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Subjects of care: Living with overweight in the Netherlands

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Chapter 6

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Transforming agency in obesity surgery and treatment

Abstract

In this article, I describe the processes through which patients diagnosed with ‘morbid obesity’ become active subjects through undergoing obesity surgery and an empowerment lifestyle program in a Dutch obesity clinic. Following work in actor-network theory and material semiotics that complicates the distinction between active and passive subjects, I trace how agency is configured and re-distributed throughout the treatment trajectory. In the clinic's elaborate care assemblage – consisting of dieticians, exercise coaches and psychologists – not only is the person actively involved in his/her own change, the subject of intervention *is* the ‘actor’: his/her material constitution, inclinations and feelings. The empirical examples reveal that a self becomes capable of self-care only after a costly and laborious conditioning through which patients are completely transformed. In this work, the changed body, implying a new, potentially disruptive reality that patients must learn to cope with, is pivotal to what the patient can do and become. Rather than aiming to become disembodied, self-contained (neo)liberal subjects that make sensible decisions for their body, the difficult task patients face is how to become active subjects through submission and attachment and by arranging support.

Keywords: *care, patient empowerment, embodiment, bariatric surgery, agency, obesity*

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Introduction

Hans is a 43-year-old security officer who has been 'big' all his life. As he recalls, he grew up in a family in which abundance of food and drinks was the rule, a standard which continued in his own household where his wife does most of the cooking. Hans feels that his impressive body grants him a certain authority at work. For a long time, he tells me, he 'denied' to himself that his body weight posed a problem. But a few years ago, he suffered whiplash complaints after a car accident, gaining more weight and developing diabetes. At the same time, he saw both his parents die of cardiovascular diseases, and his son was becoming overweight too. '*Something needs to change*', he thought. Through playing squash and controlling his diet, he managed to lose 40 kilos and get his blood sugar levels under control. But keeping the weight off proved to be difficult. Periods of substantive weight loss were always followed by weight gain. Over a period of eight years, he calculates, he lost a total of 208 kilograms, gaining 280 kilogram back.

Recently, Hans decided in consultation with his doctor to opt for bariatric surgery. When we meet he is three weeks away from having 'gastric bypass' surgery in a Dutch obesity clinic, which I will refer to here as *clinic Q*. In this procedure, a surgeon will reduce his stomach to ten percent of its size and re-attach the new stomach to the intestine about 150 cm further up (see figure 5). A large part of his small intestine will thus be circumvented, a rearrangement that if successful should result in a substantial loss of weight. But whereas surgeons determine a surgery to be either successful or unsuccessful based on weight loss and reduction of comorbidities such as diabetes, in the clinic the substance of therapeutic intervention extends far beyond the body as revealed through the 'anatomy-clinical gaze' (Foucault, 1973) of the surgeon. Prior to and after the surgery, patients at clinic Q go through an elaborate clinical program meant to help them engage in better forms of self-care. Self-management and personal responsibility are key goals in this clinical treatment.

At first, gastric bypass surgery may seem to be at odds with such calls for responsibility, as the procedure suggests a surgeon relieves the patient of the difficult task of controlling his/her behavior. This framing may

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invite a sense of comfort to the patient as finally, normalized notions of body weight may be in reach (Felder, Felt, & Penkler, 2015); however, patients also risk accusations of having ‘cheated’ their way to health (Throsby, 2008). My fieldwork, however, suggests that in practice, support and agency are not mutually exclusive. In this article, I describe the processes through which patients diagnosed with ‘morbid obesity’ become active subjects through undergoing obesity surgery and engaging in an empowerment lifestyle program. As I will show, in the clinic's elaborate care assemblage – consisting of dieticians, exercise coaches and psychologists – the self-actor is not only actively involved in projects of healthy eating; their wishes, feelings and appreciations are the very subject of therapeutic intervention.

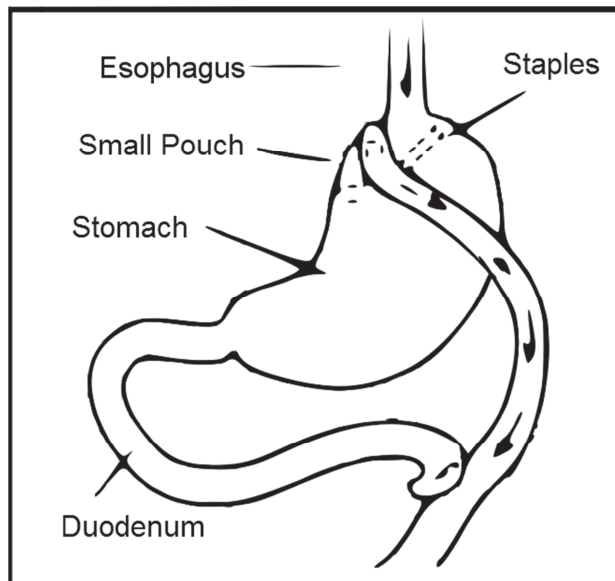


Figure 5. Model of a Roux-en-Y Gastric Bypass. *Source: Wikimedia Commons.*⁵⁰

⁵⁰ https://commons.wikimedia.org/wiki/File%3ARoux-en-Y_gastric_bypass.png, available under a CC BY-SA 3.0 license. Author: NIDDK. Derivative work: Steven Fruitsmaak. Last Accessed: June 19, 2016.

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Following scholars inspired by post-ANT and material semiotic work that complicate the distinction between active and passive subjects (Gomart & Hennion, 1999; Thompson, 2005), I trace how agency is configured and re-distributed throughout the treatment trajectory. In clinic Q's medical and psychological treatments, the qualities and abilities of the self, and the socio-material conditions through which they come to be, are rearranged. This rearranging, moreover, is to an important extent done by the patients themselves, who willingly submit themselves to objectification (by surgeons) and subjectification (by psychologists) in order to craft themselves differently. This agency, however, does not lead to liberation or control. Patients make things act on them that in turn make them act in certain ways, and that transforms them in the process. In this work, the changing body, implying a new, potentially disruptive reality that patients must learn to cope with, is crucial to what the patient can do and become. My argument is that rather than striving to become disembodied, self-contained (neo)liberal subjects who make sensible decisions for their bodies, the difficult task patients take on is how to become active subjects through submission and (re-)attachment and by arranging support. The empirical part of this article articulates how this struggle plays out in eating practices. The examples reveal a self that is capable of self-care only after a costly and laborious conditioning through which patients are completely transformed.

Obesity surgery in clinic Q

Between 2012 and 2013, I conducted fieldwork in clinic Q. While regular public hospitals in the Netherlands offer few meetings with a dietician and a psychologist to guide patients through the surgery, this private clinic makes surgery part of an extensive clinical program.⁵¹ After screening, patients are put into groups of 10 and attend seven three-hour preparatory meetings led by dieticians, psychologists and physical therapists. The post-surgery trajectory consists of meetings every three weeks in the same group

⁵¹ In the Netherlands, treatments such as these are fully funded under a system of obligatory health insurance, provided by private health insurance companies.

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composition for the first 18 months. Yearly follow-up meetings last up to seven years. To be eligible for treatment by both medical and insurance standards, adult patients need to have a Body Mass Index (BMI) above 40 kg/m³, or 35 kg/m³ with comorbidities such as diabetes or sleep apnea (Fried et al., 2014). The most common surgery practiced in the Netherlands and in clinic Q is the *gastric bypass*. On average, gastric bypass patients initially lose 85 percent of their ‘excess’ weight, with losses stabilizing over the years at 60–75 percent (Sjöström et al., 2007). Another common procedure is the *gastric sleeve mastectomy*, in which a large part of the stomach is removed, leaving a stomach the shape of a small banana. Sometimes these surgeries are performed in order to supplant a *gastric band*: a restrictive ring around the stomach that is now largely considered as an ineffective and outdated treatment.

During my fieldwork, I observed clinical meetings and various surgeries and had informal conversations and formal interviews with clinicians. In addition, I interviewed 15 patients about their history with being overweight and their decision to go for surgery.⁵² I asked them about their experiences with the clinical and surgical trajectories. They told me about their routines and strategies for dealing with the effects and demands of treatment in their daily lives, thus giving insights into how they live with what some called ‘their overweight’, and the ways in which the clinical treatment informed these practices.

Bodies, selves and agency

These days, with the increasing prevalence of chronic diseases, politicians and health policy workers often call for active patients. The new healthy citizen is informed about and actively managing his or her own treatment – indeed, preferably working to prevent the onset of illness to begin with. Given talk of

⁵² Interviews were conducted with patients, enrolled in different stages of the clinical trajectory. These patients agreed to the interview after being asked by the clinic personnel or they responded to a flyer that was put in the waiting area. Interviews were transcribed, anonymized in line with local ethical guidelines and translated into English. Names in this paper of both patients and clinicians are pseudonyms.

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how the 'obesity epidemic' is burdening nations with mounting medical costs, such calls for self-management often take on a sharp moral tone. A fat body is said to bear the mark of an out-of-control subject – boundless, spineless and gluttonous (B. Evans, 2006; Murray, 2007; Schwartz, 1986). By contrast, its desired alternative resembles a disciplined, self-contained (neo)liberal subject who makes sensible decisions for his/her body (Guthman & DuPuis, 2006; Throsby, 2008).

Given these pressures, social scientists are often wary of empowerment discourses in health care. They read them as a 'responsibilizing' mode of governing: enlisting the individual in its own controlling, thus placing a 'burden of freedom' on him/her (Rose, 1999). Often, the analytical stress is on what these institutions and programs 'make' people do. Muriel Darmon (2012), for instance, in stressing the drastic transformations that 'bodies and souls' undergo in a commercial weight loss group (a 'people-thinning institution'), presents individual motivations, will, and self-constraint as functions of external control and surveillance.

Bariatric patients' empowerment has likewise been discussed through such a lens. Knutsen, and colleagues describe the tensions that arise as 'caught between conduct and free choice' (Knutsen & Foss, 2011), patients struggle to navigate the tensions around control and credibility (Knutsen, Terragni, & Foss, 2013). As surgery in these programs is staged as a mere *tool* for weight loss, depending heavily on lifestyle change by the patient, others worry the patient now carries the burden not only of the effects of surgery but of its very success (Groven, Råheim, Braithwaite, & Engelsrud, 2013).

I contend, however, that the fact that people actively seek treatment invites a more complex analysis of agency and control that investigates what these programs make available to patients, given their motivations and options, and taking into account clinicians' notions of 'good care' (Mol, 2008b). Scholars inspired by actor-network theory and material semiotics typically attend to the ways in which situated relations and concerns might mediate institutional, cultural and medical norms. Through a focus on practice, such work does not take bodies, subjects and selves as pre-existing entities endowed with inherent capacities and qualities, but rather explores the processes through which they come into being relationally (Akrich &

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Berg, 2004; Danholt, 2013; T. E. Moreira, 2004). These analyses contrast with calls for self-management. While the latter often dream up a world of stable objects and relations in which only the decisions and actions of a pre-given subject (should) change, the former attend to the socio-material conditions for self-care and agency.

This approach depends on a particular way of studying action. More than just applying humanistic models to heterogeneous actors – stating that nonhumans and bodies *also* have agency – post-ANT work typically uncouples action from the (more or less distributed) actor(s) involved. As Antoine Hennion and Emilie Gomart (1999) stress, asking ‘who acts?’ is in these analyses, at least temporarily, no longer appropriate. A focus on enactment, multiplicity and marginality opens up agency beyond the managerial model of translation for which early day ANT analyses were criticized (Lin, 2013; Star, 1990). Only sometimes is an ‘actor-enacted’ (Law & Mol, 2008) and can action be circumscribed to a particular source. Indeed, it appears practices may not stage clear actors at all. Eating and digesting, involving semi-permeable entities that mutually transform and incorporate each other, are a case in point (Abrahamsson, 2014; Mol & Law, 2004; Mol, 2008a).

In her studies of women undergoing infertility treatments, Thompson (2005) questions the assumption that subjects are *either* active or passive. Instead, she argues, objectification through reproductive technologies is by no means antithetical to agency and personhood. Whether women experience the interventions as alienating, or as reconstituting their agency, depends on whether it was successful in achieving their goal to become parents. She describes how women actively submit themselves to these procedures, analyzing the process that structures the (dis-)alignment of treatment and women’s experiences as an ‘*ontological choreography*’: a dance between self and environment in which what parts the women are built of, what and how many descriptions they fall under and how integrated they are or need to be, changes. Through maintaining a synecdochal relation between self and parts of the body throughout interventions such as the pelvic exam and the ultrasound, women produce a desired long-range self (Cussins, 1998).

In their studies of the passions of music lovers and drug users, Gomart and Hennion theorize a similar mode of doing, which they term

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'attachment' (see also Latour, 1999). They argue that being affected (by drugs or music) is not an automatic effect of substance or sound, but depends on a 'making oneself available'. The 'competent amateurs' they study use techniques to make a set of heterogeneous entities such as drugs and music act on them in a way they desire (1999). They make choices, negotiate competing demands and exercise judgment, but they never master. Instead, their manner of proceeding is characterized by an obligatory pragmatism which permits 'not a liberation, but partial substitutions' (qtd. in Danholt, 2013: 378; Hennion, 2010: 1).

To these rich analyses of the agency of medical subjects and amateurs, this article adds a case in which the person is not only actively involved in his/her own change, but is also the subject of intervention – his/her material constitution, inclinations and feelings. As I will show, departing from a dissociation between one's wish to change and one's inability to do so, the subjects of this study move through the world making and breaking attachments. The network in and through which patients move and are moved includes surgeons, the surgically altered stomach, food, social relations and the clinical treatment. These attachments transform them, as embodied self-actors, in the process. They attachments change how patients feel, how they know and respond to their bodies and themselves, and thus open up ways of becoming while closing others. Although the effects of surgery are far-reaching, I will limit my analysis to practices of and concerns related to eating.

The promise of surgery: anchoring the will

[*fieldwork excerpt*] Mrs. Jansen, the second patient of today, enters the surgical room. She is asked to take a seat at the chair and place her calves in the holders. As she settles in, the surgeon and anesthesiologist explain to her that they will try to perform a gastric bypass, but that given her high BMI this might be too dangerous. If so, they will go for the gastric sleeve procedure, a procedure that is quicker and has less risk of complications. Mrs. Jansen knows all of

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this already. After the check, she gets an oxygen mask and the anesthesiologist administers the anesthetics. Mrs. Jansen is a bit restless, breathing heavily. 'Just let go,' says the surgeon as he strokes her arm, 'it's all good'. The next moment, Mrs. Jansen falls asleep [...]

After the procedure is done, the surgeon cuts the intestine where it attaches to the new stomach pouch, and checks one more time if all organs are in the right position and no bleeding is left. Once all instruments are removed from the belly, the medical resident and surgical nurse stitch the incisions for the trocars. The anesthesiology assistant stops the flow of anesthetic, slowly waking the patient. Due to the anesthesia, she will not be able to remember these moments in the OR. As soon as Mrs. Jansen wakes up, she asks: 'Did it work??' Busy cleaning up in his corner of the OR, the anesthesiology assistant mumbles, 'Yes, we did it.' A few minutes later, as Mrs. Jansen is still half asleep, she asks again. 'Yes, we were able to put in a bypass,' someone else confirms. 'Oh, great!!!' Mrs. Jansen moans.

The idea of bariatric surgery might suggest that the doctor comes in and corrects from the outside, thus relieving patients from the difficult task of taking control over their behavior. This framing privileges the situation in the surgical theatre as the relevant site for action, in which surgeons and equipment mechanically act on organs while a patient is anesthetized (Hirschauer, 1991). By the time the patient wakes up, the surgeon has done the work for him/her. But on closer look, a more complex interplay of doing emerges. Importantly, undergoing surgery does not necessarily imply passivity on the side of the patient. This is true when considering the practice of surgery itself – as Goodwin (2008) shows, the technological augmentation of the body in present day anesthesia provides the unconscious body with possibilities to convey its needs to the doctor – but particularly when considering surgery in a broader therapeutic trajectory. Patients actively commit and submit themselves to the interventions of the surgeon and his/her medical colleagues, making themselves a body that can be handled in the operating theatre.

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Indeed, becoming eligible for surgery is for many a task on its own. This is due to, for instance, the admission criteria for clinic Q. Sometimes people are referred to extensive psychological treatment first if their psychological problems are expected to interfere with the medical treatment and its effects. Patients who are dangerously overweight or present serious cardiovascular risks may have to stop smoking or lose a certain amount of weight to be eligible, lest they have to opt for a safer but less effective surgery. Sick leave needs to be negotiated at work, household and care tasks need to be delegated to others. In addition, patients have to be on a very strict diet for two weeks before surgery, in order to decrease the size of the liver, thus preventing complications during surgery.

Patients have good reasons to make this effort. For them, body weight incorporates such diverse concerns as immobility, pain, illness, and fear of health risks, but also feelings of intense shame and guilt. Moreover, dieting experiences were familiar to all of the patients I interviewed, who had often tried to lose weight by different means, sometimes continuously throughout their lives. In fact, to be eligible for bariatric surgery according to guidelines by the European Commission, patients should have tried and ‘failed’ to lose weight ‘by other means’, surgical or non-surgical (Fried et al., 2014). After this history of ‘failure’, the procedure holds the promise that an overwhelming and persistent problem – their body weight – will become (literally) graspable and solvable (Felt et al, 2015; Solomon, 2014). Not only will they get a ‘normal’ body, but they will have help getting there too:

Beth: ‘Surgery seemed to me the only way to lose weight and then keep that [lower] weight. Losing weight is not such a problem. I diet, and I pay attention. Now, because I know what I am like, to protect myself, I have this stomach reduction. Of course, at some point you will have a bit more cravings, but because of this stomach [pouch] you cannot eat that much anymore.’

Whereas Beth’s history of dieting locates the means to moderate consumption in her willpower and ability to ‘pay attention’, surgery allows her to bring forward the new stomach as an alternative route to success. Finally,

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restriction becomes possible and ‘pays off’: weight is lost. As anthropologist Harris Solomon phrases it in his study of metabolic surgery in India: ‘Aided by surgery, the body takes over and becomes its own instrument of therapy from the inside out. [...] Postsurgery, a person could enjoy loosened ties to the diets and medication that led nowhere and could instead invest in intimate attachments elsewhere.’ (2014: 71). One such new attachment surgery allows Beth to make is to her new stomach, a rearrangement that she says ‘protects’ herself.

Through mobilizing the surgical network, Beth makes certain parts of her body act on her in a way that she wants. Beth’s narration of the surgery begs the question: who ‘does’ what happens through surgery? Is it the patient, the surgical team, the rearranged organs, or the countless other entities involved in the trajectory? The answer is: none and all of the above. Even more interesting is what is made available through all this action. The procedure, I argue, anchors her will in her body. The promise of this materialization is that her body no longer needs to be the site of a struggle in which discipline is necessary to counter cravings. Instead, in the embodied self that surgery makes possible, will and cravings are in line with each other. The new attachment, then, does not only change *what* the patient can do, it opens up the possibility for a different *kind* of actor altogether: a willing embodied self, capable of moderately incorporating its surroundings. But as we will see, although in themselves, gastric bypasses or sleeves can be fixed in under an hour, these single attachments do not fix patients’ problems. Rather, they shift them.

Obesity in the clinic: staging problems, scripting solutions

Body weight and eating are already highly problematic for patients prior to entering treatment. But in the way obesity emerges in clinic Q, the ‘problem’ and what is necessary to counter it, becomes legible in a particular way. Through the surgery, the organs comprising the digestive tract, often referred to simply as ‘the stomach’, are brought out as, in a sense, more concrete – not only because they are literally made visible and manipulated by the surgeon,

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but also because they now display certain properties that were previously not specified to a particular body part, for instance, the (in)ability to limit food intake. As the stomach enters 'the scene of action'(Thompson, 2005) of treating and causing obesity, it takes on new meanings.

For instance, the possibility of an 'active' stomach makes visible how the body before surgery was not present in quite the same way. Consider Hans, who describes how after years of defying feelings of fullness when eating, he lost touch with his bodily signals:

'I am rarely hungry, but when I start eating it's as if a beast comes out. [...] Feeling satisfied, I don't right now - I'm never full. This is something that is not right.... here [points to his head]. So I look forward to it, because one of the effects of surgery is that you do feel satisfied. From a big plate full of meat dangling over the edge, you will go to this small piece. Well that will affect your eyes, your senses... with the huge bites I take, my brother always said when I eat a sandwich: I pity your sandwich, please act normally! So to listen to your body again, to not ignore it because then you will keep eating and eventually [the new stomach] will stretch again, one has to prevent this from happening.'

Like Beth in the previous section, Hans implies that surgery creates a new kind of embodiment which allows a moderate mode of consumption. In a very real way, then, patients' lived bodies, and their agency, come to life in the attachments made through these medical practices. A possibility emerges to become 'normal', to recreate what was somehow lost or never there to begin with. At the same time, however, in pointing to his head, Hans suggests the core of his problem lies elsewhere. Circulating 'horror stories' about what may happen after surgery revealed that in relation to the psychological problem, surgery might be disruptive, rather than helpful:

Hans: 'In the post-surgery treatment we will discuss lifestyle change. Like, how you will organize it. And yes, especially prevention, that you won't do crazy things. I hear stories about people blending big

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macs, just to be able to eat. I cannot imagine anything like this happening to me, now, but I haven't been operated upon yet!

Hans gives little impression of seeing surgery as a 'quick fix'. He anticipates a change after which he might not recognize himself. As his own inclinations and habits become part of what is taken up in treatment, he poses the time after the surgery not just as a recovery period, but as central to the change he sought when coming to clinic Q. As he indicates, surgery's effect on the amount he eats is not automatic: in order to 'work', the change requires him to adopt new strategies, to 'listen' to his body so as to prevent hitting upon and stretching the limits of the new stomach. In line with this idea, the clinic's motto – included in the very first information meeting and often repeated by patients in interviews – is that only 20% of the change comes from the surgery, and the rest 'you have to do yourself'.

Patients are not always inclined to accept this active role in their treatment. Especially in the past, clinicians faced 'resistance' to the post-surgical clinical program from patients who were only interested in getting the surgery and 'losing weight fast'. Now, patients sign a contract stating that they will attend most meetings; if they do not hold this agreement, they will have to pay a sum of money to the clinic. At stake is the very success of treatment. As my informants in the clinic tell me, although surgery kick-starts weight loss, letting the surgery 'do its job' without changing self-care practices may not prevent a person from overeating in the long run – a risk that fuels Hans's fear of stretching his stomach. Moreover, surgery's effects are not all positive. Patients can experience intestinal and digestive problems, and the pain and deformity of excess skin can make patients feel like they are worse off than before (cf. Throsby, 2012). Medical research reports a high risk of malnutrition, disordered eating and even alcohol addiction after surgery (Ertelt et al., 2008; Kalarchian, Marcus, & Courcoulas, 2008). In order to prevent these issues, clinicians in clinic Q ask patients to profoundly change the practices of self-care they engage in.

They do this through a number of therapeutic interventions and exercises. During a group session with a dietician, around eight months after surgery, the list detailed in table 1 was collectively established on the

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whiteboard. It was the result of an exercise asking patients to think about which changes in their lives were caused by surgery and which were caused by their own actions. It took a while before the group started talking, but after a bit of awkward silence, the discussion began. As the list continued, the dietician listened, summarized and paraphrased strategically to make things fit boxes or create clarity. The list demonstrates that surgery’s effects do invite certain types of behaviors (eating smaller portions) but that a surgical procedure may not change that behavior completely (‘deliberate choices’ still need to be made).

Table 1. Depiction of the whiteboard at the end of the session with the dietician.

Self	Surgery
<i>Healthy choices for products</i>	<i>Dumping</i>
	<i>Feeling full sooner</i>
<i>Eating pattern</i>	<i>Amount you are able to eat (first year)</i>
<i>Deliberate choices (saying yes/no)</i>	
<i>Losing weight</i>	<i>Start losing weight</i>
<i>Health...</i>	<i>... improvements</i>
<i>More physical activity</i>	<i>Different uptake of food</i>
<i>Better fitness</i>	<i>Smaller portions</i>
<i>More self-confidence</i>	

Part of the discussion was on ‘dumping’, the process of solid parts of a meal going directly from the stomach (pouch) into the small intestine, causing very uncomfortable bouts of cramps, sweating, nausea and diarrhea. Dumping, it was established, might be caused by the surgery – some people experience this while others do not – and is in this sense considered a helpless consequence of the body. But if one is susceptible to it, *choosing* not to eat candy because it *leads* to dumping is considered an *act*. Some people, after all, do ‘accept’ these effects and eat on anyway. Surgery thus merely creates situations that afford change. Some changes, such as increased physical activity, are facilitated by

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the weight loss the surgery induced but still depend on oneself to do it, and are thus put in the middle.

Clinicians thus make use of what Cheryl Mattingly (1994) called 'therapeutic emplotment', the production of narratives that makes surgery and what happens within the therapeutic process intelligible as leading somewhere. As talking was the main activity in the pre- and postsurgical trajectories, such narratives and exercises serve as powerful therapeutic techniques to involve patients in the treatment. These therapeutic plots also contains *scripts*. It is important to the collectively established performance of care around bariatric surgery to clearly indicate what should be done, and who or what plays which part, and when. Not only does this exercise elucidate the diversity of effects of surgery, it also makes visible certain important activities and tasks: managing complications, engaging in healthy activities, eating in a certain way, and dealing with the emotional and social consequences of bodily change. In this clinic, the message is patients cannot and should not delegate the task of managing their obesity to the surgeon, nor should they 'accept' dumping or find themselves doing what Hans called 'crazy things'. Instead, they should actively take on the work of getting in sync with, and adjusting to their new body. I will now discuss two ways in which self-care after surgery becomes a matter of concern for patients: in adjusting the socio-material practices of eating, and in arranging sources of self-care away from food.

Experimenting with unpredictable bodily limits

Many patients hope surgery will provide an opportunity to learn to eat differently, or rather, *better* (cf. Hillersdal, Just Christensen, & Holm, forthcoming). The new stomach, through radically reshuffling the sensorial qualities of eating, gives urgency to this learning process. If they fail, patients worry, they might 'stretch' their stomach again in the long run by forcing it with too much food. For some patients, post-surgery eating comes with the threat of dumping and other uncomfortable sensations. The new connection to the stomach thus does more than loosen the need for self-discipline. Bodily

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limits, and the effects of hitting them, are unpredictable, shifting. Care is in order:

Hans: 'Some things you will have to try out, there are also things you just don't want to try. White bread is a no-go. When I hear how much trouble this causes others... and for me it's easy to leave, so I won't even try. What I will do is a sandwich with aged cheese, because I think there is no point in punishing yourself your whole life. So I want to see if that works. I would rather have aged than soft cheese, it has a stronger flavor. But perhaps my taste will change too after surgery? You never know.'

In his elaboration of his plans to experiment with the limits of his new stomach, Hans highlights that he does not just ingest food (or not), but also chooses and enjoys it. He considers it important to take pleasure into account, to make life after surgery 'livable' – weighing potentially troublesome food based on what he can do without (white bread) and what he wants to keep enjoying (cheese). But nothing is set, as changes in the metabolic system may affect his food preferences.

Tastes, hungers, pains and pleasures were not just a topic in my interviews with patients, but are discussed at length in the clinical sessions, even before surgery. Moreover, clinicians encourage a specific eating technique borrowed from mindfulness practice, which should assist patients in experimenting with what 'goes down well' or not. Slow, attentive bites, according to dieticians, allow food to be better absorbed by the body and afford feelings of fullness. But such eating is not straightforward at all (see also Just Christensen, 2014). Halina, 14 months past surgery, explains:

'Old habits will present themselves soon. For example... If you eat a sandwich, and you cut it in 8 pieces. This was the advice from here [the clinic]. And eat it calmly, at a table, not in front of the TV. But then you eat 7 pieces, you're full. But you have one left, then I think: "Food should not be thrown away". It is a piece of 2 by 2 cm, it will fit. You come back from that immediately. It doesn't fit. Having a

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sleeve, it means I get symptoms like puking, sweating, being out of breath... So you notice that a small piece can be way too much. And that is how you learn. You have to try. I am at the end of my trajectory [of the clinic] now, so I kind of know what I can and cannot eat.'

Halina has to deal with a conflict between her stomach's limits, and her old habits and moral inclination: 'food should not be thrown away'. The new mode of eating, set up to help her recognize her limit, merely brings this conflict to the fore. The new stomach speaks loud and clear, but fails to be binding. Only because the effects are so severe did she eventually, through trial and error, learn what and how much she can eat. It is for this reason that some patients call 'dumping' a blessing and a curse: though very unpleasant, it will force them to eventually eat better and sync up with their stomach in better ways.

Amy, a few months after surgery, also finds it difficult to eat well as stipulated by the clinic. For her, the conflict emerges not from her moral evaluations but in her relation to the social world:

'What I now do is put down the cutlery, and chat during dinner. You need to dare to recognize when you are full. [...] You have to learn to not be bothered by anyone. Full is full. [...] You have to keep focusing on yourself if you are conversing with people. It can be very difficult, and often I'm still nauseous afterwards. One bite too much and you're done for the night. That really sucks. I have to say I get better at it, when I have the feeling I'm full, I cover the food in salt so I really won't touch it anymore. But yes, it is a matter of recognizing and some practice, but it is still tricky.'

Surgery is not enough to anchor the will to the stomach. Amy uses salt to strengthen the bond. On its own, a compact stomach size can only overrule social interactions and plate-size conventions when it is too late. Changing one's inclinations and behaviors requires more than a rearranging of the digestive tract; the socio-material practice of eating should reorder with it. The clinic offers mindful eating as a point of engagement to help fit a post-

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surgery body in daily life practices. Either patients actively link to their stomach by eating in a certain way or risk the forceful bond of dumping.

In everyday practices such as these, being an embodied person is a matter of doing (compare Mol & Law, 2004). It entails keeping a body together that is full of internal tensions, including that between a person's unruly bodily movements and his/her attempts at control. The surgically altered body is in tension with the body that enjoys food and conversation, as well as with the body that habitually and morally engages with food and eating. Eating after surgery entails learning, through effort and trial-and-error, how to reconcile these with one another. Attending to how bodies are done reveals that unity and harmony are hard-earned temporary achievements. The task patients at clinic Q face, then, is not making better decisions *for* their body, but learning how to *be*, and act as, a different eating body altogether.

Rearranging food and other sources of self-care

In clinic Q, it was frequently stated that though the patients' condition resulted from overeating, the cause of this eating is mental – Hans staged this mental realm by pointing to his head. Through the narratives and techniques offered by clinic Q and previous psychological treatments, patients thus learn to localize 'the problem' – the obesity – inside themselves. Accordingly, surgery is clearly not enough: as patients phrase it, surgeons only operate on their stomach, not on their head. Proper treatment for obesity addresses the latter too. In group sessions, the psychologists urge patients to explore what parts of themselves food and eating link up with.

For instance, they discuss words referring to ways of eating, like 'internally/externally triggered' (denoting a split between body and environment), 'restrained' and 'emotional'. Patients describe themselves as 'addicted'. Rather than analyzing how psychology constructs the 'eating mind', my focus here is on the clinic's language for what it does in directing patients towards certain forms of self-care rather than others. These categories invite patients to sketch out certain kinds of work they have to do

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in the clinical trajectory. Consider Julia, a 27-year-old woman five months after surgery:

‘Everything that is wrong here [points at head] is still there. But I learned in psychological treatments to leave problems where they are. So if someone does not do right by me, I am much more confrontational, I tell them what I think. I used to swallow [accept] much more. It’s not easy, because I’m still the same person, so my first inclination is still to take it home and eat it all away. So I have to take good care to be clear to that other person, to say: man that is not cool.’

As Julia starts relating to herself as an ‘emotional eater’, a particular form of ‘good care’ opens up. The surgery problematizes continuing old patterns – what Julia refers to as ‘being the same person’ – at least right after the procedure. One can no longer ‘eat it all away’. The terms introduced in treatment thus reveal a necessity for the head to catch up with the stomach’s changes. As both patients and clinicians tell me, the surgery will impact everyone differently. This makes the evaluation of, and work on the self, more pertinent: Being ‘me’, as this kind of eater, what will I have to face over the course of treatment?

Karin, a 45-year-old woman who underwent surgery eight months ago, mentions how in a pre-surgery meeting with the psychologist, the group was asked to explore the advantages and disadvantages of surgery. Pointing out that surgery has disadvantages underscores that the procedure is not a quick fix, but also asks patients to explore the work that still lies ahead. For Karin, the exercise made her anticipate losing a ‘good friend’:

‘I have a very busy life. I work, I have two children that I raise by myself, so I rarely leave the house on evenings. So if something happened at work, I used to think: which crisps will I buy? Cozy on the couch in the evening, with crisps, in front of the TV, that gave me a good feeling. So for me a disadvantage of the surgery was that I do not have the comfort of that food anymore. [...] I was very aware

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that I was saying goodbye to the crisps and that abundance of food. I experienced it as a kind of mourning process. It may sound very strange if you are not familiar with this... but I had the feeling you might have when ending a relationship with someone. You know you don't make each other happy anymore, and it's good like this, it wasn't right, but you still miss him. Sometimes.'

Both Julia and Karin maintain intimate relations with food, causing them to overeat. These relations risk interfering as the body's attachments to food have changed through surgery. They need to be released and rearranged. Paralleling Thompson's agency through objectification (2005), this way of dealing with oneself, I suggest, can be read as an agency through subjectification. As part of their attempt to change themselves, patients actively submit to the clinicians' psychological knowledge and techniques that, in addressing their 'head' (or psyche/mind), enact them as particular kinds of eating subjects. Despite the Cartesian distinction that talk of heads and stomachs suggests, in the problems that are talked about and dealt with, stomach and head are rather two active components of the same emerging embodied self-actor that need reconciling. This self-actor is affected by its surroundings, experiences anger, grief and loneliness, and organizes its forms of self-care accordingly. Speaking out when mistreated or letting go of crisps in the evening are not 'just' changes in behavior; both Julia and Karen work to transform their very way of being in the world. Julia makes new connections in the world and 'leaves problems where they are' instead of eating them, whereas the practice of mourning is a way for Karin to move on. In these ways, the semi-permeable boundaries of the embodied self may, for a moment, be self-caringly protected.

Conclusion

In this article I have argued that rather than taking over the task of managing one's behavior, surgery operates on the self as actor, thus offering patients a possibility to become self-caring. The transformations through treatment do

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not just make available a particular kind of agency; they change the patient as actor altogether. The self-actor patients aspire to become is able to eat moderately and experiences no internal conflict between their motivations and bodily drives. It is true that this focus on achieving moderation reinforces the image of obesity prior to surgery as a state of being out of control (Murray, 2010). The alternative that is strived for and practiced after surgery, however, is no in-control, free actor.

The self of bariatric surgery care that I analyzed is not opposed to the body, but moves with and in it; it is not engaged in choice and autonomy, but comes to act by the various relations it is part of. I have described patients' activity not as mastered choices, but as, following Gomart and Hennion (1999), the pragmatic constituting and substituting of attachments, both within the skin and outside of it. Self-care emerges as a matter of doing, aligning, adjusting, organizing, attaching and detaching. One change invites another, and in the process, patients do not only *act* differently, *they* (their feelings, inclinations and appreciations) come to *be* different.

I suggested that the way in which the clinic plots the therapeutic trajectory and scripts problems and solutions shapes how patients come to feel, know and respond to their (old and new) bodies and selves, thus opening certain forms of self-care and closing others. Rather than foregrounding the clinician's power, I stressed patients' active involvement in such constructions. Clinicians' ideas about what 'proper' self-management is do not always correspond to the patient's valuations of how much dis- or aligning one can handle, nor to how livable tensions are, or what connections one is able to make. The normative evaluations involved in the self-care practices I articulate here, however, are not static, tied to the subject positions of 'clinician' and 'patient', but emerge in the nonlinear, unpredictable process of transformation.

'Bad' and 'good' attachments present themselves and are continuously sorted out, leading to changes in the way the self hangs together. The attachment to the stomach that surgery makes sets itself apart for its particularly transformative effects. But like Hennion and Gomart's drugs and music, to be helpful, the surgery's powerful effects require a laborious and costly conditioning. In the shaping of everyday eating after surgery, and

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through the subjectification of psychological techniques in treatment, yet other attachments open up to forms of self-care. But at any point in time, attachments may fail too: stomachs block or stretch, awareness falters and old habits take over. Still, every attachment makes a difference, even if only temporarily.

Finally, this paper shows that calls for patient empowerment need not always be seen in light of neoliberal political or economic rationales, in which health is considered one's individual responsibility while self-care is the cheapest and thus most desirable option (LeBesco, 2011). The embodied self enacted in the practices I describe does not carry a 'burden of freedom' to choose (Rose, 1990) as it struggles to adhere to biomedical regimes. Enacting the patient as an actor did not result in less support or care. The question of who or what should take up the task of caring for obesity thus turns into: how might self-care practices be supported? Patients struggle, not because they are left to their own devices, but because living through transformative procedures, and living with chronic conditions, *is* a struggle.