (or fantasy) expectations about post surgical functioning were in conflict.

All recalled the process of this early learning to be "six steps forward, five steps back" (Penny), and the only learning strategy they knew was "try it and find out [what happens]" (Ivy). A co-researcher would attempt some activity or ingest a 'new' food and wait for a reaction. Based on the reaction, she either eliminate that item from the repertoire or, if the results were ambiguous, try it again until some sort of a connection between consequence and causative agents was seemingly narrowed down.

Although a felt need to become one's best and most knowledgeable advocate existed for some women at this early stage, the women felt that their own bodies were to a large degree 'strangers' to them. Because of this, they had great trouble aligning relationships between the various facets of their experience and the reactions of their bodies. They experienced disorientation on a very basic level, through having lost a taken-for-granted relationship with their bodies. This was very difficult to cope with.
This relationship was slow and difficult to regain, due to the constant variability of a woman's condition from day to day. The women were not only post operative, they were somewhat dehydrated, somewhat malnourished, undergoing rapid weight loss, changing in body size and contour, and experiencing disorientation within their social matrices.

Co-researchers had a great deal of difficulty deciding whether to 'bother' medical personnel at this time. They were unsure which aspects of their condition were 'real problems' and which were merely expected results from the surgery. During this stage of instability, there was an ambivalent wish by many women both to remain dependent on medical team and to become proactive, directing their own recovery.

Those who tended toward proactivity did tend to overly minimize their difficulties, whereas the reactive tended to commingle medical and social issues, sometimes seeking care from inappropriate sources and sometimes seeking medical care for social-based issues. The three co-researchers who went on to self-identify perspective transformation experiences adopted a proactive stance very soon after surgery. However, an understanding that one had to 'take over' one's case was reached by all co-researchers before the eighteen month benchmark. Those who were more comfortable with this called it a 'realization.' Those uncomfortable with it called it a 'shock' and, although they did acknowledge this was an intrinsic factor of the post-ileogastrostomy experience, two co-researchers continued to be angry about this aspect, even several years post surgery. These women said that since doctors had created the
state of being in which the patient found herself, the onus rested upon them to deal with any unpleasant or incommoding developments associated with the surgery.

**Perspective change in an altered body habitus.**

Relearning the body is more complicated post ileo-gastrostomy than is usually the case after surgery since, by and large, the usual postoperative patient is returning to a well-understood premorbidity baseline with certain alterations. In the average post surgery patient, body size and appearance may change, but this is most often confined within relatively limited parameters. Furthermore, most surgery carries with it a socially understood connotation: one has been 'sick', something was 'done', and now one is 'fixed up.'

In ileogastrostomy, many aspects of the body's baseline functioning have been drastically altered. During the early stages, malabsorption of fluids, nutrients and vitamins is a major factor in the recovery experience. In other words, this surgery makes women 'sick' compared to the manner in which their bodies previously functioned and physiological adjustment to this takes between four and nine months approximately. At the same time, there is substantial and rapid weight reduction. Weight loss in this culture is assumed to be a 'good thing', and this may very well be the case, but the physical adjustment to rapid weight loss can be anything but a good thing.

Five co-researchers had experienced other types of surgery prior to ileogastrostomy, and in spite of having been of substantial weight at the time of prior surgeries, co-researchers said that the recovery after ileogastrostomy was much slower and more difficult than after any other surgery. All co-researchers noted extreme
fatigue, at least some hair loss, confused thinking, dehydration, food intolerance, nausea, diarrhea, and high levels of anxiety related to the 'unknown and unknowable' course of their recovery.

Although all of these are symptoms that can be associated with poor nutrient absorption, not a single woman was advised prior to or during her early recovery period of exactly what 'malabsorption' might encompass. This led to co-researchers wondering if "something had gone terribly wrong" (Anna). Interestingly, it was proactive individuals who were the most dismayed by their postoperative developments. Irene-Teresa said,

It was quite a shock, after. I could hardly move...if anybody had told me that I wasn't going to be able to go back to work in three months...I couldn't work.

Ingrid-Tova agreed,

I just slept and slept. I couldn't get my energy back. It wasn't like me. I didn't know what was happening and I wondered if I would ever be the same (in my level of functioning).

The perception of being unable to ignore the messages of one's own body was also new to some co-researchers, particularly those who had spent a lifetime ignoring their bodies. It was very distressing to those who thought of their body as a 'worst enemy' and not to be trusted.

That was a real difference. I started to pay attention to what I really wanted instead of hearing, 'Oh, that's high fat, don't eat that', or whatever, you know, the tape recorder inside? Because when I ate what I really wanted, then I always felt better, maybe it was the vitamins, I don't know, but I always did feel better. And I also started to...I can still do it, I can feel where my food is [along the digestive tract], I mean I can really tell and so I know what's going on better... and I never did that before. (Paula)

Becoming reacquainted with or newly aware of the physical self has taken some co-researchers many months, and sometimes even years, to deal with.
Changes in perspectives about weight, size, and food.

All co-researchers were more than happy to 'own' the more rewarding and pleasant aspects of surgery, particularly a euphoria associated with body size reduction and weight loss. It was rare for any co-researcher to use negatively-oriented language when speaking of these and related issues, and there was uniformity of experience and affect in speaking of these aspects. A marked contrast was drawn between all previous weight-reduction experiences and the present, seemingly effortless process.

It was speculated that because the co-researcher's attention was occupied more toward simple recovery (ie: incisional healing and very notable side effects), the present weight loss did not have the same 'mental effort component' as had usually accompanied it. Co-researchers were shocked to realize how much of their daily lives had been invested in weight, weight loss, and body size issues. All commented on how much 'energy' had been released from these concerned to be refocused toward other aspects of women's lives.

Notable was an immediate change in perspective about what food is and the trappings surrounding the act of eating. This difference in co-researchers' relationship to both food and eating was an alteration in their worldview which was clearly visible to them, but which also affected much tangentially related to it in a less visible manner.

I suppose I am eating different things [than I used to], but it's not for the same reasons...I mean, I can eat whatever I want to, I guess, and that makes it easier for me to have this rather than that (Alicia-Tammy).

And there's no mistakes, you know? I mean, so I go and eat this thing that's 'bad' and I'll probably suffer from it. But I don't have to beat myself up about being a bad person because I'll still lose weight anyway. I learned...I'm still learning...how to let up on myself. I mean, it's a process (Anna).
The process of rediscovering a relationship to food on a very foreign basis to that preoperatively was tentative and somewhat disconcerting. For some women, it was a process fraught with difficulties that had not yet been successfully negotiated by the time of this study.

I just eat whatever I want. I don't care. It's going to make me sick anyway, so I just don't care any more (Patricia).

Others were able to gain some control by calculated forays into realms associated with problems:

I know I'll be sorry [whenever I eat peppers], but I just love them. I make sure it's Friday night, so I have [my days off] coming up (Paula).

Thus Paula taught herself how to trade off the unpleasant consequences of some food choices by sacrificing other aspects of her life to the anticipated results. Again, the choice of language used to describe the two positions is notable; essentially, both women describe similar reactions to food choices, but the framing of these descriptions is quite different.

Learning of how to 'negotiate' with one's body and reach a compromise was a prominent feature in both the early post operative phase and continues to be that of long-term experience. Of course, far more clusters of learning events focused around the early, more medically complicated period. The frequency of such events tended to decline as physiologic stability was achieved, and the patient's knowledge of her changed habitus was improved. Interestingly, effective negotiation or trade off strategies were described as an important coping skill only by those who felt that their ileogastrostomy
could be described as successful, and were not considerable viable strategies by those who felt otherwise.

**Felt Learning Needs and Responses to Them**

The belief that one was able to cope effectively was very closely allied to a personal mandate to take a proactive role in one's care. Some women saw themselves clearly as being primarily 'in charge' of their case:

> Well, me and my [GP], we make a pretty good team. I don't run in for every little thing, I mean I keep an eye on things, but when I know things aren't right, I don't just wait around, I mean, when something's wrong, I can tell and I'll just go right in there and say, "Look, this and this and this is happening." And he knows I'm not fooling around (Irene-Teresa).

Its antithesis was feeling ill-prepared, deficient in basic knowledge, or resentful of any need to undertake a coordinator's role. These latter positions tended to be associated with a woman's diminished confidence in her ability to give herself care, monitor her condition, or trust her caregivers.

**The need to be informed.**

Regardless of stance, co-researchers were generally upset when they talked about how little information was available to them and to their primary care physicians, especially over the long term. The more proactive the co-researcher, the more likely that 'lack of information supplied to the self' was cited as the greater problem:

> Once you're finished with that last interview [at eighteen months postop], you're history. You never hear another word out of them. After that, it's just you...and your doctor (Irene-Teresa).

> I need to know any new developments, I mean it's important to me [that] I can find out what I need to know (Paula).

The more reactive the patient, the more likely that 'lack of information supplied to the
family physician' was identified as the greater problem:

And doctors don't know...I mean, my doctor went to the [Woodward Biomedical] Library and looked some stuff up...[he showed me] this little pile of stuff (Patricia).

In both cases, a feeling of being abandoned by the surgical team without help and without information, to the care of non-specialist physicians who also were not kept informed, created considerable anxiety.

**Self-generated educational strategies.**

In response, co-researchers attempted to educate themselves. Their strategies might be as simple as re-reading hospital supplied materials or might encompass visits to libraries searching for other material about ileogastrostomy. Two co-researchers went so far as to visit the Woodward Medical Library to look for material there, but did not find this particularly rewarding because of the 'medicalese' in which the articles were written.

Self-education also encompassed 'picking the brains' of any ileogastrostomy-knowledgeable persons (such as former patients) with whom the patient came in contact. Resultant information (or misinformation) was used as a guide for either trying to figure things out (the more proactive) or as a guideline for checking up on medical care (the more reactive).

**Augmenting understanding through experience.**

All women read the information pamphlets, diet sheets, and related materials given out during the preoperative and in-hospital phases repeatedly. Co-researchers noted when re-reading materials shortly after surgery, several nuggets of information
'appeared', which they thought they must have skimmed over during previous readings. It was "as if I had never seen it before, though of course it was there" (Paula). In the light of each new experience, which yielded widening horizons of comprehension, they re-interpreted the material that had been given to them, finding 'new meanings.'

At the time of the study, co-researchers continued to wonder about 'hidden meanings' remaining that they could not yet detect, because these meanings would not yet fall into a framework within their present scope of experience. The sense that there were things that they could not yet know was unsettling.

The amplified meanings supplied by daily experience allowed more comprehension. Differences between 'common usage' and 'medically-based' language usage became more apparent. As perspective horizons broadened, the physical experience augmented 'intellectual' comprehension:

Like 'diarrhea.' Everybody knows you're going to get it...but nobody said a word to me about the hemorrhoids! Or the pain along with the diarrhea. I mean, you've gotta go but you're afraid to (Anna).

Because proactive co-researchers now understood that medical usage might not be the same as common usage, they now knew to resort to particular and very specific questioning about medications and symptoms. They were likely to remind physicians of their limitations in a way that suggested that physicians instruct them.

Reactive women were more likely to remind the physician that there were limitations of comprehension beyond which they could not go. These women wanted their physicians to 'learn their case', remember it, and deal with it.
The role of the medico-surgical team in postop learning.

For women who were reactive, the perceived trustworthiness of those they perceived themselves dependent upon was of very great importance. It was very stressful to them to consider that their caregivers might be 'flawed', or to accept that information had been withheld from them, whether this 'withholding' was purposeful or inadvertent. They said they were 'very disappointed' by the lack of a close relationship between themselves and members of the surgical team. They felt snubbed and ignored.

Proactive women remarked that they had 'liked' and 'gotten along well' with members of the team, although they too, felt the surgical team's approach to postoperative care was deficient in many areas. Particular emphasis was placed on the amount of time spent with the patient, chronic lateness of appointments, and a perceived lack of concern for or interest in the patient's post-operative learning and adjustment process. This aspect of care was a "rude awakening" for the reactive (Anna) or "regrettable" (Ingrid-Tova) for the proactive.

Women who became proactive early on, or had made strides toward proactivity over the eighteen-month follow-up period, felt they were able to get their needs met by restructuring post-op appointments in their own favor. They felt they did this by focusing on their concerns in an insistent manner.

You need to shove a word in edgewise, you know (Ingrid-Tova).

So [the surgeon] is busy. So am I...and I just drove in two hours and sat out in the waiting room for another half hour. Maybe he is busy, but I'm pissed off! (Ivy)
Reactive women expressed neglect or being brushed aside, and being unable to change this pattern of interaction:

Five minutes in the examining room, 'Fine, fine, looking good' and two minutes in the office, 'How are things, good, good, see you in three months...' and he's gone! And I'm out in the hall way going, 'But, but...' Like once he's done the dirty work, he's just going through the motions (Anna).

Both reactive and proactive women thought that their post-operative learning and adjustment would have been much enhanced if the surgical and medical team would have focused somewhat more on the woman's adjustment and somewhat less on the medical recovery. It was thought that these visits were the logical forum for the hospital team, or their representatives, to introduce "the things I didn't know to ask" (Irene-Teresa) at appropriate stages.

An example given was the first post-surgical viral illness. Three women fell victim to such an illness shortly after surgery. They said that it was only at the moment they fell ill that they realized they had not only no idea of what they should do, but no idea of what they should not do. Ought one "Rest and drink plenty of fluids" while in the throes of fluid-balance difficulties? Alicia-Tammy commented:

Well, maybe it was stupid of me not to ask, but I have had only one [ileogastrostomy] operation and they've done lots, so why didn't anybody else say anything?

The lack of this education was seen as a type of neglect. Co-researchers felt, on looking back over their own experience, that there were several crucial moments in their recovery when "a hint" (Ingrid-Tova) or "some guidance" (Ivy) or "a little information" (Alicia-Tammy) would have made learning a great deal shorter, less painful, and easier.
It was felt that if procedures like ileogastrostomy are to be performed, then there must be someone who takes ultimate responsibility for assisting patient recovery over both the short and the long term. The implication that medical and surgical teams should be prepared to assist patient understanding at appropriate stages in the recovery process indicates that patients believe that universal stages of recovery exist.

**Patient-centered care and learning.**

In the patient-centered philosophy outlined by Gerteis, et al (1993), a key component for successful recovery management is indeed the establishment of a flexible framework of educational support that involves the medical team, the patient, the extended support network of that patient (family, family physician, others involved in care). This framework responds to the expressed needs of patients as well as needs that an individual may not be aware of, but that have been established by a community of similar patients.

Co-researchers of this study believed the hospital care team were the most appropriate educators for ileogastrostomy patients. They were convinced that the hospital team did, indeed, 'know everything about' ileogastrostomy patients' learning needs. Not only did co-researchers believe that this was so, they believed that the hospital team would be best able to anticipate what patients would need to know and when they would need to know it. "Who else," stated Penny succinctly, "sees everybody?"
Confronting Reality, and Committing To It

Although a few women spoke of their struggle to accept a 'flawed' body as a continuing aspect of their postoperative experience, the majority did feel relatively content with their 'new' body size and shape. "I think I look pretty good, really," commented Irene-Teresa. Ivy commented,

Well, you have to be realistic. I mean, I have always wanted to have long hair. Losing a lot of weight hasn't made my hair grow differently and it still drives me crazy when I try to grow it out, so I still don't have it long. Well, I guess that's life, isn't it? You work with what you've got.

Scarring as a metaphor for change.

One issue of body dysphoria was prominent among all co-researchers, both proactive and reactive. The extensive scarring associated with the procedure was a strong focus of negative attention. Indeed, five of eight wanted to show their incisional scars to the researcher and ask her opinion on whether they were 'ugly'! This seemed to be a seeking of reassurance that scars looked the way they ought to, and would whiten or diminish with time. Women mentioned trying to 'talk themselves out' of this attitude, saying they thought this behaviour 'silly' (in one case, 'neurotic').

It did appear as though the scar played a significant role, in that it had come to represent an outwardly visible manifestation of the ileogastrostomy. The incision line was used as a metaphor for the invasive nature of the procedure, and the extent of the incision line was used as a visible illustration parallel to the extent of changes experienced in the woman's life. Of particular note, women would gesture toward their scar line unconsciously when talking about 'hard medical' aspects of their procedure and, in particular, any postoperative struggles.
The women commented on how shy they were of having the scar seen by others, and thus being 'forced' to account for it. Women talked of their struggles to come up with a self-protective, yet not dishonest answer.

Well, what do you say? I let some doctors cut a big piece out of me so I wouldn't be so fat? People think you're nuts. They just don't understand (Patricia).

This mixed reaction of shame about having been extremely obese, shame about having sought a surgical solution to that problem, and shame about being ashamed of both these aspects was closely associated with talking about the scar. Only once did a woman mention a desire to protect personal privacy when talking about her reluctance to explain it.

Defending altered perspectives against 'outsiders.'

Interestingly, the language chosen to talk about scars was similar to the language co-researchers selected to describe their experiences if they had to 'justify' their surgery to 'outsider' medical personnel (professionals either not well acquainted with—or indeed sometimes hostile to—ileogastrostomy). Women who suffered postoperative complications that required the care of medical personnel other than the primary care (GP) physician or the St. Paul's Bariatric team called these encounters either 'experiences' (proactive) or 'horror stories' (reactive). Once again, objective content of such experiences was similar between cases.

In three cases, postop complications resulted in a trip to an emergency ward in a hospital other than St. Paul's. In two other cases, women required treatment by specialists from disciplines other than bariatric surgery, or internal medicine. All five were disconcerted to discover that attending personnel had little understanding of and,
on one occasion, had never even heard of, ileogastrostomy procedures. The proactive
women met this challenge by 'educating' the staff:

So I just got out my little paper [the description of the operative procedure] that
Dr. Cleator gave me and I just said, 'Here, you better read this right away', and
I made them all read it (Irene-Teresa).

Proactive women said that this situation had only cemented their realization that they
had to act in "self defense" (Irene-Teresa) and become as well versed in as many aspects
of their care as they could.

Now I take care of it all...when I need this or that, I just go on in [to my GP]
and say, 'I think maybe my iron's down again' and then we do the tests' and nine
times out of ten, I'm right. [My GP] says so. He says I'm a better doctor [for
ileogastrostomy] than him (Irene-Teresa).

Reactive women, on the other hand, remembered these encounters as frightening and
bewildering, and they responded by becoming anxious and upset:

I told them to call [Dr. Cleator] and I wanted them to transfer me over there,
but they wouldn't...and they didn't know nothing, not anything (Penny).

So I tell them that I can't tolerate taking the pills; if I do, I'm so sick and if I
don't, I'm so sick. And [the specialists] just look at me. Nobody is able to tell
what they should do. And it's because of this [ileogastrostomy] (Patricia).

Equally disconcerting for the reactive women was an impression that 'outsider'
physicians--and even some primary care physicians--disapproved of the procedure itself.
Proactive women were more likely to tend to ignore or discount indicators of negative
or hostile attitudes, and utilized a 'spilt milk' attitude when confronted by medical
disapproval:

Like I said to them, 'Well, so who cares how I got the big incision, right now it's hanging open!' I mean, what I did or didn't do to myself isn't really the problem, is it? Besides, it's my problem and I'll deal with it. (Irene-Teresa)

Reactive women voiced a sense of betrayal and much anger that they were "kept in the dark" (Patricia) about the controversial nature of the procedure and, by implication, those who perform it.

Although all co-researchers had held high expectations, co-researchers had reached a nadir by the eighteen month benchmark. The proactive felt they had the best working relationship with the surgical team, but they also felt that this role was not a large one. They felt that they and their primary care physicians, working in conjunction, had taken and continued to take the largest role in their care, education and recovery.

The reactive stated they had a poor relationship; two had discontinued follow up entirely before the last visit. The reactive felt that either learning needs they had were being met inadequately, or else that further learning was not possible. In reactive women, turning to other sources for care created additional anxiety if they received conflicting advice from different sources. They had difficulty 'sorting through' not only advice per se, but deciding which physician they ought to trust above which other. They felt pulled from pillar to post and, after a time, simply gave up decision making.

One [doctor] tells you one thing, and the next [doctor] says the exact opposite. And no matter what any of them says, it doesn't work the way they said it would because none of them understands. (Patricia)

This was a very anxiety-provoking and upsetting situation for them.
Success and Failure of Ileogastrostomy

Co-researchers spoke of change taking place across three venues; physical (bodily) change, social milieu change, and intra-personal change. Co-researchers felt that there was a very complex interaction among these areas that determined the extent of a global sense of 'success' or 'failure' after ileogastrostomy.

When co-researchers were asked to explain what 'success' meant, the proactive described having reached a balanced state between what they wanted to do and what their condition would allow. They called this state "knowing what to expect." Being able to anticipate a predictable result gave them a latitude in which they felt comfortable making choices. Learning these new boundaries was called "figuring out what's going on" and "getting the hang of it", and self-diagnosed achievement of this stage was an important indicator that the procedure would be described as 'successful' by a co-researcher.

Interestingly, a perceived sense of what was successful was quite independent of objective measures. Putting to one side the single case in which medical personnel urged reversal (which would of course be objective medical failure) the range and variety of side effects demonstrated was dramatic. Post-operative sequelae ranged from wound dehiscence to electrolyte imbalance to a near-absence of any side effects; and it was not those with the more serious or more extensive postoperative complications that felt themselves to have had the less successful results from surgery.

Success was explained in relation to two major factors. First, perceptions of success were related very strongly to how much weight the woman had lost and how
much she had expected to lose preoperatively. If there was close agreement between these two factors, the woman was more likely to be 'satisfied' with her procedure.

Second, perceived success related to how early on in the postoperative period the woman was able to achieve a sense of having some control, at least, over her situation. The precise nature of control (physical, emotional, cognitive) seemed to be not as important as the belief that the woman would be able to utilize effective tactics that would yield predictable results.

Perceived 'failure.'

The lack of a sense of control was the most pervasive feature in reactive women's descriptions of their experience. There was considerable transfer of attention from issues formerly associated with obesity toward issues related to ileogastrostomy. One would have to question whether this transfer would reflect 'negative' perspective shifting, or would better be described as displacement of a pre-existent pattern of concern from one area into another.

Ileogastrostomy was said to be a 'learning experience' even for reactive women. This often meant, unfortunately, that the patient found out too late what ileogastrostomy "really" was. This discovery came only as a result of first-hand, in-the-body experience, which only permitted a full comprehension of key concepts after surgery.

Women did not believe that the knowledge had been purposefully withheld from them, but rather that not all efforts had been extended to "make [the patient] understand" (Anna) what would follow surgery. Women blamed themselves, as well, for
their condition because "I had my mind made up and I wasn't listening" (Patricia) and "I wanted it" (Penny), which was very reminiscent of the pattern they had used to explain how they came to be obese initially.

Perceived 'success'

Irene-Teresa, Alicia-Tammy and Ingrid-Tova felt the conditions they had experienced related to ileogastrostomy had either created, permitted or exercised an influence on the course of their postoperative intra-personal development. They stated that although they did not perceive themselves to have changed ("I'm the same person I always was" [Irene-Teresa]), they said their whole lives had changed, and therefore their procedures were 'successful.'

The Subjective Experience of Perspective Transformation

Those women who experienced perspective transformation spoke of this as a process both still under way, yet also encompassing a 'before' and 'after' condition. They knew that their perceptions of how 'things ought to be' had changed, and that this change had provoked considerable diversity in their social and intrapersonal range of 'permitted' experiences compared to before surgery.

Co-researchers said 'change' meant two things concurrently. It was used to mean the moment in time that successful, result-associated modifications to behaviour and/or thought were achieved; or it was a state of mind a woman found herself in when she noticed that modifications had taken place.

Proactive women found it very important that the researcher understand that the moment of enacting changes in behaviour was not necessarily the moment that they
became aware that they were consistently acting from an altered perspective; in fact, these moments of understanding were not necessarily correlated very closely in time with behaviours.

Quite often, women acted "on automatic pilot" in "old patterns" for a period of time during which they "switched over" to new beliefs and new patterns, in a seemingly imperceptible process. This was not, however, a smooth and seamless transition. More often, a perspective had changed on a 'deep' or fundamental level but had not 'filtered up' to conscious awareness for quite some time.

Women called these changes "revelations". They "suddenly could see" they were allowed to live differently and they could do this because they believed it. A typical revelation moment was Irene-Teresa's experience:

We were in this [place] and this man was looking at me, really staring at me...and I had been feeling so good but I started to feel uncomfortable. But I said to myself, 'Irene-Teresa, just ignore him, he's probably not even looking at you.' But I still felt him looking at me. Then he came over and he said something like, 'You have the most beautiful smile' and we were talking and all of a sudden I realized--it just clicked into place--'I am not fat any more.' And I really, really knew it.

Co-researchers had a great deal of trouble deciding whether behaviours or perspectives changed concurrently, or which followed the other, and by how long. They stated that when they were "just ready" (Alicia-Tammy) change "just happened" (Ingrid-Tova).

A complex interplay between behavioral learning in one realm (eg: the physical) and its integration with beliefs in another realm (eg: the emotional) seemingly accounted for an 'incubation' and 'revelation' pattern. Each of the three women who felt that she had experienced global change described at least one significant epiphany
moment, as well as series of small awakenings. Only on becoming aware of such perspective shifts were they able to reflect on them, and trace a course back from altered behaviours to altered beliefs. It appeared that not until change had occurred and been integrated across realms that it became 'visible.'

Co-researchers said that once they were encouraged in the research setting to look back and examine their 'before' and 'after' attitudes and beliefs, they then could identify watershed experiences related to change. They also could identify when and where differences began in behaviour and attitudes, though co-researchers felt that they "had never thought about it" (Ivy) before being asked to do so by the researcher.

During the course of the study, no one was able to predict impending change. Some tentative attempts were made to delineate areas in which it was felt that 'something' was happening. "I'm working on that" was a catch phrase--a humorous deflection--for realms in which women felt a vague sense of disquiet, unease or "not knowing what's going on" (Alicia-Tammy). It was generally agreed that 'revelations' were preceded by an incubation period of doubt and confusion.

For the three transformative women, as well as several other co-researchers, a process of replacing the attitudes and beliefs they had been functioning from (those of obese women) with attitudes and beliefs pertaining to 'normals' (which had been 'fantasy' beliefs preoperatively) was a large part of their postoperative experience.

Some co-researchers stated explicitly that their preoperative state had been one of division. They had held an image of themselves that was essentially split between the 'Real Self' and the 'Fat Woman.' They spoke of their obese body as a shell, or a type
of container, in which their 'Real Self' was hidden or trapped. This secret self was built around potent fantasies augmented by limited experience garnered during forays into thinness.

This would tend to confirm the existence of parallel belief systems thought to exist in obese women's worldview, as it appeared that while the women's primary state had been that of obesity, they had cultivated a secondary belief system that they fantasized would guide their lives, should they escape obesity. These beliefs were, of course, largely untested, until ileogastrostomy did provide the lived experience 'laboratory' to undertake this.

Conflicts between the reality of the recovery period and the untested parameters of this 'Real Self' were said to be the most difficult learning experience undergone. The greatest task of the post ileogastrostomy state was to occupy the 'territory' of a normal weight woman. This was an uneven process, easier in some realms for some women and more difficult relating to other realms. The experience of epiphany was very closely allied to a sense that the woman now believed completely that her new perspective was correct, appropriate and permanent.

This total commitment to the 'new worldview' was a focus for transformative women. Irene-Teresa found it "marvellous", in the sense of amazing or incredible, to look back on her past as an obese woman. Although she stated that she "remembered" and "understood" how she felt and thought, she now finds it extremely difficult to put herself back into that picture. She feels oriented "to now and to the future" and is not
able to comprehend how she could ever have thought otherwise than she thinks now.

It's funny, I think back and I remember how it used to be, but I can hardly believe it. I think now, 'How could I ever have thought so little of myself?'...because now I know that I am a human being and I have the right to be treated like one (Irene-Teresa).

Ingrid-Tova and Alicia-Tammy were in agreement that their basic substance, their 'core', was not changed, but that their 'approach' had changed, and by changing had affected their interactions with the world. Alicia-Tammy thought of herself as the "same person as I ever was, except improved." Ingrid-Tova felt that she was as she had always been but "better." At the same time, both claimed they could 'never go back' to their old ways of thinking! Although both were horrified by the idea of becoming obese again, they were convinced that if such a thing should happen, they would not return to being the same women they had been, because some indefinable substance in them was irrevocably altered.

Each of the three acknowledged that irreversible change had occurred over multiple venues, and that ileogastrostomy was a pivot event in this process. They described it as a 'challenge' that they had met successfully. These three women had experienced alteration in their worldview of a magnitude sufficient to qualify as perspective transformation. Ingrid-Tova summed her experience up nicely:

When I had surgery, I got my chance to really get it all together. I mean, all my life I had worked so hard on this one thing, and maybe it shouldn't have been such a big deal, but it seemed like everything else connected to it...so when things settled down [physically], I got a chance to really concentrate on aspects of my life [that had been neglected when I was obese] (Ingrid-Tova).
Perspective shifting and ileogastrostomy.

All women in the study, including the two that considered the procedure a failure, appeared to be in a process of movement toward alteration of perspectives. However, in those who experienced 'failure' accommodation between experiences and beliefs was more proscribed. Some spoke of great positive strides that had been made in a few areas, but considered other areas of their lives unsettled or unsatisfactory.

Paula and Ivy both felt they had intrapersonal growth issues to address. They said that the fantasies of what 'rules' would govern their lives as non-obese women (their secondary belief systems) were proving unreliable and difficult to integrate with the banalities of everyday life.

Anna, Penny and Patricia continue to suffer substantial medical difficulties, even a number of years after the procedure. Much of their energy is directed toward their physical state. Anna is the closest to her surgical date, and so it is possible that her condition will alter with time.

Penny had reversal of the procedure under medical advice, much against her will. Although her physical condition had been extremely difficult from the time of surgery onward, her improved social context was "so good, so wonderful" that she preferred to (and did) exhaust all her options before submitting to reversal. Patricia refuses to allow reversal because that would bring with it the return of her obesity.

This 'vision' of each woman's understanding of the permanence of her condition was expressed in different ways by the reactive and the proactive. Patricia called it a "life sentence." Alicia-Tammy said it was "no going back." Accepting that the body
would remain altered, even if surgery were to be reversed, marked a coming-to-terms with the irrevocable nature of the decision to have surgery. In this, all women in the study shared an equal relationship. All agreed that, however serious the medical implications might be, there would be misery of a far greater degree in a return to their previous state.

As if subscribing to that old saying, "how can you keep 'em down on the farm, after they've seen Paree?", the difference between positions was simply one of degree and of the point in time when a particular woman knew there could be no return. Women who felt their perspective had been transformed had committed themselves earliest to their new status. They adamantly refused to consider reversal. Irene-Teresa and Ingrid-Tova went so far as to say they would prefer to die of complications, if that were to be their 'fate', than to relearn or adjust 'backward' to the life of an obese woman.

I couldn't go through [becoming fat] again, knowing what I know now, having lived like this. That would kill me or this [ileogastrostomy] could kill me. I'll take my chances with this (Irene-Teresa).

They preferred a lifetime of iatrogenic illness to resuming the life they had known as obese women. This finding reflects reports in the popular press about bariatric surgery. In Chatelaine Magazine (Fat In a Thin Society, Sept. 93), a study from the University of Florida found that gastric bypass patients preferred blindness, deafness or loss of a limb to returning to their obese state.
Chapter Five: Discussion

Transformation and Ileogastrostomy

The ileogastrostomy patient wakes up after surgery in a state of medically imposed trauma, with little or no option for retreat. Before surgery, the woman knows her world will change, she believes it must change, and she hopes that it will change for the better—but she does not know how. She projects herself into a changed world, tentatively, but into a world that is largely unknown.

After surgery, she moves through the experiences that delineate the horizons of her new reality. It is in this world that she must live and to these horizons that she must make accommodation. It is not required that she make a growth-centered, positive, or life-enhancing adjustment, however desirable that outcome may be to others involved with her care, simply that she achieve stasis.

Because transformation is the cumulation of many, perhaps minute, changes over a range of realms, the process may be 'hidden' from the co-researcher for much of this interplay. When this complex interaction reaches a critical mass, and becomes overwhelming, it is then 'visible' to the women experiencing it. At the time that it does become visible, it appears to have sprung from nowhere, to have 'just happened.' The 'clarity' of this state is particularly evident when it is compared to the state that it comes out; which was described as sense of disorientation or confusion. This 'not knowing what is going on' seems to 'magically' clear at the moment of 'revelation.'

Presurgery positioning toward change.

For obese women undergoing bariatric surgery, it does seem that Taylor's first
phase, "Generation of consciousness" (see Appendix B) is entered when the woman allows herself to consider the prospect of changing her condition through surgery. However, **within** this stage lie Cochran's (1985) "setting the stage" and "envisioning an end." "Setting the stage" for change in this situation includes the orchestration of consultations, visits, lab tests, and decision-making that when successfully completed allows the contingent "envisioning an end" to come into play. Envisioning the 'perfect world' resulting from one's decision, appears to fall *between* Taylor's Step 1 and Step 2, and completely outside the sphere of Mezirow's discussion points.

It would appear, with ileogastrostomy patients, it is after positioning for change has already been emplaced for a considerable amount of time that the "disorienting dilemma" is then encountered; that is, the difference between the 'envisioned end' and the post-surgical 'reality.' In co-researchers who experienced perspective transformation, the nature and quality of the envisioned world had great influence on the post-surgical course, and it appears that the process of perspective transformation was intimately related to successful negotiation of very early change phases. By the time that the co-researcher had entered the 'apparent' beginning of the experience, that is, the disorienting dilemma, much groundwork had already been laid.

Evidence for this would be the claim made by transformative women that their 'attitude change' had been perceptible to others before surgery had been performed—certainly long before any physical or bodily changes had taken place that would 'account' for such change. Even in women who had not undergone transformative
experiences, a change in attitude before surgery had affected their behaviour:

There was a personality change (when I got my surgery date). It was still four or five months to go...and I was more genuine, more open. I kind of laugh about it now, but suddenly (I was) beating guys off with a stick (Ivy).

This experience apparently had roots planted during the stage of 'anticipation' or 'positing', part of the envisioning process (Cochran, 1985). The most apt scenario is that some women, even pre-operatively, had reached a stance of being 'ready' or positioned toward successful perspective transformation. They were 'arranging' conditions fertile for such a change, post-operatively, if only in imagination, and that anticipation or positing of results was preliminary to the disorienting dilemma.

Interestingly, in relation to ileogastrostomy, it did seem to be almost irrelevant as to whether this potential world was reality-based or not. Much of the positing toward their futures that women in this study recalled was entirely fantasy-based, simply because some women had had very little experience of adult life as nonobese women.

The remainder of the perspective transformation experience was the movement between the reality of the disorienting dilemma following surgery toward integration of altered perspectives. The subjective experience was that of "filling the gap" (Cochran, 1985) between the pre-operative fantasy and the post-operative reality in such a way as to create a harmonious adjustment among thinking, belief, and perception.

Commitment to one's position.

It was found in this study, as Taylor asserts, that an important aspect of perspective transformation is a sense of personal commitment to the new position, called by her Step 5, within "Phase III: Integration of consciousness". In this study, this
commitment was not part of an end-stage experience. The need to make a personal commitment was an important issue in both the pre- and post-operative period.

Post-operatively, it became an ongoing issue. It was essential that a woman accept the inherent 'selfishness' of her act, that of undertaking a controversial and risky surgery in order to satisfy what would appear to the world in general as 'vanity.' Justification to the self and others of one's allowing restructuring of a known and essentially functional system into one that was disordered for a reason so 'selfish' as weight loss was an essential component of commitment to one's decision.

Co-researchers had to place themselves 'center forward' to make an optimal recovery, and it was difficult to practice this 'self-centered' behaviour. Co-researchers said they were far more likely to put others' needs ahead of their own while they were obese. This is a behaviour common among women in general and markedly prevalent among obese women. To make this commitment possible, women struggled with questions which more closely reflect Mezirow's Step 2, "Self-examination, with feelings of guilt or shame" than they do issues of integration of changed perspectives.

Instead, questions revolved around the woman's upcoming 'voluntary trauma.' Had her 'obese experience' really been so bad as to make surgery a viable option? Were the probable risks and the unknown side effects concerning which she had no practical knowledge really a 'fair trade'? Was the quality of her life after surgery really going to be better? Could it be worse?
Critical reflection, or introspection.

Introspection, or "mulling over" played at least some role in all co-researchers' experiences of post surgical change. It played an extensive role for many, in particular for the three women who had undergone perspective transformation. High levels of introspection would tend to confirm the necessity for a "critical reflection phase" as an component of successful completion of perspective transformation (Mezirow, 1990).

Critical reflection apparently fulfils a crucial role in the process of realignment between past perspective horizons in accord with present experience. Patients must successfully integrate their horizons into a smoothly functioning pattern that will provide the 'hidden blueprint' that underlies the structure of day-to-day life.

It is doubtful that one can enjoy a high quality of life while 'between beliefs', and equally doubtful that one can or should endure the fatigue associated with long-term perspective disequilibrium. While the unexamined life may be an undesirable state, a life that must be examined in all its aspects from 'what to eat' to 'who am I now' is no more desirable. Post-ileogastrostomy, patients must regain familiar ground. If old territory cannot be reoccupied, new ground must be mapped and explored, until it fades into the subconscious realm and becomes 'how things are.' Since we allow our meaning systems to diminish our awareness of how things really are in order to avoid anxiety, creating a zone of blocked attention and self-deception (Mezirow, 1991a), we find it more comfortable to be fish who cannot see the water in which we swim. It would be far too disconcerting to spend our lives cross checking all our activities against
our belief systems before deciding what to do or what to think. We need a framework of norms from which to work, as best we are able, to guide our thinking and behaviour.

Subjectively assessing change.

While behaviours are notable in the physical world, attitudes are often hidden and their process of change is less identifiable. When behavioral change depends on attitudinal and emotional complexities, it is assumed that change leading toward desirable outcomes is always 'good' change. Yet, it is possible that 'bad' change (e.g., ongoing physical problems after surgery) can be associated with a desirable outcome (substantial loss of weight and enhanced social acceptance).

With ileogastrostomy and the resulting physical state that is neither as predictable as expected, nor as controllable as had been hoped, a process of 'looking back' while in a context of 'going forward' was begun. It was this assessment of present functioning against the woman's personal past, that formed the 'judgment criteria' for the success or failure in the woman's perspective and established her 'quality of life.'

Quality of Life

The phrase 'Quality of life' is used often in discussion of the pros and cons of bariatric surgery, and the validity of this concept has been criticized, mainly due its subjectivity. By this, it is meant that there has not been developed a standard criterion for objective measurement to be applied across studies. In the case of ileogastrostomy surgery, one must conclude that a person seeking weight reduction by this means must have, at the very least, a personal assessment of a poor quality of life; otherwise, one would hardly expect them to be willing to undergo a procedure of such magnitude.
It is only with the introduction of 'outside' opinions and, therefore, judgmentalism as to whose perspective is more valid that complications regarding quality of life assessment arise. If, for example, a woman obese since childhood calls the quality of her work life 'much improved' because she is now working for the first time--as a waitress--ought that response to be valued more than the response of another woman who says her work life is 'not improved' because she continues working as a lawyer, the same as she had before surgery? Perhaps to work as a waitress does yield a higher quality of life than to work as a lawyer, but to conclude such from statistical averaging seems doubtful.

The role of denial in quality of life assessment.

Patient recall has also been criticized as it is asserted that co-researchers may not remember their experiences so well as to be able to rate them. In this study, co-researchers were able to recall--even to re-experience--emotions associated with their experience of being obese very well, indeed.

In fact, four co-researchers declared that it was only after surgery that they were able to admit the pain and despair that had been an integral aspect of their obese condition. As Ingrid-Tova stated,

I didn't care if I died [in surgery]...really. I know that's a terrible thing to say, but I was suffering, I was desperate. But I didn't even want to admit that out loud. I finally talked to my husband...he was amazed. He didn't know how much it hurt me.

This finding bears out the Solow et al. (1974), Crisp et al. (1977) and Rand and McGregor (1990) studies in which pre-surgical levels of denial were reduced post bariatric surgery, which only then permitted patients to acknowledge the limited and
unsatisfactory nature of much of their preoperative functioning. It was noted that questionnaires about the quality of these patients' lives would have been answered quite differently, though equally 'honestly' if given before or after surgery. Rather, differences would have reflected the presence or absence of denial about past experience. Similar findings were confirmed in this study.

'Success' and quality of life.

These studies (Solow et al., Crisp et al. and Rand & McGregor) also found a correlation between a patient's subjective belief that she had met postoperative challenges effectively; had dealt with crises competently; and had achieved personal growth, with the strength of her belief that surgery had been 'successful.' If patients believed surgery had been a success, they also believed their quality of life was improved, whether or not their post-operative experience could be classified medically (objectively) as 'good' or 'bad.' Similar findings appeared in the present study.

Furthermore, in the present study, the quality of life experienced by women was very closely related to the likelihood that learning needs were met and whether such learning led to behavioral change and a sense of control. In a cyclic manner, it was again those who felt they had best control over their post-op condition who considered their procedure a success.

In accord with this, co-researchers who had the most difficulty with physical sequelae were not necessarily those who had minimal subjective improvement in the quality of their lives. Indeed, it was those co-researchers who said they had achieved new perspectives over the widest range of venues who reported the greatest
improvement in the quality of their lives. Those co-researchers who had either small changes over a wide range of experience or, conversely, changes in narrow ranges had the least subjective improvement. Even women who said they had minimal overall improvement did consider their quality of life improved in those venues in which they felt they had 'good' changes in their perspective.

**Extent of Change in This Study**

By the time that co-researchers entered this study, each considered herself irrevocably an ileogastrostomy patient, ie: affected permanently by surgery. This new perception of herself could not be undone: there was no way to 'unknow' that which had been learned. This process did, in some women, extend to encompass perspective transformation, while in others, it remained limited to perspective shifting with modification of only some aspects of a woman's life.

All women, including the woman whose surgery was eventually reversed, experienced shifting of perspectives. Thus, the quality of a woman's life is conceptually related to changed perspective horizons and is perhaps a product of changed expectations within those horizons.

A transformational event may be a logical progression through a short time period, punctuated by predicable steps in learning and integration. In another case, the process may take years in duration and be of a convoluted nature. Indeed, it may be that the tasks involved in transformation are too much for some individuals, and they may never achieve that condition.
As well, the time frame associated with such change after ileogastrostomy can vary widely and appears to hinge on the position the woman had taken toward surgery preoperatively, what kind of expectations she had of herself and her future, and how much change she is prepared to admit into her life, as well as how quickly she can integrate it.

The likelihood of transformation also appears closely related to how much divergence from posited outcomes each individual is able to cope with, how many facets of her personality and lifestyle will be affected, and how close to her core self these factors are.

Since such factors are often very closely allied to characterological issues, it is likely that resistance will play a very large role in whether transformation is permitted at all, and if permitted, how much and how quickly. Resistance may also play a vital role in whether, and how, change is acknowledged, and when that acknowledgment will occur.

In the literature, perspective transformation is usually spoken of as a global event. Does that invalidate shifts in perspective that occur to a degree less than global? Is a state of 'partial transformation' pre-transformative, an incomplete transformative state, or a state that will never become transformative?

In this study, five women said their experience lay between 'some change' and 'a great deal of change' and displayed somewhat more restrained assessment of the effect on the quality of their experienced lives than did those who experienced transformation.
These statements align with current ideas on perspective transformation, as it is stated that varied degrees of change had major effect on personal development and the social context, giving rise to altered perceptions of and perspectives on the 'way the world works' for that woman. This would indicate results of a more or less comprehensive re-visioning of at least some aspects of each woman's world.

More problematic are two cases where surgery failed; on the one hand, the failure state was 'objective' with reversal, and on the other, a failure was subjective, as expressed by the patient.

The patient who had reversal believed in concert with transformative co-researchers in several key perspectives. She said she was now and would always remain "an ileogastrostomy patient" (Penny) because her outlook on herself had been intrinsically altered. She was very careful when speaking to separate the 'medical failure' aspect of her surgery from the 'social success' component. She was sufficiently committed to her stance concerning the surgery's potential for life-enhancing results to say that she would have no qualms about having her surgery reinstated, if it were medically feasible.

The second patient felt that she had "jumped out of the frying pan into the fire" (Patricia) as far as her day-to-day physical situation was concerned. Yet, she also stated that her perceptions about obesity had changed, and her social interactions had changed due to her substantially diminished weight. Though this patient did not consider her experience to have been 'transformative' in any sense of the word, she acknowledged that she had had substantial alteration in her perceptions about herself, her rights, and
her role in life, and she was loathe to risk losing these gains and this was reflected in her refusal to consider reversal of the procedure.

Encapsulated within her discussions, like those of the woman who did have reversal, were repeated references to altered perceptions of her body, its state of being, and her expectations about its present and future functioning. Therefore, it would seem that at least some shifts in worldview do accompany even a 'failure' experience.

Three cases of perspective transformation.

In three cases, this re-visioning extended into a global perspective transformation event, in which the woman holistically committed herself, in confirmation of Taylor's final phase, toward an irrevocable stance--her new 'taken-for-granted' perceptual horizons. Those identifying this global change also claimed a wide-based, life-enhancing result from ileogastrostomy. They considered it to be a major and positive watershed event affecting the quality of their lives.

Key themes and factors in transformation.

One key themes in the development of a perspective transformational experience was the strength of an individual's sense of self as core to the experience. If this centrality was well established, the individual was more willing to incorporate new experiences and new data, and could thus move earlier toward regaining a sense of control over her world. This sense of being the key player in any interactions was associated with being able to build new, 'stable' horizons around herself in which she saw herself as the constructor of a worldview as an ileogastrostomy patient/normal weight woman that could be depended upon in a 'taken-for-granted' manner.
Another key issue was the amount of type of mastery over one's condition, and the understanding of the meaning of one's experiences. Validation of one's perceptions by peers, printed information, trial and error experimentation, comparison and reflection, and other means supported and reinforced the patient, reassuring her. From this, she was able to extrapolate that her experiences—although unique—were not necessarily wrong or novel, but rather her unique expression of what 'ileogastrostomy' meant.

**Shared traits in transformational women.**

It was the case that those who felt that they had undergone transformation did share some personality traits. They said that they had always had high levels of curiosity and a tendency to 'go find out' what they wanted to know. Perhaps as a result of this tendency, they exhibited considerable levels of comprehension about the nature of the procedure they had undergone.

They seemed to throw themselves wholeheartedly into working through to compromise with their state—whatever state that was—in order to reach a comfort zone as soon as possible. They attacked issues, rather than allowed issues to come up. They felt equal to finding and monitoring appropriate care, with minimal assistance, and saw problems in their search for ongoing assistance as a solvable problem.

They saw *themselves* as the central generators of the quality of their experience. Although they did suffer similar side effects, equal concerns and frustrations as did other patients, transformers felt these factors had not affected them in a significant manner. Such things were 'irritations' that could be dealt with.
They had had a lifelong tendency to take control over themselves and their experiences, with a pattern of doing 'whatever it takes' to get the results they aimed for; in short, they were ambitious. This pattern had also been rewarded, for the most part, with notable successes in many life areas (particularly when one looks at the effects of obesity stigmatization against which they struggled). Their single area of consistent 'failure' had been their obesity.

Finally, transformers showed high levels of loyalty and gratitude toward the procedure and, by extension, toward the medico-surgical team. They were not hero-worshippers; they had perhaps the most clear grasp of areas of inadequacy in their care and follow up, as well as the most specific suggestions to remedy those. They gave 'credit where credit was due' and frequently expressed happiness for their "opportunity" (Ingrid-Tova) to take command of a distressing and upsetting aspect of the lives.

At the time of this study, they expressed a sense of closure about having had surgery. They stated that their 'biggest gain' from surgery was a feeling of fulfilment of their own potential, or a "new lease on life" (Ingrid-Tova) that they felt they could never have achieved otherwise.

Since such a state could be considered a desirable or successful outcome, it would certainly seem reasonable that aid and assistance should be offered to facilitate development of such a state, or a state as closely approximating this as possible. The onus appears to be on those associated with ileogastrostomy patients' care to aid and abet the development of this state.
Chapter Six: Teaching And Research

Identification of the Learning Moment

In order that a person be able to recognize that choice exists in any situation, they must first be able to perceive that there are at least two positions, and be able to compare them. Change implies the consideration of movement between two positions, with a permanent move finally made from one stance to the other, and considerable ambivalence or wavering between the old and the new stance that likely accompanies, or precedes, perspective shifting.

Particularly in the case of issues related to 'core' perceptions, a novel concept might be hastily rejected on first presentation. But after a concept has been entertained once, it is more easily re-entertained. If conditions are apt and experiences appropriately constructed, novel perceptions may re-present themselves until a condition of 'false stasis' is reached, when the 'old' and the 'novel' perception become almost equally balanced. At this point, there is an inability to invest oneself wholeheartedly in the 'old belief', yet much difficulty in pulling away and investing in the 'new belief' (see Appendix B).

Co-researchers in this study spoke of this phase as one in which they felt a diffuse sense of unease and/or confusion, periods in which they felt that they "didn't know what was going on." They subjectively experienced a sense that all that they had ever known was no longer valid, but they didn't yet know anything else. During these moments, they could see that their old ways of thinking no longer fit, but new ways were undependable.
It was at precisely these moments that co-researchers thought not only that they most needed learning assistance, but that these were the learning moments in which they would be most open, and most receptive to change. When assistance was not forthcoming at these times, women experienced a subjective sense of being 'abandoned to their fate' and were quite angry about this.

**Learning Assistance and Interventions**

Information supplied to the patient.

All co-researchers in this study, as well as one additional woman who acquired the researcher's name from a co-researcher, strongly protested the lack of information available to them both pre- and post-surgery. Information that was available was felt to be insufficient (at best) and inaccurate (at worst). A further complaint was that updated information had not been routinely made available to them or to their primary-care physicians. An ileogastrostomy patient not in the study group was motivated by her 'need to know' sufficiently enough that she contacted the researcher to ask for a copy of the thesis; in addition, all co-researchers requested copies. If ileogastrostomy patients in general are so motivated, it would seem appropriate to give them what they request.

All patients believed a yearly newsletter (or similar) to be an important need in the post operative period. In one patient's words, "I am going to be an ileogastrostomy patient for life...doesn't that entitle me to one stamp and a few xeroxed pages per year?"

This would go a long way toward alleviating patient distress and anxiety about their future course. Patients have a strongly expressed need to have a sense of commitment and concern over the long term on the part of their medical practitioners.
Information supplied to the primary care (GP) physician.

Patients and the two primary care physicians spoken to indicated that not enough information is passed to the physician on a regular basis. Although information is given to the physician, this information may not include ample data on common sequelae, and recent developments in treatment are not routinely distributed. It was thought not unreasonable that a library of articles be developed and maintained by the hospital team, to be available as a resource base. This could be as high-tech as a modem-based file-transfer system, or as simple as a citation index of articles available through the local medical library.

Clarification of the medical status of ileogastrostomy, and its effect on the patient.

Ileogastrostomy patients are frustrated to discover to what extent their procedure is considered to be 'controversial' by other medical practitioners. Although the researcher does not have an opinion on how much of this debate should be made privy to the potential patient, it is an aspect of future care that patients must be prepared to deal with. Patients ought to be informed that many medical practitioners will be unaware of the nature of this procedure and it may well be up to the patient to make basic information available. Of course, the patient will not be expected to explain details, but they will need to have a comfortable understanding of it when they need to interview a new primary care physician, or need to visit an emergency room, or need care during the absence of their experienced primary care physician. In some situations,
such as an emergency, they may have to rely heavily on their own knowledge, and the more comprehensive this is, the better care they are likely to receive.

Co-researchers saw being informed about these issues as representing a commitment between themselves and the hospital team in a peer-to-peer relationship. They felt that information volunteered by physicians would be representative of commitment to that relationship, as this would imply respect for the patient as a 'member of the team', rather than someone to whom a procedure 'had been done.'

**Pre- and post-op teaching.**

Patients requested varied methods of instruction, such as videos about the procedure, classes or groups about care in non-medical language. They wanted information to be translated in what physicians might consider an 'overkill' fashion, and to be as simple and explicit as possible. They requested that written material be prepared and then discussed with them, in which each symptom would be clearly described with its associated ramifications, as well as first lines of defense and indications of when to seek professional guidance.

This last was very important, because patients are torn between their concern about their 'new' unpredictable body and an equally strong desire not make a nuisance out of themselves. Obese women have had a long history of attempting to make themselves less noticeable and less troublesome to others, and often have considerable difficulty in being appropriately assertive in follow-up care.
A handbook on ileogastrostomy.

Co-researchers wanted a 'handbook' of considerably more scope than the few pages given on hospital leaving. This handbook would outline in clear, simple language what they can expect to happen as a most-common scenario, as well as descriptive explanations of the less common sequelae and how to recognize developing situations.

Post-op peer support groups.

The co-researchers involved in this study were annoyed with having had to each 'reinvent the wheel.' They were absolutely convinced they would have had a much higher quality of and a quicker adjustment experience if they had had access to a peer support group. Some still felt a need as much as eight years post surgery to be in contact with others like themselves, because, as Alicia-Tammy said, "It takes one to know one." The rarity of their procedure and the rarity of the experience preceding it left these women doubly isolated. This need to be interconnected was further supported in this study, when it was discovered that no-one in this study refused to initiate contact with other patient. Indeed, several volunteered to do preoperative and/or in-hospital visits; all offered to be part of a 'phone tree' system, or a 'buddy system' for potential and newly-operated patients.

Contact with other patients was thought a good strategy for aiding patients in psychological adjustment. As Anna stated succinctly:

I have scars, you know, some you can see and some you can't. And really nobody understands what you're going through except someone else that's been through it.

A similar sentiment was reiterated when co-researchers thanked the researcher for
'allowing them' to talk about their experience. For many, it was the first time they felt truly 'understood', both in their experience with surgery and the pain that had led them to chose this option. They deeply appreciated what had been for many a unique opportunity to reflect on the profound adjustments that had followed surgery.

**Professional counselling sessions/groups.**

Patients undergoing ileogastrostomy often have had very limited experience in what are considered 'common' social settings and activities. The majority of co-researchers felt that counselling concerning such issues would be of value. Issues of self-confidence, self-image, and 'assertion' versus 'aggression' were specified by all; though other issues were mentioned by some women and not others. Those who had been obese as children or obese since puberty felt ill-equipped to deal with some life situations, specifically situations from which they had been 'insulated' by their body size. For example, as Irene-Teresa remarked,

> When I lost my weight, there were times... you know, I'd go really too far and say mean things. Stuff I used to say like a joke, when I was fat, people thought I was so sarcastic now. I had real trouble with that. I didn't want to be like that, but old habits die hard.

Professional counselling was also requested to help relieve interfamilial distress generated as the obese patient went through the roller-coaster of emotions and physical sequelae after surgery. In many cases, the changing expectations of the formerly obese individual placed heavy demands for change on significant others, sometimes to the extent that relationships crumbled under the strain. Although co-researchers to whom this had happened were philosophic about it, all were vocal in their desire to have
assistance with "The things I never even thought about" (Penny), ie: the stress of ileogastrostomy on significant others.

Learning programs as evidence of physician commitment
to the ileogastrostomy patient.

Co-researchers felt that learning programs associated with their care would indicate that they had not been 'left alone to face the music', which was indeed a significant factor for reactive women. Although proactive women were able to work around this issue, it would seem more prudent to provide this sense of commitment, if it were at all possible. Patients indicated that the following stratagems would indicate physician commitment:

- preoperative consultation arranged with peers so that patients can allay fears about the procedure; ideally this should be in a group setting
- more involvement of the patient's family to prepare for the crucial postoperative recovery period of rapidly changing physical, social and emotional experiences
- an extensive, illustrated, and detailed handbook of 'tips and tricks' about dealing with the ileogastrostomy recovery period for patients to read both before and after surgery
- postoperative, perhaps in-hospital, visits by 'graduates' of the procedure; with a 'buddy-system' phone tree for the immediate post-op period,
- followed by long-term support groups meeting perhaps every third month, to compare experiences
- a newsletter, perhaps bi-annual, sent out to all ileo-gastrostomy patients and their family physicians about current research and developments in the field
- a reference list of articles (or a library of articles) be maintained to supply family physicians with information about sequelae of the procedure, updated as necessary.
- a formal teaching program for both before and after surgery would be useful.
Co-researchers in this study thought that the emplacement of at least some of these strategies would have greatly enhanced the quality and effectiveness of their postoperative adjustment, no matter to what level it was carried.

One would also think it reasonable that if such complex procedures are to be performed, and persons on whom these procedures are performed are demonstrated to undergo massive adjustment phases afterward, the learning needs associated with these states ought to be addressed. When patients self-identify relatively simple interventions as crucial, one might then again be forgiven for questioning why these needs are not being met. It is to be hoped that lack of information about such needs has been the only impediment toward their fulfilment.

**Suggestions for Further Research**

**Issues in learning and adjustment.**

The "positioning" of oneself toward change (Cochran, 1985) is crucial for efficacy in the re-visioning of experience and the alteration of perceptual horizons. An enhanced understanding of the 'why', 'when' and 'how' of such positioning may prove predictive of the likelihood of perspective transformation before its occurrence. If the context in which transformation were likely to occur was predictable, perhaps provocation of transformation could then be made more likely.

It does remain problematic whether women experiencing substantial change in perspective were already poised on the brink, so to speak, into which context the choosing of this procedure represented movement within an already-established position.
Was it the case that offering the procedure activated a latent position already in existence?

The three women who had apparently undergone perspective transformation said change had sprung out of surgery, but had not been caused by surgery. Surgery was seen as a choice, and implied within stance was a choice not taken. Having been positioned to make a choice implied a consciousness already at least somewhat prepared for change. A long-term goal had been imagined, and an 'open' position taken toward a perceived need for associated substantial adaptation.

I had had enough of that life...I knew I had to make a big change. I was ready for anything, anything it took (Irene-Teresa).

Is it possible then that persons experiencing perspective transformation associated with ileogastrostomy are already in a state amenable to this magnitude of change before being offered surgery, and so enter into the surgical experience in the earliest stages of perspective shifting? For these reasons, it would be interesting to follow patients from the time of initial contact with the Bariatric Service (both those who do go on to have surgery and those who do not) in an attempt to determine when the 'decision to have surgery' is actually undertaken.

While it is likely that all patients will say that they are prepared to change, some are prepared to change radically and others will strongly resist making global changes. Yet others may accept more restricted change, or need more time to accommodate change. It would be interesting to see whether particular characterological traits underlie the limits of change that individuals can encompass, as well as when change can be integrated.
Additionally, assessment of ileogastrostomy patient must thus incorporate some method of assessing the amount of deception-function (denial) operating preoperatively as well as post-operatively; and if possible, it would be of great interest to note what becomes of the energy previously focused into the maintenance of denial about obesity and its issues.

It would be interesting, then, to follow patients from first presentation to Bariatric Services before any discussion of bariatric surgical options has been made. A broad based personality inventory such as the MMPI (Minnesota Multiphasic Personality Inventory) augmented with in depth interviews focusing on positioning issues as well as investigation of the patient's subjective quality of life ought to be done at this time as a base line.

Since there also appears to be a correlation between achievement or success in areas outside of weight control pre-operatively and successful postoperative adjustment, attention to patient's perceptions of their life skills would be interesting to assess.

Lastly, as many patients seen in the clinic do not go on to have this or any surgery, it would be interesting to see if there are any unifying characteristics or life criteria among those patients who opt for surgery.

In this study, there appeared to be intrinsic differences in viewpoint among the three obesity onset age groupings. It is appears that similar differences exist between men and women, and possibly between ethnic groups. Such factors have played little or no role in Quality of Life studies examined by this researcher. If differences were found to exist in patient populations, but have not been included in assessment, it is
possible that current 'objective' measures may reflect more accurately a medico-academic bias toward the perceived 'good things in life' than they do reflect actual patient experience.

Therefore, measures to identify very subtle gradations in subjective quality of life might enhance the understanding of the effects of obesity, as well as assist in optimal adjustment postoperatively. Since it does seem logical to understand where someone was trying to go before assisting them to get there, so understanding the subjective quality of both experiences would augment comprehension of what patients consider 'success' after surgery, regardless of how closely that 'success' might follow a standard model.

Three medical questions.

In those realms associated with biomedical functioning and processes, this researcher would like to call attention to three aspects of biomedical functioning emphasized by co-researchers in this study.

First, postoperatively, patients developed a strong disinclination for very sweet foods, particularly those of a sugar/fat combination. This is in marked contrast to patient's presurgical likes and dislikes as well as being in contrast to generalized human feeding patterns (Morris, 1994). Surprisingly, this disinclination was not limited to the healing period, but persisted and became a feature of life to the extent that several co-researchers mentioned being able to keep 'treats' in the house without touching them.

No mention of this facet of the post surgical experience was found in any of the researcher's readings with the exception of a peripheral reference to gut peptides in
normals in Smith & Gibbs (1992). As mentioned, as the researcher has no training or experience in such fields, attention is drawn to this issue only as a sidelight to this research, bearing in mind the wide realm of biomedical investigation with which the researcher is not conversant.

Second, ongoing diarrhea seems to be a feature even many years post surgery of much more prominence and severity in those persons who smoke cigarettes. No literature indicating connections between smoking and this symptom were found, except for tangential reference to the habit of smoking and tea and coffee drinking. It was unclear whether the coffee or the cigarettes was thought to contribute more to these side effects, but no directly relevant literature was found.

A short article in a lay publication, Consumer Reports (Caffeine's Side Effects, February, 1996) connects caffeine with bowel disturbances and irritation, and further investigation into any connections among these three would be of value to ileogastrostomy patients who smoke, take caffeine, and have ongoing diarrhea.

Third, during the research period, an article about the prevalence of Helicobacter pylori in ileogastrostomy patients was published (Cleator, 1994). The symptoms associated with this bacteria closely parallel the gas/diarrhea/cramps complex suffered by patients in this study.

As infection rates were near 100 percent in subjects examined by Cleator, it may be interesting to call in patients still troubled by similar symptoms to test them for H. pylori. Results could give further data on infection patterns, as well as provide a protocol of treatment for long-term side effects associated with this surgery.
Closing Remarks

As long as those suffering from morbid obesity are stigmatized by our culture, there will exist an interest in ileogastrostomy and related procedures as a means to eliminate it. Although it is of vital importance to understand the medical implications of such procedures, it is equally important to understand the 'whole picture' into which these procedures fit.

The woman entering the operating suite to undergo ileogastrostomy is a woman volunteering to undergo radical revision not only of her body, but of her life. Revisioning of a life between that of a victim of severe stigmatization and that of a normal weight person would represent challenge enough, but this woman must also confront challenge in multiple venues. At present, meeting those challenges can be fraught with difficulty and, far too frequently, learning needs are not met.

It is hoped that the present study will provide some insight into what it means to be an ileogastrostomy patient, and will provide some indication of how the difficult and painful transition between two 'states of being' can best be negotiated. It would seem reasonable that if learning needs are identifiable, as they seem to be, efforts should be made to assist such women to meet expected learning challenges successfully and effectively. It would also seem reasonable to assume that, if these needs are met appropriately, more women will find themselves reaching the state of positive orientation toward ileogastrostomy associated, in this study, with perspective transformation experiences.
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Appendix A

Mezirow's Ten Steps

1. A disorienting dilemma
2. Self-examination, with feelings of guilt or shame
3. A critical assessment of epistemic, sociocultural, or psychic assumptions
4. Recognition that one's discontent and the process of transformation are shared and others have negotiated a similar change
5. Exploration of options for new roles, relationships, and actions
6. Planning a course of action
7. Acquisition of knowledge and skills for implementing one's plans
8. Provisional trying of new roles
9. Building of competence and self-confidence in new roles and relationships
10. Reintegration into one's life on the basis of conditions dictated by one's new perspective.
Appendix B

Taylor's Phases and Steps

Phase I  Generation of Consciousness

Step 1: Encountering trigger events
Step 2: Confronting reality

Phase II  Transformation of Consciousness

Step 3: Reaching the transition point
    (a) Decision to shift vision of reality
    (b) Dramatic leap of shift that "just happens" in a way not consciously planned

Step 4: Shift or leap of transcendence

Phase III  Integration of consciousness

Step 5: Personal commitment
Step 6: Grounding and development
Appendix C

Fields of Inquiry

Each woman was asked about the age of and circumstances surrounding her becoming obese, and what that experience had been like for her.

She was asked about how she had discovered, been selected for, and decided upon having this particular surgery, and about her recall of the events surrounding surgery itself.

The process of recovery was explored with reference to the immediate postoperative period, any medical or surgical complications, and the process of long-term physiological and psychological adaptation.

Women were asked to summarize their present experience as post-ileogastrostomy patients, and to reflect on what strategies might assist another in making post-surgical adjustment.

Finally, they were asked if they would 'do it all again' knowing what they now knew, and if they would recommend that such surgery be performed on someone they knew.
Appendix D

Kay's Experience

Kay is a busy and active person, which surprises many people, since she weighs more than a hundred pounds above her ideal body weight. She is careful about her grooming but tends to wear whatever clothes fit her, rather than being able to pick and choose colors and styles, due to the limited selection available to her. She has periods of intense dislike of her body and her appearance, though for the most part she has developed an ability to 'not see' herself.

She is very aware of her obesity, since being freakish or 'not okay' is reinforced for her every time she goes out of the house. Consequently, going out of the house has become more infrequent as her weight has increased. On the one hand, it is physically difficult and challenging to go anywhere; most of the world is not made to accommodate her size. At times Kay just does not have the strength to want to draw attention to herself.

Kay finds it very difficult to maintain healthy self-esteem in a world that is very judgmental about looks. She solves this problem by building her self-esteem by 'over-performing' many tasks, and by 'forcing herself' to do things she may not be comfortable with--like speaking up in public. She names her weight problem as the single biggest obstacle in her life, and feels it is not only 'her' weight problem, but is a problem for those around her, such as her children and her spouse.

Kay blames mainly herself for her difficulties, and expresses an exasperation with her inability to cope with her weight problem, even though she has proven herself to be a very 'successful' dieter. She has been on dozens of them; usually losing weight--sometimes very substantial amounts--but inevitably regaining that weight, plus more. Kay cannot help but think that there is just something 'wrong' with her--either physically, emotionally, or behaviorally--since she just cannot seem to get a grip on whatever lies behind her obesity. When she considers this issue at length she becomes very discouraged and has a strong feeling of herself as a personal failure and of herself as a burden to others.

Kay also has developed some physical complications related to her body weight, ranging from 'minor inconvenience' problems such as sore knees, to serious life-risk problems such as stroke and diabetes, and so her weight problem is not merely one of looks or 'psychological' aspects; there is risk to her well being, both now, and increasing in the future.

From a friend or from some source usually other than a family doctor, Kay hears about and considers obesity surgery. After consultations and screening, ileogastrostomy is chosen and she is given a date on the surgical waiting list. Kay, at this time, gives up
her problem to those who assure her they know how to deal with it. Kay now allows herself to believe, however tentatively, that at last something really will 'work' for her and permanent weight loss will be possible. She is somewhat frightened by the thought of surgery, but excited about becoming 'normal.' She daydreams about what life will be like. Most of her ambitions are simple--she does not expect to become 'beautiful'--she wants to be able buy clothes that fit her in 'normal' stores.

Kay does have concerns about the side effects she has been told accompany this surgery, but is rather in the dark as to exactly what those will be, although these have been explained to her in consultation. Kay has only the vaguest idea of what the surgeons propose doing inside her body, but ignorance is bliss. Although she hears fairly high numbers in percentages for those who suffer postoperative complications, she is confident that she will come through the surgery well. She can hardly wait for surgery. She feels like she is marking time until the 'big day.' But Kay's new confidence seems to 'show' and to attract unusual attention from others, even before any weight loss could explain it. She discovers that people are paying more attention to her, and she is less inclined to be submissive and deflect that attention than she used to. She is 'riding high' and very up. Rather than disturb this state with unpleasant ruminations, she prefers to just assume that everything will go wonderfully well during and after surgery--why shouldn't it? Kay much prefers to devote her energies to imagining her life 'After': what will happen to her?

In Hospital and The First Three Months.

Surgery is quite a bit more complicated and painful than Kay expected. The hospital experience overall is a somewhat negative one, and Kay notes that ward staff seemingly do not understand the limitations of her 'new' body. For example, they send food trays featuring items she has specifically been instructed to avoid. Kay discovers that not only do people who 'should' know about her condition not know, they expect her to know.

Kay is given some teaching sessions about her condition while in hospital, mainly by a dietician, and is also given a small amount of printed material to read, but she is surprised by how scanty this information is. She reads the pamphlets several times over the next months, hoping to glean more from them than is actually there. But by the time she goes home, Kay is delighted to discover that she is losing weight. She is caught up in the process of recovery from abdominal surgery for the most part, but she is also forced to pay far more attention than she is accustomed to doing to the 'basic' functioning of her digestive system. She is attentive--indeed, forced to be so--to learning what her changed body will and will not tolerate in the way of foods, spices, drugs, and beverages; and in what ways it is going to let her know what is does and does not want.
Kay has some trouble sorting out what part of her postoperative condition is related to having had surgery (of any kind) and what is related specifically to ileogastrostomy. She has stomach pain, incisional pain and intestinal pain; diarrhea, gas and bloating; and very foul odours associated with her digestive processes. Although these are common usage words that Kay "knew" before surgery, most have taken on new meanings particular to ileogastrostomy. Although Kay might have a wider comprehension of the medical meaning of these words, she sometimes finds her enhanced understanding to be of little practical use to her.

She finds it very difficult to utilize either her 'old' or her 'new' vocabulary, since many people are literally disgusted by her side effects. Kay herself is worried and embarrassed about them, and has trouble finding anyone she feels she can talk to. She feels that people do try to understand as best they can, but it is as difficult for them to comprehend ileogastrostomy as it has been for them to understand the experience of obesity that drove her to choosing ileogastrostomy. Furthermore, Kay also feels that since some people look at her as ultimately responsible for having created her present condition, just as she was ultimately responsible for having created its precursor, she shouldn't make too much of a fuss.

Sometimes, Kay wonders if she will ever improve from her current state. Perhaps she has jumped out of the frying pan and into the fire? No-one seems able to offer her any reassurance. She doesn't know anyone who has had this surgery before. Her family physician is going through this learning experience as much as she is. The surgical team at the hospital is very busy. When she calls the office, they do try to answer her questions, but Kay has begun to wonder if she knows the right questions to ask.

She feels she is living day to day; never really knowing what to expect between morning and night. She is concerned about her nutrition, and her vitamin and fluid intake, because it is obvious that whatever she puts in her body is out of it again before it can do her any good. She sometimes feels so weak and washed out after a round of diarrhea that she has to lie down. Occasionally, when a day has been particularly hard, she wonders if she hasn't made a terrible mistake. Maybe being obese was her cross to bear in life and she should have just put up with it, learned to deal with it.

But, on the other hand, Kay is losing weight, and quickly. She feels wonderful emotionally at the same time that she feels terrible physically. And there are circumstances following surgery that are reminiscent of her 'dieting days', but with a twist. She has dietary restrictions, but these are all odd ones: the foods that make her feel like she's on a diet are all on the new 'No List.' Lettuce, roughage, whole grains, cereals, raw fruit, raw vegetables, some cooked vegetables, and milk products are all 'no.' She feels like she is eating 'all the wrong things.' This has previously been associated in Kay's mind with feeling bad about herself--and gaining weight--but she is now eating mashed potatoes and white toast and losing weight.
This apparent contradiction sometimes throws Kay for a real loop. It's hard for her to get her mind around the idea that her old Good Food and Bad Food beliefs are not valid, at least at present. Kay ends up allowing her body to 'choose' what it will tolerate. She tries at first to follow the hospital-provided diet sheets religiously, but soon discovers that much of the advice in them does not suit her--at times, the advice given actually hurts her.

For example, the diet sheet recommends an orange-juice based rehydrating drink: it takes Kay a few tries before she sums up the likely connection between this acid-salt combination passing very rapidly through the bowel and an abraded, raw anus and her intense pain after intake of this mixture. So Kay gives up this drink, and extrapolates to plain orange juice, grapefruit juice, lemonade, lemons, limes, oranges and grapefruit: better to be safe than sorry. Later on, when things settle down a bit, Kay thinks she may experiment with reintroduction of these fruits; but for now, the result is that she loses some confidence in her hospital advisors.

At the same time, she worries that the problem may lie with her alone. Maybe everyone else is fine with orange juice. It seems such a little thing, that she doesn't know if she should ask about it; but then, she can't tell which are the little things and which are the big ones. Kay feels very odd to be like a stranger living in what used to be her 'own' body.

Three to Six Months After Surgery.

By three months after surgery, it's very possible that Kay either will develop--or discover--an incisional hernia. She has lost enough weight that her body is starting to droop and her skin to be baggy around the abdomen. She still cannot eat anything, it seems, without a rapid follow-up of diarrhea. Her incision has healed enough that she is able to sort out surface belly pain from deep, and both of these from intestinal pain; nevertheless, she still has periods of a lot of pain.

On the one hand, Kay feels she is recovering more slowly from this surgery than from any other that she has ever had. She feels very tired a lot of the time. She was hoping to return to work, but that looks impossible for at least a few more weeks--perhaps even a few more months. She is dismayed to find, on the bottom of her shower stall, evidence of the predicted postoperative hair loss. For some reason, this is one of the 'side effects' she was sure would not bother her much, but when she sees how much hair she is losing, she cannot help but be concerned.

On the other hand, people are starting to notice her weight loss. Because of her former size, they often cannot detect that it is weight loss they are noticing, so they comment on how well she looks--how happy, or how cheerful. She is cheerful; the experience is like all the ups of all the diets she's ever been on, without the accompanying downs of deprivation and struggle.
Best of all, this is permanent! Kay feels like, at last, her nightmare existence is really, really over. She isn't going to be a fat woman ever again. That thought alone compensates Kay for just about everything that might be considered a 'down side' of ileogastrostomy. As well, since her doctors say it takes almost eighteen months to really get over this surgery, there's still lots of time for improvement physically.

Kay feels lighter emotionally as well as physically, and more confident. There are lots of very 'up' moments, when she is thrilled to be able to put on smaller clothes, or sit comfortably in chairs that she didn't used to fit into.

Best of all, she feels free to pay attention to other things in life besides eating or not eating, dieting or not dieting. She turns more of her attention outward on those more and more frequent days when her physical condition seems to be a little better. She has learned during which parts of the day she can predict her physical course.

Socially everyone seems to be responding to Kay positively, which is a novelty. She had become so accustomed to being subtly maltreated that the absence of this treatment is more noticeable than the maltreatment was. Sometimes it makes her angry now to see how differently she is being treated. She wonders why she couldn't have been treated the same way before—wasn't she the same person? She sometimes mulls over the 'whys' and 'why nots' of her experience of obesity. It is as if, now that she has escaped from what seemed like a life sentence of obesity, she can start to look back on and really assess her experience. Kay mulls over her present dilemmas and problems and compares them to those of obesity. She usually concludes, "Now is better."

Six Months to One Year.

By six months after surgery, Kay has learned more or less what types of foods her body will not tolerate, but her digestive system is still far from predictable. She has noted that it is not only foods that have an effect on the processes of her digestion. Even a 'safe' meal of crackers and cheese may be upsetting if she is angry, sad, or anxious. Now is a likely time for Kay to have her gallstones make themselves known; perhaps she will have surgery again. But her fluid balance has now sorted itself out for the most part, so her diarrhea has decreased; but it's still very much a part of her life.

At last she is able to return to work. She can get out for more exercise than she could when she was obese; interestingly, though objectively she is still very heavy, Kay feels differently about what she is 'allowed' and is 'not allowed' to do. If she feels like buying bike shorts and wearing them to try out some rented roller blades, she does. She laughs to recall that as an obese woman, she would never have dared to behave this way, that fat women are not allowed to do such things. She says it is funny to think about, but now she knows that since she is only 'temporarily fat', she has different rights than she used to. She now more readily allows herself to have what she considers the good things in life.
Kay is coming to an understanding that she will never 'get over' her personal range of side effects. She has become very aware of how little support there is, both in the medical community and among the public at large, to either help her with the many big and little concerns that she has or to comprehend why she would have chosen the route she did.

Her follow-up visits with the surgeon and the internist are lightening fast and Kay often cannot manage to get her real needs attended to, because she does not know what symptoms she should stress. She doesn't know herself and her functioning well enough, nor does she understand the procedure well enough, to determine which symptoms are serious, as opposed to things that she will just have to learn to live with. She is frustrated to find, sometimes after many weeks of suffering, that something she thought was 'just part of the deal' is actually a treatable condition.

She doesn't want to make a nuisance out of herself, but there are so many things she needs to know and to discuss; and most people just don't understand. Some medical people are so ignorant that she has even run up against a few who think that she has had surgery in order to "have her cake and eat it too"—in other words, they believe that Kay can now practice unlimited and uncontrolled gluttony and still lose weight. Needless to say, these people are not particularly helpful to her.

Kay still feels that it is almost impossible to talk to people, in general, about her surgery. They react to her in a manner that is between repelled and fascinated, so she tries to deflect the inevitable weight-loss questions with vague answers. There is still much insecurity and confusion in her thoughts about her health and her condition. She wishes she knew at least one other person who had been through the surgery, somebody she could turn to, to express her fears and trade information.

Overall, she's happier than she has been in a long time. She allows herself to eat out, to go out, and to participate in activities that she had not been part of in years. She feels like she has a 'sweet secret': she knows that she has, at long last, gained control over a situation that has caused her much pain and anguish. She is willing to consider the trade-off between her state of concern over her physical condition and her future, and her state of mental and emotional contentment, as being a reasonable one.

One Year to Eighteen Months.

Kay has grown accustomed to her new body's habits and is able to predict most of the time what it is likely to tolerate. She has noticed relationships between stress and diarrhea, between foods and overall health, and between her menstrual cycles and diarrhea; as well as fluctuations in her tolerance to different foods. She has, through trial and error, discovered which of her side effects can be diminished and which do not respond to any treatment.
By the one year mark, Kay may have had further surgery for any one of several complaints; it is even possible that she has had surgery twice more. Removal of the gallbladder, removal of stones, hernias, revisions of the ileogastrostomy itself, or ailments leading to gastroscopy are the most likely candidates.

Kay can now acknowledge that the woman in her 'Before' photos is both 'really her' and 'really fat'—something that she was not willing to address previously. Now she admits that she 'knew' this but didn't want to have to acknowledge it. She avoided this confrontation by not allowing many photographs of her to be taken at her heaviest, or by hiding herself in the backgrounds of shots, or at the back of groups, so as not to be noticed.

Kay has now something she always wanted, but never knew how much she wanted it: nobody looks at her any more than they look at others. She loves to go shopping for clothes, she is delighted by the richness of choices. She savours the sensation of being 'average', and fitting in. She appreciates the simple sensation of moving through a crowd and not being stared at. She does have trouble at times with old habits: if someone does stare at her, she feels angry and defensive and must remind herself that this person cannot be staring at her obesity, because she is no longer obese. Although she is still overweight by societies' current standards, Kay doesn't give a hang about it.

Kay is having a little trouble finding a middle ground between her old, other-dependent stance (wherein she allowed people to 'walk all over her', ignore her, and talk rudely to her) and a new tendency to be overly assertive and see offense where none is intended. Sometimes she thinks that she is 'getting her own back' after all the years that she knew she was best off to shut up and keep a low profile.

She eats pretty much whatever her body is willing to tolerate, without spending too much time agonizing over her decisions. Sometimes she will eat things that she knows will disagree with her, to try to train her body to accept them. Sometimes this strategy works and sometimes it does not. Diarrhea still comes and goes rather inexplicably; sometimes she can track it down by thinking back over her food choices, but sometimes a virus or stress seem more likely to be responsible, though there are occasions when diarrhea is spontaneous and unrelated to intake or activity.

Eighteen Months to Three Years.

Kay feels herself to have reached a plateau of 'health' for the most part. She is meticulous about taking vitamins and supplemental shots and her nutritional intake. She is confident that she is doing the best she can to care for herself at present. The initial euphoria of her weight loss is slowing down, as has her weight loss. It looks as though her weight as pretty much bottomed out. As predicted preoperatively, Kay is still about 20% above the 'ideal' weight for her height. She is a little unhappy with this,
but not very much, since she feels that she is of 'normal' weight.

Her outlook is now far more future oriented than it used to be; and little of this is related to the specifics of diet and body image. Her range of vision was for a long time limited to 'when will the diarrhea stop' or 'when will I have lost my weight.' It has come into her mind, and she feels somewhat silly to not have understood it before this, that she is an ileogastrostomy patient and will be for life.

Although Kay 'knew' this before undertaking surgery, it now feels as if this knowledge has become part of her, blood and bone; and so a great deal of her present interest in her physical state centers around her long-term prognosis. Kay finds that little information is available to help her do this. Not only is little known, but that little is couched in very medically-dense reports and terminology that she cannot readily understand.

Further, although what is currently known is told to her, Kay is somewhat upset to realize that unless she seeks out information herself, there is no means of receiving updated information about new discoveries in the field as they appear. She is irritated by this and feels that she has been left 'holding the bag.' She feels like she, as the recipient of a very complex surgical procedure who is not a medical professional, and the health care professionals involved with her care had a 'contract', and they are not keeping up their part of the bargain.

Because Kay does not have either access to nor the understanding of medical language necessary to research material related to the field, she has to rely on her family physician to do this for her. Like most general practitioners, her doctor does the best possible for her, but has neither the time nor the facilities to explore ileogastrostomy literature at length. Kay is particularly annoyed that there isn't even a hospital-based intermediary, nor even a peer support group, to help keep her and/or her primary care physician up to date; and help her make a smooth transition into the highest possible level of life-long functioning.

Three Years Plus.

When Kay reaches the three years' post surgical dateline, the thrill of being 'newly-thin' has dissipated, and Kay sometimes finds it hard to remember how it felt to be fat. She does recall the emotional pain associated with the state, but has to 'go looking' for that pain.

Kay has rejoined the national preoccupation of 'normal' women--that of being not as 'thin' as society would like her to be. However, unlike others, she does not express any desire to get involved with dieting. She claims she is still food-concerned, but thinks she is not food-centered in the same manner that she was before surgery.
For the very obese woman, much of the pleasure that she has in life is transferred into food-related activities, since she is excluded from so many other pleasure-producing ones. Furthermore, the frequent struggles associated with successful dieting--counting calories, weighing portions, planning every bite and every meal--occupy equally intense time and energy stores, and thus place her relationship to food and eating at the center of her existence. Food had been both a pleasure and a pain, with frequent rounds of dieting followed by equally distressing cycles of regain.

Kay believes her history of yo-yo dieting played a significant role in her development of massive obesity. This belief underlies her conviction that she will 'never diet' again, so as to avoid re-entering this mental state. At present, Kay is far more likely to think of taking up an exercise program or cutting down on fat in her diet as strategies for any change in weight she might like to make.

Because her reduced weight has allowed her to expand her interest base and to enter more into 'outside' life, she now has a much wider sphere of interests with more options to choose from without paying much regard to body size and shape when considering activities. Kay is more likely to be involved in a variety of activities such as yoga, dance, or an aerobics group.

Kay believes she can accomplish things that are important to her, and that there is nothing likely to impede or interrupt these activities in future--her weight is not, this time, going to 'come back' as it always has before. Therefore, she has invested in her new 'self': she buys nice clothes, has a bicycle, joins activities with her children (rather than dropping them off at the door), has more frequent sex, perhaps has a new job. She feels generally optimistic about things, as if she has now dealt with the most complex problem she is ever likely to suffer; everything else life gives her, she can handle, if she has to.

The single dark spot on her horizon, though, are ongoing side effects, which Kay now recognizing as 'hers for life.' Particularly distressing are the socially unacceptable and pain-producing ones related to gas, bloating and periodic diarrhea. At times, these can be very disruptive to her life and difficult to control. The need to monitor her nutritional status constantly through periodic blood work is rather wearing, and Kay 'has heard a few things' that have frightened her. She is always 'watching herself'; wondering what will happen next; hesitant as to whether such-and-such a symptom is a indicator of serious trouble developing or just a transient reaction.

She finds her body is still somewhat unpredictable to her; what is fine today may react badly tomorrow. She wonders if perhaps she hasn't just become a 'worry wart.' She often thinks that if she just had a little more knowledge, a little more information, she could lay many of her fears to rest.

Very few physicians seem to know much about this procedure and many of those
who do know of it are negative about it. Kay's feeling of being 'on her own' because
of the rarity of the procedure and many physicians' lack of knowledge about it
sometimes makes her feel quite anxious, and almost as much of a 'freak' as she used
to feel as an obese woman.

She worries about what will become of her should anything serious happen in
some location where there is no-one to help her. She worries about whether any future
complications will be picked up on as stemming from ileogastrostomy and then dealt
with effectively. She wonders what will become of her and other ileogastrostomy
patients when the specialists dealing with her procedure at St. Paul's are no longer
practising.

Kay has lost confidence in her medical safety net: while doctors in general don't
seem to know what she thinks they should about her case; she also feels that she,
herself, cannot be expected to be the medical authority on her care. She might not
mind taking on this responsibility, but doesn't think that it is feasible, given her
experiences to date. Although she is now several years post surgery, Kay wishes now
more than ever that she had contact with other ileogastrostomy patients.

Kay has occasional anxiety-loaded dreams in which she cannot control her weight
gain, and finds herself massively obese again. Although these dreams are not frequent,
they are very disturbing to her. She wonders if perhaps she is still trying to deal with
the pain that her obesity caused her; a pain that she repressed and has had no
opportunity to deal with. She cannot talk about this with other obese women.
Sometimes she will show 'before' pictures of herself and sometimes she talks about the
surgery, but she feels that most 'normal' people do not really understand either what
being obese was like, nor why anyone would choose the kind of surgery she has
undergone.

Kay is no longer on the high that accompanied the thrill of her weight loss, and
people are not making such a nine-days-wonder out of her. Many people don't know
that she was ever obese, nor that she had surgery. She thinks that there are people out
there who probably would think of her as a 'nut' if they knew about this surgery. There
are some parts of her experience that she realizes that other people will never share
and it saddens her to realize that, in that sense, she will never really be completely
'normal.' It is very hard for Kay to put into words why she feels that this surgery was
her best chance, perhaps her only chance for a 'real life'; and she feels it is almost not
worth talking even trying to talk about it with some people.

Kay would like to put the past behind her: she would like to forget that she ever
was a fat woman. She remarks that it's like remembering a nightmare. Kay talks about
her past as an obese woman as a living hell, and stresses that it is a past to which she
will never return--no matter what. When asked what she would choose if faced with
serious complications demanding reversal of ileogastrostomy (and an accompanying
return to an obese state) or to risk death if that should result from these complications, it takes her many long moments of pondering to decide.

Although her present level of physical adjustment is likely going to remain as it is or, if anything, become worse over the years, Kay vehemently declares that she would do it all over again. Her quality of life is so much improved, in her own opinion, that ileogastrostomy has been worth anything and everything it has cost her. Kay declares herself reasonably content with her situation.

She is ambivalent about her 'before' status as an obese person, and wishes that there could have been some other way for her out of her situation; by which she means some other way to lose weight. A secondary 'way out' for Kay would have been social acceptance as a fat person, but this is a distant second to another method of successful, long-term weight reduction.

It is clear that Kay considers her preoperative obese self ugly. Regretfully, Kay acknowledges this and says that she wishes things were different in the world, that it was society that made her have surgery—that made her want surgery—but realistically speaking, that's just 'the way it is.' She makes no apologies for thinking as she does, and declares that, indeed, she is certain that the majority of obese people would make the same choice—by that she means thinness over fatness—if they could. She doesn't believe all would want to choose surgery, but she does believe all would choose weight loss if they could be successful.

Kay believes that she more than paid her dues, both before and after surgery. Preoperatively, she had tried numerous weight loss schemes, but nothing had 'worked' for her. She is firmly convinced that if she had not had ileogastrostomy, she would still be as obese as she was—or worse. Kay often wonders if she would still be alive, since her medical condition was going from bad to worse, and her mental state was not of the best.

All things considered, Kay views the choice she made as the best possible one under her particular circumstances; and that this surgery was perhaps the only answer available under her particular circumstances. She declares the life she led before surgery was intolerable, and she was ready for drastic change.

When asked if she is a 'fat lady' any more, Kay replies that inside, she is the person she always was, but now those outside her can see the 'real Kay.' She says she is not a different person to what she was before surgery, but that the person she always knew she could be is able to 'come out' and interact with the world. She says that what ileogastrostomy has done is create congruency between her 'inside' and her 'outside.' At the same time, she acknowledges that she just doesn't look at things as she used to, and reflects back on how 'oddly' she used to think. 'I don't really know why I was like that,' she says, 'it seems hard to believe.'
But because Kay remembers that it was like that, she has learned to cope with whatever she has to in order to maintain her sense of being 'okay.' She considers her experience with ileogastrostomy to be a success in that respect. She is ambivalent about how successful the physical side of the procedure is, but is willing to tolerate it—it is no worse, for the most part, than the physical side effects she was suffering from being massively obese.

Kay remains frustrated that the medical community, who seemed so willing to give her a complex and rather poorly-understood procedure, were not there for her in the ways that she needed them after the initial postoperative period. She is particularly upset that the emotional and psychological adjustments that she now realizes were inevitable accompaniments to her surgery and her recovery from obesity were not addressed. Looking back, she wishes she hadn't had to go through those changes alone, and realizes that a peer counsellor, or better yet, a group, would have been invaluable to her.

As a result, Kay would like to help out somebody else who is trying to make the decision whether to have surgery, and would like to lend a hand to anybody who has recently had it. She thinks that she has more or less successfully negotiated this road and thus would be able to help someone else along it.