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Being Big, Becoming Small: Conversations with Māori Women about Weight Loss Surgery

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Abstract

Weight loss surgery is increasingly being used to combat obesity, resulting in recipients becoming more visible in society. This in turn facilitates the normalising of what once would have been considered a radical medical procedure and the proliferation of discourse that more often than not measures success against models of slimness and appearance and underplays the downsides of surgery. Through the use of a narrative phenomenological approach, this research explores the experiences of surgery recipients, specifically Māori women, and asks the question; 'how does the embodiment of radical change impact on relationality, interiority, conviviality, and 'being in the world'?' Through learning from Māori women, this research also explores how being Māori shapes experience both before and after surgery and in doing so, contrasts to literature which frames experiences of indigenous women through a Foucauldian lens of colonialism. I argue that, as Māori, these women are supported by the collective – significantly so – but also have to grapple with and push back negative discourses that leak into their world. I also argue that life post-surgery is entangled with both liminality and potentialities; precarious, unsettled and unsettling, while being simultaneously imbued with hope and focused towards an extending future. Surgery does transform bodies through enabling tremendous weight loss but also transfigures far more than it is designed to do.

Keywords:

Anthropology, Aotearoa, Bariatric Surgery, Becoming, Commensality, Conviviality, Eating, Food, Kai, Mana, Māori Women, New Zealand, Obesity, Phenomenology, Weight Loss Surgery

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Chapter One: Introduction

A disturbance in the staffroom unsettled what had been an ordinary day at the office. Strands of hair lay on the floor and tears fell from large brown eyes. Malnutrition, somebody said, and we were all worried – really worried. The day the hair fell out was the day this research began. My colleague, post weight loss surgery (WLS), had shed dozens of kilos, reversed her risk of life threatening disease and really did look a million dollars. All the while however, she had to grapple with a drastically different gut – a digestive tract now struggling to hold on to food and absorb nutrition. Her hand shifting to her stomach signalled nausea and this happened often.

I began to realise that WLS¹ could not be thought of as simply a ‘before and after’ – with the ‘after’ often presented as the new beginning of an unencumbered life – but rather as both complex and challenging, freeing and limiting, unfinished and ongoing. I wondered what this experience was like for surgery recipients. What other narratives are entangled with the stories of success? Are new possibilities, embodied in newly slim, almost disease-free bodies, laced with compromise? As newly slim people, are WLS recipients treated differently by others? If so, how does this treatment differ in differing social and cultural contexts? Are relationships reshaped by the big-now-slim and do social hierarchies shift in response to this? As these questions arose I became particularly interested in the experiences of Māori women.

Many Māori women I know are, to put it simply, movers and shakers in their families, wider whānau,² in community and on marae. They are often the ones that make things happen, and a lot of these happenings involve kai – sometimes large amounts of kai for large numbers of people. Growing up, my Pākehā mother used to say (generalising but) with some authority, “If you need people to organise, coordinate and oversee a large event – ask Māori women – they are the ones that have the know-how”. I have had this confirmed many times in my life. With potency, Māori women enliven community through manaakitanga and kai – eating, sharing, strategising,

¹ Weight loss surgery is also referred to as bariatric surgery – I use these terms interchangeably.

² All translations are in the Glossary of Māori terms on page 102. I take the position that, in contemporary Aotearoa New Zealand, Māori words should stand alone in the text.

making, creating, connecting, providing, nurturing, and loving. Post-surgery, I wondered, how does it feel to be that person now?

Four Māori women generously agreed to participate in my research and our conversations drifted into the past – back when they were slim, to gathering and preparing kai and to what has changed in recent years. We talked about being Māori and the love and support of whānau and all the way through we talked about what can no longer be taken for granted – eating. Their stories moved from being slim to getting big, from being big to deciding to have surgery. From entering the bariatric surgery program and having surgery to re-emerging with an altered gut (drastically in some cases) and a rapidly downsizing body. All the while, as related to me, these experiences did not land in concrete places – easily defined as good or bad, better or worse – but rather as being enmeshed with many others – health, sickness, precarity, new futures, success, frailty, being visible and being objectified, eating for health and barely being able to eat at all. In countering the framing of WLS surgery as a ‘before’ and ‘after’ success story, this research focuses on the complexity of such an experience by foregrounding the stories of these Māori women.

I argue that surgeons, in the process of altering and removing parts of the digestive tract, change much more than they set out to do. João Biehl and Peter Locke note that: “the process of medicalisation [has] the tendency to obscure the social etiology of affliction and reduce it to a biological reality amenable to medical intervention” (2010: 330). I take this position further by arguing that the promotion of bariatric surgery – a highly medicalised weight loss intervention – obscures the social outcomes of having had that surgery. For example, commensality and conviviality, so central to the Māori world, are disrupted when eating can no longer be taken for granted. Conversely, bariatric surgery may both release previously unimagined potentialities (including extending *life* itself), and facilitate the possibility of cultural change as bariatric processes entangle with cultural and social processes.

Something else emerged in our discussions. The narratives did not fit neatly into accounts that frame indigenous people with health issues as victims of the state as is typified in a lot of social science research. These women seemed to access a deep reservoir of strength and I believe that this capacity emanates from the embodiment of mana. Mana moves from the ancestral past into the present, ensuring a degree of

efficacy in adversity and corporeal self-assurance – regardless of shape and size. From thinking about mana to contemplating the difficulties of eating, the tendrils of this research seemed to dip into every quarter and risked spiralling out into multiple fields. To contain this I imagined a line of analysis that begins in the bodily interior and then moved outward towards the world.

Theoretical Framework: Thinking from Bodies towards the World

Beginning with the interior, the visceral place which shapes post-surgery experience, phenomenological ideas on embodiment, consciousness, and perception helped to focus my attention on the body as a site for ‘being-in-the-world’ (Leder, 1990; Csordas, 1994; Merleau-Ponty and Landes, 2011). Significantly, Drew Leder’s (1990) work on how living with an altered interior can re-orientate consciousness resulting in a different way of being – elucidated post-surgery experiences. The embodiment of culture (Csordas, 1994) as shaping perception also corresponded to the way in which the women narrated their experiences from a Māori point of view. Mana as embodied emerged as an important way of considering how these women perceived both themselves and their place in the world. Moving the line of thinking from the body towards the world brings others into view and selves can then be thought of as constituting and reconstituting in relation to others (Crapanzano, 2014). Intersubjectivity became pivotal in thinking about how selves are shaped within a dynamic of changing bodies and shifting hierarchies. ‘Embodied becoming’ presented the opportunity to see experience and the re-constituting of selves as a flux and flow – malleable and not necessarily fully prescribed by the fields in which lives are lived (Biehl and Locke, 2010). ‘Embodied becoming’ also enabled my thinking to move beyond (but not be exclusive of) accounts of social inequity that typify health research in the social sciences. Before exploring some of these central ideas in more detail, I also need to account for transformation as this is what these stories pivot on. The (interview) narratives, replete with the metaphors of change and challenge, shaped in my thinking as a *rite de passage*, an experience of entering a process of transformation – albeit one with unfinished endings.

Rites de Passage & Liminality

An understanding of the stages of a *rite de passage* has helped anthropologists to interpret and understand the function, shape and transformative potency of ritual and ceremony. The stages are commonly described as the ‘separation’ (preliminal), ‘transition’ (liminal – also known as betwixt and between) and ‘incorporation’ or re-integration (post liminal) (Bowie, 2006). Separation for potential surgery recipients begins with a referral to the hospital and a commitment to meet the initial goals of the program.³ Meeting these goals requires a step away from life-as-normal, a different way of eating and an emotional commitment to being a part of the program. Once accepted and prepared, recipients are moved into surgery (the liminal) and undergo a transition and bodily transformation that will alter the trajectory of their lives. From hospital, they are discharged back into society. Unlike transformative rituals in which participants are reintegrated into society with a new status (into the post liminal), surgery recipients, I argue, experience both an ongoing liminality and a precarious status. In order to understand this liminality I draw on phenomenological ideas on health and wellbeing. Hans Georg Gadamer (1996) described health as the following:

Health is not a condition that one introspectively feels in oneself. Rather it is a condition of being there, of being in the world, of being together with other people, of being taken in by an active and rewarding engagement with the things that matter in life. ...It is the rhythm of life, a permanent process in which equilibrium re-establishes itself. This is something known to us all (Gadamer cited by Groven, Råheim and Engelsrud, 2010:3).

Leder (1990) builds on Gadamer’s idea that healthy bodies are outwardly deployed or orientated towards the world. This state of wellbeing depends upon an inner body that is receded, below consciousness, taken-for-granted – absent. Most inner-body functions, when we are well, are absent from consciousness and even the more present digestive tract is taken for granted. As Leder states: “I absentmindedly chew and

³ Initial goals involve losing up to 10% of their bodyweight above a BMI of 25 kg/m². Many do not make it with an attrition rate of up to 54% (Taylor *et al.*, 2018).

swallow” (1990:38). Well bodies with taken-for-granted interiors lead to a positionality that Merleau-Ponty called the “I can” rather than “I think that”. “I can walk, eat, run, [and] gesture”(Merleau-Ponty cited in Leder, 1990:20). In living with an altered gut, those post-surgery can no longer take eating for granted. I argue that the ‘I can eat’ becomes ‘I think I can eat’, drawing consciousness in, affecting mutuality and unsettling (post liminal) re-integration. The body is the site for thinking about these experiences and in the following I return to some of the central ideas of the theoretical framework.

Embodiment, Embodied Becoming & Mana

Thinking with bodies unleashed a plethora of analytical possibilities with many perspectives viewing the body as representative of cultural and social processes. As noted by Thomas Csordas, the body in cultural theory is no longer thought of as a “brute fact of nature” (1994:1) but as, for example, a site of performativity, constructed gender norms, identity, practises, symbols – shaped by culture, history, inequities, and power. Depicting the body as representing social and cultural phenomena opens up a large field of inquiry but as Csordas argues, embodiment has often been taken for granted and bodiliness overlooked (1994:4). Bodiliness, however, matters in developing an understanding of post bariatric surgery experiences. Slim bodies move differently in the world. They can walk easily through crowded spaces, sit in fragile looking chairs without concern, cross legs, tuck feet up, not breach the borders of skinny airline seats and front up unencumbered by both fat and the fat-bias of others. Bodiliness also matters when the perspective shifts beneath the skin to the biological. Ingestion, digestion, absorption, malabsorption, repulsion and excretion are potentially experienced physically, emotionally, culturally and socially by those post-surgery. Bodiliness and embodiment merge in my analysis – being seen as shaping perception, influencing experience and (re)orientating consciousness. This body-centeredness is refracted in this research through phenomenology. As noted by Csordas, the body-centeredness of phenomenology, adds “sentience and sensibility” to ideas of selves and “materiality to our notions of culture and history” (1994:4).

Phenomenologically “the body is not an *object* to be studied in relation to culture, but is to be considered as the *subject* of culture, or in other words, as the

existential ground of culture” (emphasis in original, Csordas, 1990:5). The body is then seen as having ‘existential immediacy’ (citing Turner in Csordas 1990, Masquelier, 1997: 940) and the embodied self as “a certain setting in relation to the world” (Merleau-Ponty cited in Csordas, 1990:36). The body is the place from which perception begins – from *subject* to *object* as consciousness orientates towards the world with perception ending in objectifying (or abstracting) phenomenon (Csordas, 1990). Importantly, this ‘being-in-the-world’ perceives from a setting but perception is not fixed nor determined by that setting. The flux between *subject* and *object* is the indeterminate space in which *selves* can be reconstituted, this position then invites inquiry into the constitution of *selves* “in the ongoing indeterminacy and flux of adult cultural lives” (Csordas 1990:39-40).

If our perception “ends in objects” the goal of a phenomenological anthropology of perception is to capture that moment of transcendence in which perception begins, and, in the midst of arbitrariness and indeterminacy, constitutes and is constituted by culture (Csordas, 1990: 9).

The women in this research identify as Māori and arguably think, perceive, feel, and move in the world as Māori. I explore the flux between these women and their social and medical encounters and the potential for these entanglements to map back onto *selves* and into culture; processes which, as stated, unsettle (bounded) weight loss narratives of before and after.

Similarly, relationships may be unsettled by weight loss in unexpected ways and intersubjectivity is used to think about the ripple out effects of WLS. Vincent Crapanzano, discussing the work of Husserl and Heidegger, notes that “the ego is constituted in relation the other”. Intersubjectivity is experienced primordially through the body and between bodies, and consciously as perception occurs between minds within a “shared perceptual field” (2014:268). The influence of another on an individual’s ego is comprehended as ‘my ownness’. Heidegger refers to this as ‘being with’ – selves shaped through intersubjectivity. The shaping of selves’ life trajectories and selves in relation to others remains unfinished, fluid, dynamic, and conceptualised for the purpose of this research as embodied becoming.

Since starting this research I have been asked many times “well, what do you think – should people have the surgery?” That, frustratingly for some, I cannot (and am not qualified to) answer. As stated, post-surgery narratives are not definitive but reveal experiences of the good and the bad, feeling both strong and weak, being sick and well, having potential and feeling loss, of making courageous choices and of not having had a choice. The narratives also reveal the ‘unfinishedness’ of people’s lives, of their ‘becoming’ or even their newly ‘embodied becoming’ having reset the trajectory of their life-path with a radical shock – bariatric surgery. João Biehl and John Locke (2010), in drawing on the work of Deleuze and Guattari note that *becoming* involves shaking loose wherever possible from, “determinants and definitions” and in doing so, opening up the possibility of diverse trajectories of living, of creating something new, and in turn, foreclosing other possible pathways (2010:317).

Paying attention to actual trajectories or ‘lines of flight’ opens up the opportunity for learning from people rather than reducing their accounts to presupposed and predetermined conditions of living (Biehl and Locke, 2010). This close attention to the singularity of a person’s life may reveal stops and starts, openings and closures, decisions and impulses, chances and choices, limits and freedoms – patterns of becoming and logics for living. As Biehl states, “[a]t stake is finding creative ways of not letting the ethnographic die in our accounts of actuality” (2013:583). When my thinking strayed into wanting to frame accounts in dynamics of power and powerlessness, Biehl and Locke’s work on ‘becoming’ reminded me to concentrate on what was said to me and let those words lead the way. The words of these women reveal their logic for living, their ways of perceiving the world, their ways of accounting for what had happened and what was happening to them. I endeavour to let their words be foregrounded in the text and purposefully leave them as unfettered by analysis as possible. Not everything was spoken however. There was something else present in our interviews, something that was harder to pin down, something that seemed to account for an inner strength and I believe that thing was *mana*.

Thinking with *mana* means thinking about what *mana* is and defining such a term runs the risk of dissolving meaning in translation across languages. There is no single equivalent word in English which leads to a list of words endeavouring to

encapsulate the term. As a noun, mana is commonly described as: “prestige, authority, control, power, influence, status, spiritual influence [and] charisma – a supernatural force in a person, place or object”. As a verb: “to be legal, effectual. Binding, authoritative, [and] valid” (*Māori Dictionary*, no date). While mana is often thought of in terms of strength and authority, it can also be considered in terms of ethics (Tomlinson and Tengan, 2016). Ethically, mana relates to the moral duties that exist between kin, giving mana a “fundamentally social nature” (2016:19). The mana of women is also associated with reproductive power – the ability create life (*TeAra.govt.nz*, no date) and acting for the common good. Importantly for Māori, mana tūpuna is handed down from the ancestors and binds family members together (Metge, 1995).

As I talked to these women, I heard them reference whānau and whakapapa in relation to ‘self’, I felt their strength, saw their Māori-ness shining through and in these moments it was an awareness of mana that helped me understand the unexpected ways in which they saw themselves. For example, no one had a problem with body image when big – they all laughed this suggestion off. Mana seemed to trump the self-consciousness of an image-conscious time. The unexpectedness of this response represents what was to become, at times, par-for-the-course in this research – seeing, hearing, feeling, thinking one thing and reading another in existing research material. The most jarring and difficult aspect for me to reconcile was the defining of Māori lives statistically in terms of health (and other) deficits – while concurrently hearing in the interviews how Te Ao Māori holds, nurtures, and potentially keeps people afloat even when times are tough. Theoretically I needed to be attuned to the possibility of deficit statistics mapping back onto my findings and overshadowing the narratives of these women.

Negative Statistics: Stigma & Resistance

Statistics can shape and shift as they move from the global to the local, group up in the cultural and become embodied as personal. Obesity, for example, is now considered a global epidemic – a problem so widespread that it is now common for researchers to refocus “the standard questions about why people are overweight, and instead ask how some people maintain a normal weight in obesogenic environments”

(Brewis, 2010:130). This global obesity problem is often racialised, personalised and then embodied as a form of cultural and personal irresponsibility. Negative statistics relating to Māori (and Pasifika)⁴ are used to justify the delivery of interventions such as WLS but concurrently these statistics serve to shame the ethnic groups concerned. As Māori researcher Virginia Tamanui states: “I loathe these statistics for their tendency to define us or give permission to others to continue to define us” (2013: 36). Similarly, in highlighting cultural deficit theorising in Māori health research, Elana Curtis argues that this approach commonly results in blaming the victim by associating poor Māori health with: “deficits and deficiencies that are internal to Māori “culture” or are inherent to Māori culture as a social grouping” (2016:402). The health research that underpins and helps to define the context of WLS delivery does the very thing these researchers are flagging as a serious issue for Māori: identifying them as a group that needs help, a group with issues, and a group with deficits. This is not a problem I can resolve but Ghassan Hage’s work on racialised subjectivity helped make me aware that statistics need to be considered discursively and with care.

Hage, in reviewing the work of Frantz Fanon, notes that “[r]acism is continually shown to be a process of ‘fixing’ the racialised in a negative particularity” (2010: 115). Subsequently, a racialised subject may consider themselves to be part of the whole, (which Hage calls miss-interpellation), the universal – but then simultaneously have their particularity reflected back at them through negative statistics and experience this affectively as a rejection from the universal. Hage calls this a “drama in two parts” (2010: 122) and it speaks to some of the experiences recounted by the women in my research. They (as big and post-big) seemingly moved adeptly between the particularities of being Māori and the universality of being citizens in broader society. Simultaneously however, Māori – who live in a country that in many ways embraces aspects of Te Ao Māori – paradoxically (and perhaps crushingly) also have to live with the negative statistics and racism that cast shadows upon, and define, their population. Aotearoa New Zealand hails ‘haere mai’ on one hand and follows with ‘you are a problem’ on the other. Knowing this helped me to understand the moments during my research when the energy seemed to leave the room, when accounts were

⁴ Pacific Island peoples

framed as a 'Māori problem'. Stigmatising statistics map back onto identity leaving Māori the weighty task of re-negotiating identity or, as Erving Goffman called it when referring to living with stigma – “navigating life with a spoiled identity” (1990 [1963]). Statistics quantify and categorise the delivery of bariatric surgery but attention must be paid to the difficult space that Māori occupy in this data and the potential for these statistics to leak into the narratives of my interviewees in stigmatising ways – but also to the way in which the women’s narratives escape this framing.

Conclusion: Theory – An Assemblage

There is no one way to think about narratives that touch on a multitude of social, cultural, physical, biological, political and historical fields. At times, feeling overwhelmed, I found it anchoring (theoretically) to think from the viewpoint of a (drastically altered) body, moving about in broader society as a cultural and social being. Post-surgery experience is influenced by the fleshy altered interior, the shrinking and reshaping exterior and the fluid and ongoing embodiment of Māori-being – including mana – in a complex post-colonial social and cultural world. Following the lead of Biehl and Locke (Biehl, 2005, 2013; Biehl and Locke, 2010), I use the words and ideas of the women I interviewed as my guiding lights. This involves taking care not to presuppose the trajectories of their lives as suggested by their social fields but rather let their narratives reveal their logic for living, and conclusions, based on their own experiences as surgically altered Māori women. Change is conceptualised through a *rite de passage* model and health is considered phenomenologically from the perspective of a conscious being, orientated towards and engaging with the world. Intersubjectivity gives explanation to the way in which a shrinking body affects others and selves can be seen as shaping and re-shaping in relation to the other. The unfinishedness of people’s lives is framed as ‘embodied becoming’ – allowing space for nuance in narratives and more often resulting in conclusions hard to pin down in concrete ways. Discursively I am attuned to the stigmatising ways in which Māori, as a statistical group, are defined in data on health and health policy. In conclusion, my theoretical overview is not so much a tidy contained framework but rather an assemblage of differing but overlapping perspectives guiding thought through

complex encounters. The following review of the literature is assembled in a similar way – cross disciplinary and connecting with a variety of research fields.

Chapter Two: Reviewing the Literature

Bariatric Surgery

As indicated in my theoretical framework, my research could not be simply situated in a single body of academic work. The literature on bariatric surgery comes from an almost overwhelmingly wide range of fields – biomedicine, nursing, sociology, psychology, psychiatry and anthropology – to name a few. I organise this cross-disciplinary literature in a twofold way. Firstly, I briefly outline research that provides some context for the delivery of WLS in Aotearoa New Zealand. This section also identifies some specific issues faced by Māori. Secondly, I draw on examples in the broader literature that come close to the design and focus of my research i.e., qualitative and concerned with WLS surgery experiences. These examples will be organised under the following themes – ‘being big, choosing surgery’, ‘biopower care and action’, ‘changing relationships’ and ‘health and well-being post-surgery’. This literature generally foregrounds the deciding factors in choosing surgery and the challenges that come with having made that choice. I am unable to locate any research within this literature that focuses on the experiences of Māori women and this is the gap that I hope to fill. I begin by outlining the context of the delivery of bariatric surgery in Aotearoa New Zealand and specific issues for Māori, including the difficult space that they occupy in health statistics.

Bariatric Surgery – Aotearoa New Zealand

There is a fine line I walk in this research. This is the line between needing to describe the context within which bariatric surgery is offered and the discomfort I feel in reproducing statistics that may serve unwittingly to re-name and re-shame the ethnic groups concerned (Tamanui, 2013; Rahiri *et al.*, 2018). One argument counter to this position is that the only way to address ethnic disparities is to know what those disparities are (Ploeg and Perrin, 2004). So the obesity story that follows needs to be viewed on two levels: one that provides an understanding of the scale and shape of the

problem⁵ and a second that notes the potential for statistics to classify, stratify, and re-stigmatise.

According to the Ministry of Health (2015)⁶ obesity rates in Aotearoa New Zealand are the third highest in the OECD. Currently one in three adult New Zealanders over 15 years are considered to be obese,⁷ and one in ten children. Statistics (2015) show that 47% of Māori are considered obese and 67% of Pasifika peoples (Ministry of Health, 2015). The global phenomenon of obesity amongst indigenous peoples is typically aligned with socio-economic disadvantage born of and a history of colonialism and structural racism (Howe *et al.*, 2015; Bell *et al.*, 2017).

Māori (along with Pasifika) clearly carry much of the burden of obesity and its comorbidities. Māori not only have shorter life expectancies but also shorter experiences of healthy lives or ‘health expectancies’, with illness and disease common in late adulthood, more often than not as a result of obesity (Theodore, McLean and TeMorenga, 2015). Obesity has become so commonplace that, as one scholar notes, “[i]t seems at times that the development of these [obesity related] disorders has become a part of the aging process for Māori” (Warbrick, 2011: 175). To address this issue, it is argued that the state, under the Treaty of Waitangi,⁸ has a responsibility to redress the inequitable health status of Māori (Theodore, McLean and TeMorenga, 2015). State policy may involve approaches that attempt to curb obesity by targeting the causes of obesity in what are considered to be obesogenic environments – places with “particular physical, social and economic characteristics” which influence the rates of obesity (Colls and Evans, 2014: 733).

Obesogenic frameworks, which focus on phenomena such as ‘food deserts’ and the availability of cheap, calorie-dense commodity foods in poorer neighbourhoods, move the emphasis from individual responsibility to a more ecological model. Some argue, however, that labelling places as ‘obesogenic’ and many of the people within as

⁵ Some researchers adopt the position that the ‘obesity epidemic’ has been constructed through a lens of fat bias, moral judgement, and the mistaken belief that fat must equal bad health (for example see Pausé, 2017).

⁶ Data retrieved from NZ Ministry of (Ministry of Health, 2015)

⁷ The New Zealand Health Survey defines obesity as having a BMI of 30 kg/m² or over.

⁸ The Treaty of Waitangi (Te Tiriti o Waitangi) is a treaty first signed on 6 February 1840 by representatives of the British Crown and Māori chiefs from the North Island of New Zealand. This founding document requires the Crown to adhere to three main principles, commonly referred to as the three ‘P’s’, – partnership, protection and participation.

‘obese’ by extension has the (unintentional) consequence of stigmatising those places and those people (Pearce, 2012; Colls and Evans, 2014; Rosenberg, 2017). Further to this, critics argue that looking for causes of obesity in nebulous (uncontained) environments is overly simplistic and that obesogenic measures may “reflect elite ideologies” (Colls and Evans, 2014: 741).

The scale and complexity of the obesity issue has seen many general practitioners (GPs) become ambivalent about behavioural (diet and exercise) solutions and see bariatric surgery as the only effective option available to patients. One study concluded that the majority of GPs believed that most diet and/or lifestyle based weight loss interventions were not going to be successful and reported that very few obese patients ever achieved long-term weight loss (Claridge *et al.*, 2014). These GPs also conveyed a caution about bariatric surgery, seeing it as a drastic intervention with high inherent risk. Many discussed the difficulty in discussing weight with patients in general and one GP, who worked predominately with Māori, noted that obesity could be a source of considerable *whakamā* (Claridge *et al.*, 2014:216). It is ‘between a rock and a hard place’ that GPs find themselves – with bariatric surgery presented as *the* only effective solution on offer in a complex encounter; and despite the risks it is a solution whose efficacy is supported by considerable evidence in medical literature.

Biomedical research supports the position that bariatric surgery is the most effective strategy for inducing long term weight loss and alleviating or reversing co-morbidities (For example – Dhabuwala, Canna and Stubbs, 2000; Sammour *et al.*, 2009; Lemanu *et al.*, 2012; Samaras *et al.*, 2012; Dalbeth *et al.*, 2014; Humphreys *et al.*, 2014; Kumar and Gomes, 2017; Mackay, Zhou and Schroeder, 2018). This position is stated emphatically in the introduction to the *Bariatric Surgical Guide*⁹ which declares that “[t]he *evolution* of bariatric surgery is one of the biggest *revolutions* in the field of surgery” (emphasis not in original, Kumar, Gomes and Palanivelu, 2017:ix). There are however cautionary aspects raised in many of these articles which point to the serious nutritional issues that may arise after surgery. For example, the *Bariatric Surgical Guide* ends with a twenty-six page chapter on nutritional management after surgery which outlines an extraordinary range of possible deficiencies (2017:271-297). However,

⁹ Not written in Aotearoa New Zealand but references ANZ procedures and data.

the cost of contending with nutritional deficiency is believed to be outweighed by the benefits of surgery and this cost is downplayed in a strong rhetoric of successful outcomes. This literature does not consider the experiences of people who live with both the costs and the benefits and therefore I draw on qualitative research in the social sciences that explores the complexities of life post-surgery.

Being Big & Choosing Surgery: Precarity & Stigma (or not?)

A challenge I faced writing this literature review was that I struggled to fit my work easily into any specific existing body of work in WLS research. “Struggling to fit” I soon realised however, maps to the theoretical framework of this thesis (see pages 5-6) in that thinking with ‘becoming’ must allow for both social reproduction within context and changes that arise out of context. Change or ‘becoming’ is imagined as the trajectories of thinking and logics-for-living that spiral out of context and point to different or more ambiguous conclusions. ‘Becoming’ can then be thought of as a process through which both potentialities and differences manifest. Consequently a body of work on WLS may speak to my research on one hand and then, on the other, not. These differences point to the insights that my research offers. The following discussion of key literatures will illustrate this movement from embeddedness within a body of literature, to a critique of that literature, by beginning with research on the dominant reasons for choosing WLS – choices often made within a context fraught with stigma and precarity.

Moral precariousness enmeshes with the experiences of being big, deciding to have surgery, and becoming small post-surgery. It is hard to escape the watchful eye of others all the way through. Research on being big, for example, shows that people may experience stigma in multiple ways, as identified by Juyeon Park (2015): direct stigma – being discriminated against; indirect stigma – being looked at, judged, and fearing humiliation, and environmental stigma – acute embarrassment experienced in ill-fitting public spaces (Brewis *et al.*, 2017). Diagnostic categories have also been critiqued in Fat Studies with terms such as, ‘obese’ or even worse, ‘morbidly obese’, shown to be devastatingly stigmatising for those given those labels (Pausé, 2017). For this reason I only use the ‘O’ word when referring to research from within, or close to, the medical field. Having been judged as ‘obese’, surgery recipients then risk being re-

judged or re-stigmatised for choosing an option that is believed by many to be an easy way out (Throsby, 2007; Drew, 2011). In order to curb derision, decisions to have surgery are more often articulated as a 'last choice' or as 'not having had a choice' (Synne Groven and Engelsrud, 2015). Emphasising a 'lack of choice' can be seen as a way of seeking understanding from others that judge recipients for having opted for WLS. This publically held perspective on bariatric surgery is particularly problematic for Māori, who are already often portrayed in the media as lazy, lacking discipline and heavily dependent on state resources (Rahiri *et al.*, 2018). Having opted for surgery, WLS recipients then have to construct or renegotiate "ethical selves" (Knutson, Terragni and Foss, 2011, 2013) and may use discursive strategies such as describing WLS as 'just a tool' while emphasising the considerable effort and commitment required on either side of surgery in order to lose and maintain weight loss (Synne Groven *et al.*, 2013).

My research, at times, uses stigma as a way of accounting for actions and experiences but does not adopt it as a recurrent and dominant framing. The Māori women I spoke with recognise stigma in retrospect – from the perspective of being-in-the-world in a newly slim body and being treated differently, but only occasionally allude to stigma. Importantly however, they more often account for their experiences and decisions from a position of strength and agency – a place of feeling fine about who they were (when big) and who they are now. The place in which precariousness, and not stigma, did shape narratives was where the participants spoke about their health and their life expectancy (especially the older women). At these points, the decision to have surgery is about not having had another choice. This may be, to some degree, voiced as a discursive tool deployed in order to renegotiate an 'ethical self' as argued by Knutson, Terragni and Foss (2013) but primarily it is a reflection of a stark reality – disease being well and truly present and death potentially eminent. I argue that while (fat) stigma and racism are endemic, Māori women with mana are not swayed by derision but act out of concern for themselves and in response to concern from their whānau.

Understanding this point of difference is also important when considering the literature on the desire for slimness, outlined in the WLS research as a strong influence on women's decisions to have surgery. It has been found in one study, for

example, that around 30% of recipients choose surgery as a way to alter their appearance (Park, 2015). Research focussing on choosing surgery as ‘obese women’ may also adopt a feminist perspective with an emphasis on the downgrading of large female bodies in an image-conscious capitalist world (Orbach, 2005; Westwater-Hobbs, 2010). In stark contrast to this position, none of the women in this research said that they chose surgery to be slim – in fact they emphatically denied this. They described themselves as ‘big’ (not obese) prior to surgery and being big, for them, carried no negative connotations around body image. Being slim does present new (and exciting) ways of presenting to the world, but the possibility of being slim did not motivate them to go under the surgeon’s knife and have their innards irreversibly altered. I argue that the image-consciousness intrinsic in the above scenario would be anathema to these (previously) big Māori women with mana. Similarly, they did not see themselves as disempowered victims when they entered the health system seeking surgery but rather as people who were, on the whole, comfortable with who they were (aside from ill health), taking up a service offered by people who care, within a system that provides care. The review of the literature that follows shows that while health research typically focuses on issues around power (biopower) and inequities, there is also a body of work that critiques this position, noting a failure to account for ‘care’ in medical encounters – and which is closer to the position I foreground in my research.

Biopower versus Care & Action

Health research from a social science perspective often adopts a Foucauldian theoretical framework with an emphasis on biopower (power over life), discipline (as subjects), and governmentality (for example – Westwater-Hobbs, 2010). Governmentality is a term used by Foucault to describe modern states’ regulation of the individual by encouraging compliance with existing norms and discourses (Knutsen, Terragni and Foss, 2013:67 – in discussing Foucault). Some bariatric surgery research from this perspective argues that although the discourse on health services emphasises the (neoliberal) empowering of individuals to take responsibility for their own health, individuals are in fact, through choosing surgery, conforming to normative standards promoted by the state. The discourse promoting ‘empowerment’ and individual responsibility is then seen as another form of power and discipline in

Foucauldian terms (Knutsen, Terragni and Foss, 2013). Research from this perspective argues that dietary requirements, as stipulated and monitored by the health system, are another form of surveillance and discipline resulting in a form of Foucauldian moral biocitizenship (Trainer, Wutich and Brewis, 2017). I did get a sense that the women in this research felt, at times, ‘watched’ – under surveillance from others as they sat to eat, with a sense of discomfort intensified by a voice in their heads telling them over and over, ‘don’t put on weight, don’t put on weight’. A sense of powerlessness does not come through in their narratives however. This is the case particularly when they talk about their positive encounters within the health system. All the women I interviewed spoke of the caring (even lifesaving) relationships borne of these medical encounters. They also spoke about the courageous and difficult actions they undertook in order to change their lives. Care and action are foregrounded by them and consequently my research supports the literature that accounts for such care, individual actions and the engagements between people (amidst institutional norms) (For example – Yates-Doerr, 2012). This literature also provides a critique of health research which only focuses on power and inequities.

These critiques note that a focus on power does not account for the complexities of modern human lives. Anthropologists now seek to understand these complexities and human subjectivities by engaging, through ethnography, with the particularities of “affect, cognition, moral responsibility and action” (Biehl, Good and Kleinman, 2007:1). Yates-Doerr notes that Foucauldian health research fails to account for ‘care’ by reinscribing “action, all action, including care – as a deployment of power” (2012:138). She goes on to say that the health-care engagements she observed (in researching obesity in Guatemala) demonstrated “an affect of tenderness, empathy, compassion, and respect” (2012:139). My research does not explore the deployment of power and I concur with Yates-Doerr about the need to focus on the complexities of human encounters within medical systems. This is not to say that inequities nor the compulsion to follow normative processes do not exist, but rather that, by following the logic for living of individuals and thinking about care and agency, more nuanced conclusions can be reached. Yates-Doerr (2013) also argues that the measurement of obesity in health is reified, not necessarily indicative of health, and that the overuse of measurement results in a “flattening, a silencing of diversity” (2013:64). Similarly, I

argue that accounts focusing only on biopower and inequities flatten and silence the diversity of people's experiences with surgery. In order to counter this possibility, I people the text by giving ample room for the words of the Māori women, rather than have their voices subsumed by theories that constitute them primarily as victims. Being big and becoming small manifest in my research not as a 'before and after', easily explained by theory and illustrated by much existing research, but rather as a complex entanglement of factors – factors which include the way in which the effects of 'becoming small' move beyond the body and affect relationships with others.

Weight Loss Surgery and Relationships

Weight loss surgery precipitates radical change and others who are close experience change too, including changes in the way they relate to the newly slim person; changes in the way they eat together; changes in the things that they do together; changes in status within groups and changes to intimate relationships (Clark *et al.*, 2014; Ferriby *et al.*, 2015; Pratt *et al.*, 2016; Wallwork *et al.*, 2017; Ratcliffe, 2018). Not all of these changes are positive. Some partners, family and friends of surgery recipients may feel newly optimistic, embracing change and new experiences in their shared lives such as differing diets and increased exercise. Others, however, especially those who have weight problems themselves, may miss the way that they once were together, the food that they ate and the lives that they lived (Ratcliffe, 2018). Similarly, one partner may have been a caregiver for the other and post-surgery this relationship can be threatened and deeply unsettled by a substantive change in roles (2018: 173). Some resist change by pushing back against the 'new normal' and continue with old habits, including refusing to change their own poor diet (Wallwork *et al.*, 2017: 1976). This is seen as both sabotaging weight loss and as a lack of support for those who are focussed on losing weight (Romo, 2018). Push-back can also happen within groups. Post-surgery, many recipients will feel confident, more comfortable about leaving the home and experience an increased sociability in general. There is however the potential for socialising to be fraught, with some social groups rattled by the dramatic weight loss of one of their members (Ratcliffe, 2018). Ultimately dramatic weight loss unsettles the status quo.

My research contributes to this body of work concerning relationships and weight loss surgery. All of the women I talked to spoke of social shifts and sensitivities that they now had to be mindful of. These shifts can be subtle: noticing a change in a mother-daughter relationship; uncomfortable feelings of no longer belonging to a group; seeing a wave of insecurity flash in the eyes of a husband; feeling a shift in the hierarchy at work, and more calamitous shifts, including the near breakdown of a significant family relationship. I concur with Wallwork et al. (2017) that weight loss surgery needs to be considered relationally. By paying attention to the ways in which dramatic weight loss impacts relationships, surgery recipients can avoid both pitfalls and being blindsided by negative consequences. Others can also be prepared for change and this preparedness could see them more readily able to support those going through surgery and weight loss (Ferry et al., 2015). This dynamic of change, which ripples between people, provides a lens on the way in which selves are constituted in relation to others (Crapanzano, 2014) – a broader theme that is addressed in this thesis. Another broad theme is the consideration of what it means to be healthy, how well-being is connected to engagement with places and others and how WLS impacts and shapes this being-in-the world.

Health & Well-Being Post Surgery

Thinking about how WLS impacts on being-in-the-world requires thinking about health and well-being and the connection between the two. When focusing on health in this research, attention is paid to the (very often serious) physical problems that manifest for those seeking surgery, both problems that are alleviated post-surgery and those that may emerge as a result of surgery. A focus on well-being requires thinking about the way in which a person experiences the world through their bodies, both before and after their surgery. In order to establish an understanding of these experiences, I draw heavily on phenomenological ideas on health and well-being (see page 8) and literature from the social sciences that focuses on post-surgery bodily experiences.

Although biomedical research emphasises the substantial reversal of obesity co-morbidities post WLS, there is a body of research from the social sciences that disrupts the idea that the loss of substantial weight will inevitably lead to a heightened

sense of well-being post-surgery. This research focuses on the physical complexities of living in a post-surgery body (Synne Groven *et al.*, 2010; Groven, Råheim and Engelsrud, 2013; Natvik *et al.*, 2014; Synne Groven, 2014; Groven, Galdas and Solbrække, 2015). In this body of work, sickness is shown to be a common experience with particular emphasis given to nausea and dumping syndrome which are often suffered by surgery recipients (Synne Groven *et al.*, 2010). Dumping syndrome is caused by “the rapid delivery of carbohydrates to the small intestine” causing “excessive insulin secretion” leading to symptoms including an “irregular heartbeat, drop in heartbeat, diarrhoea and nausea” (Groven and Engelsrud, 2012:37). Feeling ill affects well-being and physical lightness does not necessarily equate to a lightness of being. This is certainly the case for some of the women in my research. While surgery recipients are generally more optimistic and freer in their movements on one hand, they are still held back, to a degree, on the other – tentative in their approach and taking care not to become (embarrassingly) uncomfortable and unwell.

Concluding thoughts – Continuity, Newness & Becoming

As in an overlapping Venn diagram, there are places where my research sits with the current literature and places that it doesn't – the latter providing gaps that I hope to fill. These gaps, being openings for newness, also correspond to the concept of 'becoming' that underpins this thesis. New ideas emerge from intellectual contexts in the same way that newness forms through the trajectories of lived lives, resulting in both continuities and change. I emphasise this point because this thesis could easily have been situated in the body of work that frames indigenous women with health issues as victimised and lacking agency. Had I used such a framework however, the significant findings of the thesis would be de-emphasised – those that centre on agency, mana and the way in which being Māori shapes experience. Adopting a narrative-driven approach, underpinned by the concept of becoming, allows new perspectives to emerge, some of which disrupt assumptions in health research. 'Obesity' studies for example – including those with a feminist perspective – often point to poor self-image as a precursor for WLS, but the women in this research do not see themselves through this lens. They see themselves, through whakapapa and mana tupuna, as part of something bigger than themselves – something beyond shape,

size and weight. Similarly, the way in which they accounted for their experiences as being robustly agentic was not reflected in literature that paints them primarily as victims. While literature does show that there are widespread health problems in indigenous communities – from which we can extrapolate deep seated inequities – it is however important not to assume that these inequalities and inequities are ultimately determining, and through doing so, to use the terminology of Yates-Doerr (2013), flatten and silence diversity. Giving flesh and giving voice to Māori women unsettles assumptions and thereby offers newness – a different way of thinking about the experiences of others. Learning from these women requires listening to, talking to and being open to narratives that shape and reshape in unexpected ways. In order to facilitate this process I use a narrative phenomenological approach.

Chapter Three: Methodology

Knowing through Narrative

A narrative phenomenological approach foregrounds the experiences of the women who talked to me and the way in which their experiences then connect back, explicitly or implicitly, to a sense of self (Mattingly, 1998; Lawlor and Mattingly, 2000). Narratives give insight into how people couch their experiences in their social, cultural and moral worlds and how they assign meaning to significant events. Narratives can also be perlocutionary – affecting both the speaker and hearer – serving to renegotiate identity and influence future actions (Mattingly, 1998; Lawlor and Mattingly, 2000). Consequently, I adopt the position that narratives not only give insight into the women’s experiences but also reveal the actions that they took, the meanings they attached to these experiences and actions and the way in which stories shape identity post bariatric surgery. Narratives are co-constructed through an interaction between “teller and receiver” (Lawlor and Mattingly, 2000:12) and this interactive space has to be given careful consideration when the research is being conducted by a Pākehā within a Māori field.

On being Pākehā in the Māori field

I approached my research topic with some trepidation knowing that the issue of research with Māori by non-Māori has been rightly contested and grappled with in Aotearoa New Zealand across decades. These debates have more often than not resulted in a post-colonial position that it is Māori who clearly need to be researching and writing about Māori. I was mindful then that I needed to find a place in the field that respected this point of view and offered a way of reconciling my own position as a Pākehā working with Māori. This required reflexivity all the way down. I reflect on growing up as a Pākehā among Māori and how these experiences show that there is an intersubjective place within which Māori and Pākehā can meet and talk – across difference and between similarities. I deploy Clifford Geertz’s idea of ‘being there’ and interview experiences are remembered as comfortable, resonant and imbued with nostalgia. Still with Geertz, ‘being here’ (in academia) is sometimes the opposite –

dissonant, uncomfortable and imbued with a resounding feeling that I should not be doing the research at all. In establishing my positionality, I look to and acknowledge the importance of the debate and then move the discussion into the present. I argue that the time is ripe for new stories to be respectfully and carefully told across culture and between people – a potentially fertile ground for conversations to emerge.¹⁰ Beginning with ‘being there’, I reflect on being Pākehā in the Māori field.

Clifford Geertz famously spoke of the gap between ‘being there’ in the field and ‘being here’ in academia – the field being rich with human encounters and academia a place in which so much is stripped back under the scrutiny of a critical eye (citing Geertz in Stoller, 2007: 175). For me ‘being there’ has meant being in a place of comfort, hanging out, of remembering, a place where I was connecting with people, and being in a familiar space in which the Māori and Pākehā worlds intersect – worlds which form to a degree through an entanglement with each other. As noted by historian Angela Ballara, “[f]or over 200 years each set of cultural influences [Māori and Pākehā], introduced or already present in New Zealand, in all its variety of manifestations, has profoundly influenced the others” (2000: 25).

As a Pākehā growing up in Rotorua,¹¹ the Māori world was not a distant other – it was my neighbour, my neighbourhood, and a part of my childhood. In the 1970s our Pākehā and Māori mothers bottled each other’s excess fruit, gardened, shared produce, and swapped hand-me-downs over the fence. Our fathers worked at the local saw mill and rode the mill bus together. The Māori world influenced my own. When my father died, for example, a neighbour from over the fence spent the funeral day at our house to stomp the spirits away. She also draped his casket with two korowai befitting the man – this was fully appreciated and unquestioned. Over time, the coloniser had swamped and dominated but the Māori world still manifested concretely in the Pākehā world – not as artefact but fact – present and palpable, and I believe these entangled realities in part formed the person I am today.

¹⁰ Historian Michael Belgrave also adopts this position in his article entitled *The Politics of Māori History in the Age of Protest* (2014). He notes the need for new histories to be written in a more nuanced way in the post treaty settlement period in Aotearoa New Zealand.

¹¹ Rotorua is a city in Aotearoa NZ in which Māori, as per the 2013 census, make up 37.5% of the population.

Anthropologist Ghassan Hage talks about nostalgia as being a yearning for “an idealised past” – lacking in the present and imbued with the hope that this idealised past will eventually manifest in the future (Hage, no date). Perhaps it is with an uncritical, nostalgic eye that I view the past, but my conversations with some of the women who participated in this research certainly evolved within an atmosphere of reminiscence. This common ground created an intersubjective space in which conversations happened with ease. Sitting with my participants – three of whom are middle aged like me – was in some ways like going home, nostalgic and imbued with a shared understanding of those times and places. We laughed – we really laughed – we chatted, we nodded in agreement, and although I can’t say I know the Māori world as Māori, I can say I know the Māori world as Pākehā – from over the fence.

Dissonance or discomfort begins for me in ‘being here’ – in academia. In the 1990s Linda Tuhiwai Smith ([1999], 2012) demanded that methodologies be decolonised and within the wider postmodern discourse at that time, all positivist prioritising of knowledge was brought into question. Ultimately universities and researchers were seen as an instrument of colonisation. In Aotearoa New Zealand self-determination work by Māori was happening throughout the latter part of the 20th century. Māori departments were established in universities, Māori research methods developed, and in communities Māori language schools were established, along with Māori health delivery models and social services (Smith, 2013). The decolonising project (across decades) necessitated that Māori academics both shore up boundaries and formulate appropriate modes for research commonly known as Kaupapa Māori Research¹² (Van Meijl, 2009; Durie, 2012; Salmond, 2013; Curtis, 2016). Māori were no longer prepared to be ‘othered by’ ‘defined by’ and ‘researched by’ others. Consequently the politics of Aotearoa New Zealand have run like a deep vein through academia shaping knowledge and research practise (Belgrave, 2014). It is therefore tentatively and with a sense of vulnerability (ah, the boot is on the other foot!) in this

¹² In outlining Kaupapa Māori research, Elana Curtis notes the following aspects as being central to this model. Kaupapa Māori research needs to be; transformative and beneficial to Māori, under Māori control, informed by Mātauranga Māori, a critique of issues of power, privilege and racism. It also needs to promote social justice, reject cultural-deficit theories and support decolonisation (2016: 401-403).

politically charged post-postcolonial context, that I enter the field as a Pākehā researching Māori.

Earlier on in this thesis I mentioned ‘walking a fine line’. At the beginning of this project I found myself teetering on another; that was the line between what I will call ‘the politics of permission’ and being able to enter the field without too many restraints on inquiry. These restraints emerge out of cross cultural sensitivities, ethical and political issues around representing others, and a fear of not wishing to offend or over-step research boundaries – a fear that may well pre-determine both what is written about and how it is analysed. The resulting tension is not only experienced by Pākehā but as noted by Māori anthropologist Marama Muru-Lanning (2012), in situating herself in a piece of research, “the issue of positionality has epistemological implications within Māori scholarship”. These issues typically emerge out of a “tension between tribal obligation and academic freedom” (p.156). She goes on to note that in the post claimant¹³ era, she may have more academic freedom than other Māori scholars who are still assisting their tribes with the land claim process. With her ‘positionality’ unresolved, Muru-Lanning concludes, “being a Māori anthropologist in the 21st Century can be very difficult at times” (p.163).

As a Pākehā researcher who wanted to research with Māori, I too found myself grappling with positionality. I argue that the process of strengthening the position of Māori in the wake of colonisation, and clarifying the position of Pākehā (or rather non-Māori) researchers, has inadvertently driven a wedge between the two. Dichotomous thinking is reinforced and conceptualised as ‘two worlds’ which in turn shapes access to the Māori research field. For me to move from one ‘world’ into the other requires permission and as this process emanates from deeply political roots, I call this the ‘politics of permission’.

The Politics of Permission

In order to carry out this research I have sought permission from the Massey University Ethics Committee (a full application was required), the Māori Cultural Advisor (it was not her role to give me permission explicitly but rather, to hopefully

¹³ Muru Lanning’s iwi land claim was settled over a decade ago in the Waitangi Tribunal.

support my research topic and, thankfully, I left our meeting feeling very relieved),¹⁴ from my participants (whose permission mattered the most) and lastly – myself (I’d talked myself into and out of this research many times). Each of these encounters was overwrought, perhaps overthought, and in some ways almost paralysing (Tolich, 2002).¹⁵ This sense of ‘needing permission’ also seeps into my thinking, my writing and manifests at times as fragile inquiry – too tentative to be robust. The process has left me wondering how to reconcile political/cultural sensitivities with academic curiosity and who exactly gets to give permission and why.

Firstly on permission, I turn to my participants. It would be easy (and arguably appropriate) to view them as victims of colonisation – disempowered or ‘lesser than’ empowered academic thinkers and therefore in need of protection from further harm. This is not what I encountered in the field. I found women with mana who are savvy, dynamic thinkers and more than capable of making decisions on their own terms. I suspect that they (having given someone like me permission) would take issue with any process or discourse that suggested that they needed academia to act on their behalf and stipulate the terms of engagement to protect them. ‘Do no harm’ (the premise of an ethics/permission application) may in fact be a patronising process reinforcing power hierarchies, keeping people in their place and quietening voice. The politics of permission may also stymie cross-cultural excursions by bordering up the potentially fertile ground of in-between spaces, limiting research possibilities and lessening the possibility of finding something new.

Academic Roving & Differential Distancing

Didier Fassin (2014) lends a helping hand through the sticky politics towards a (raggedy not fully actualised) form of intellectual liberalisation. Fassin traces his discovery of something new – a concept he calls ‘the politics of life’ (2014:54). Thinking

¹⁴ See Appendix A

¹⁵ Martin Tolich (2002) argues that the discourse underpinning the ability and appropriateness of Pākehā to research amongst Māori more often results in a sort of ‘Pākehā paralyses’. Subsequently Māori are, in many cases, being (quietly) left out as potential research participants. He sees this act of exclusion as a breach of the principles of the Treaty of Waitangi.

that he was dutifully deploying¹⁶ philosophy (in this case Foucault) in anthropology, he realised, after being challenged from the conference floor, that he had in fact been, to a degree, mis-translating Foucault. This took the form of mis-interpreting a concept and applying it differently than intended, but through doing so – discovering something new. He calls this an act of ‘abusive fidelity’ (a term coined by Philip Lewis, 1985) and argues that any “form of respectful and loyal treason is justified every time it produces something interestingly new in the process of translation from one discipline to the other” (Fassin, 2014:52).

Applying theory then, is not about strictly adhering to a theoretical framework with religious fervour. Rather it is about deploying malleable and unbounded ideas (like algebra with endless variables) towards complexity in divergent ways, in the hope of seeing better and knowing better than which you hope to see and know. In the spirit of Fassin and acts of treason, I wish to extend this idea to argue that what he is saying could be applied to any situation in which being released from a particular way of doing things (while still holding fast to an ethic of care) can lead to new insights. In the following quote I supplant ‘philosophical’ with ‘political’ and imagine myself (given permission to be) distanced from the somewhat ossifying nature of cross cultural research discourse in Aotearoa New Zealand. Fassin invites a, “differential distancing, if not liberation, from a [political] philosophical hold that often withers the originality of thought and the richness of ethnography” (2014:54). Academic roving becomes about not ‘sticking to’ what is there but ‘stepping out of’ and in some ways ‘stepping into’ the margins where the wild things grow and very interesting people have stories to tell to those who are willing to listen.

The People

Four Māori women generously agreed to participate in this study. Two of the women I have known for many years and consider to be friends, two I met through a third party. Three of the women are middle aged and one in her late twenties. I make this point as the older women have entered into the bariatric surgery program after many years of ill health and the younger only after learning she faced this prospect.

¹⁶ Ghassan Hage (2016) suggests that theory be deployed analytically rather than exhibited as a form of cultural capital.

Subsequently these age groups manifest in my research as having distinct differences and different potential consequences influencing their decisions.

Knowing two of the participants means that I inevitably brought experiences and knowledge to the research from long before I was a student of anthropology. I knew them when they were big, I knew them when they decided to have the operation, and in one case, had regular contact for several years after the operation. These personal experiences led me to develop my research topic and I do need to reflect on my own positionality and preconceptions and acknowledge the potential for having ‘made up my mind’ about bariatric surgery long before the interviews started. I endeavour to counter this possibility by including strangers in the study and by using open ended interviewing. The women led the discussions and were given the space and time to shape their narratives based on what was important to them, which for some meant going back in time and “taking a few side roads” (Stoller, 2016) along the way.

Interviews: Context, Place & (what is?) the Māori World

I too took a ‘few side roads’ along the way in order to interview my participants. Roads that took me to places that matter to the women in my study and connect them through story, memories, familial and tribal ties to other places and other times. These connections are forged and sustained through whakapapa – a sinew that endures in the face of change. Anthropologically, ‘place’ and culture in ‘place’ can be problematic in a neo-liberal world with scaling-up globalising processes. Change accelerates through technology across porous borders and ‘place’ is more often thought of as a process, involving practises, materiality and making meaningful connections in the face of such change (Massey, 1994; Cresswell, 2009). Niko Besnier (2011), in his examination of modern Tonga, argues that modernity can be seen as a negotiation between local factors and global forces, between “rupture and continuity”, iterations and reiterations. In order to contextualise ‘place’ or ‘the field’, in this increasingly complex world, ethnographers more often now think in terms of assemblages, circuits, scapes and flows (Marcus, 2012). Te Ao Māori is not only embedded in significant places, but also stretches cross time and between people. The circuit or flow that settles in and moves through ‘place’, connects ‘places’, draws the past into the present

and shapes, to some degree, the perspectives of the women in this research, can be conceptualised through whakapapa. As Anne Salmond notes:

The world is linked by whakapapa, with people, plants, animals, winds, sea and earth joined together in multi-dimensional webs of relations. These are animated by the hau ora, the energy that drives the cosmos (2012: 4).

Whakapapa is agentic as well as descriptive. As the women elucidated understandings of their world in terms of deep connections to people and places, they were ‘making and remaking’ the ‘Māori world’.¹⁷ It is this worldview that gave effervescence to our interviews and refreshingly reassured that Māori ontology moves like a strong current in a sea of change.

As noted, flows and circuits (and whakapapa) settle in and move through places; context still matters, as Gregory Bateson noted, “[w]ithout context, words and actions have no meaning at all” (1979:15) Clifford Geertz also stated that, “culture is not a power, something to which social events, behaviours, institutions, or processes can be casually attributed; it is context, something in which they can be intelligibly – that is, thickly-described” (1973:14). What follows is a ‘thin’ attempt at ‘thick description’ of my interview process and the places I went to meet with my participants. ‘Thin’ because names are changed and identifying details left out, such as tribal affiliations and the naming of Māori land, significant landmarks are downplayed and personal connections skimmed over. ‘Thick’ because I attempt to *show* the interview process in context through narrative (Narayan, 2012) and in doing so, add dimension to each encounter.

Interviews in Story

Gumboots in the car boot, this being the muddiest time in the muddy North, I set off for what was to be my first interview as a would-be anthropologist – I knew I had a gate to open and paddock to cross. This trip was punctuated by a stop at a bakery and me agonising over the appropriateness of taking cream doughnuts to an interview

¹⁷ Nelson Goodman argues that: “worldmaking as we know it always starts from worlds already on hand; the making is remaking” (1978: 6).

with someone on the far side of bariatric surgery. I knew she loved them before. Would she eat them now? I bought them anyway¹⁸ and yes, they remained un-eaten. The gravel road wound forever up a hill that eventually pitched me over the top to a view of an expanse of ocean and a vast acreage of coastal Māori land out of the reach of city developers. Georgina's little ramshackle cottage and adjacent wool shed lay in the distance, a short way from the sea.

On a cold winter day, we sat and talked for nearly three hours in front of a grill heater, me in borrowed slippers she had ready at the door, corned beef boiling on the stove, photos of family looking down from picture frames, cows chewing their cud through the murky rain-splattered glass and warmth and hospitality second to none. Various animal guests made their way into the lounge too, Georgina's babies enjoying the warmth. She has lived alone for many years but she tells me she's never lonely.

My questionnaire languished (as it did in all my interviews) on the sofa and we talked like we tend to do, with her teaching and me, on the whole, listening and occasionally prompting her to expand on pivotal moments in her (being big/bariatric) story. Being in her sixties, Georgina's memories stretch back to a predominately pre-obese, deeply Māori world with connections through elders to an even more distant past. The resulting story is so broad, deep and intersecting with myriad social, cultural and political dynamics that to do it justice – I soon realised – was beyond the scope of my research. There was, however, a thread that began to emerge, which re-emerged in later interviews and began to form a collective story of bariatric surgery.

A couple of months later I met Billie in a road stop town on the northern strip, her family's little house nestled amongst the shops, significantly so, as she recalled her 'big-eating' days when dinner was a matter of choosing between the various takeaways at her doorstep. Crochet rugs cover sofas, a bed in the lounge for a long term guest, family portraits across the walls, a hot cup of tea and lamb chops on the stove for family gathered in the kitchen. Again I am humbled by the hospitality, warmth and generosity of the people I am privileged to meet. Billie, young and positive – Bubbly B she calls herself – is a stark contrast (physically) to those who have spent many years

¹⁸ Taking kai to hui with Māori is culturally appropriate but given the complexities of eating post-surgery, I opted not to do this in future interviews but rather, bought refreshments of their choosing when in a café or bar.

dealing with ailment, illness and disease. I realise that age matters in this research and that 'frame of mind' or perhaps disposition, intrinsically shapes narrative resulting in similar experiences *experienced* dissimilarly.

I soon realised that 'point in time' matters too. In early spring I waited for Suzanne in a gentrified pub in a town now a magnet for the middle classes. Through the door she bounded, with her granddaughter in tow; smiling, slim, lean and radiant. Was this the same woman I had met six months earlier (to discuss the research), worryingly thin, sick, quietly spoken and saying after a long pause, "had I known then what I know now, I may never have had the surgery". Months later she was better, definitely better, but over the course of our conversation she revealed that this 'better place' involved a constant negotiation between food, eating, digesting, nutrition and a severely altered interiority. This on-going negotiation was spoken of in all my interviews and I began to get a sense of the sheer effort involved in trying to reach an equilibrium – as one woman remarked, "[i]t is like climbing a mountain, it really is!" Post-surgery life manifests as being between states, getting-there but never quite getting-there; as liminal, dislodged, precarious and unfinished.

There was one more interview to do. Snatching a moment pre-Christmas, I set off down the stretch of highway that runs along the not-so-pretty side of the country, with cabbage trees and flaxes edging borders of too flat reclaimed land and forlorn unfinished projects here and there. Marama and I met in a bustling café in an old river town where gumboots are left at store fronts, and where her whānau have deep ties to the land that reach back across centuries. Old friends catching up, we settled into a breakfast that looked a little large for the post-bariatric. I realised in that moment that surgery stories are as diverse as the people themselves. We move away from the noisy café to a football field where Marama has spent countless Saturday afternoons and there talk turned to the past, to eeling in the creeks, fishing, looking for puha; to a food supply that came from love and labour and 'passed through the hands that had prepared it'. What followed echoed the words of the other women; bodies changing in synch with a significantly changing food supply and lifestyle, leading to an arguably drastic encounter with the state – bariatric surgery and a new way of being-in-the-world.

What Follows

After attending a seminar by Renato Rosaldo, ethnographer Kirin Narayan notes two of the valuable things she learnt were “that stories are incipiently analytic, and that in the sequence of reasoning, analysis has a narrative form’, which involves “ following the consequences of actions and shifts in understanding on the part of various participants, including the writer” (2012: 8). The following chapters take a narrative form that metaphorically shapes as a journey – going back in time, moving across time, struggling through a dramatic medical encounter and re-emerging significantly changed but not necessarily having arrived. Analytically, I also do not necessarily ‘arrive’ with conclusive answers but rather rove about attempting to illuminate experiences, both as narrated by the participants and through shifts in my own understandings. Purposefully, stories bring the ‘human’ onto the page and reveal ‘actual lives’ replete with singularities and ‘collective inflections’ (Biehl and Locke, 2010: 320), agency and limits, contingency and subjectivity.

In writing ethnography, anthropologists have long grappled with the ethical implications of representation (Vargas-Cetina, 2013). Writing ethnography involves collating stories and observations, interpreting what has been gathered, deploying theory and reaching conclusions. Amidst this process, the words and logics-for-living of the research collaborators can take second place or even third, and that process, in itself, feels like another colonising act. In order to counter this, I endeavour to let the women’s words lean forward in the text by dropping some of the engagements with literature into footnotes. This strategy was deployed in order to lessen the impact of a recourse to theory (Biehl, 2013) which potentially leads to a reification of the words of academics and the concurrent sublimation of the words of participants. Biehl noted that he often returns to the words of Catarina (his interlocutor in *Vita: Life in a Zone of Social Abandonment*, (2005) as this is “the place where thought is born” (2013:577). The words of the women in my research are the “places where thought is born” and I have attempted to leave them as unfettered as possible but also acknowledge the inevitabilities in interpreting these words. What follows begins where stories often start – at the beginning, in the past; vital lives remembered with vitality in bodies free of disease.

Chapter Four: The Road to Being Big

Back When We Were Thin

Marama and I find a park bench in the shade beside a sports field on hot summer's day. She is nowhere near as big as she once was but still has a massive presence; the ram-rod posture, the intake of breath when she is about to speak - drawing from a deep well of mana, courage, savvy and a fair dose of humour. I enjoy her company. She always makes me laugh. We move the conversation from a catch up to an interview – the recording starts and we talk about the past.

Clare - Thank you for coming – you know I mean that.

Marama - You're very welcome.

Clare - Can you tell me about your home environment? How many kids were there?

Marama - There were eleven kids in our family – I'm the youngest of the girls... Mum was basically a stay at home Mum – she worked in between. She was the head cook because we couldn't afford to waste food. So it was pretty controlled.

Clare - Did your Mum have a garden? Were you up at the marae – where did you grow up?

Marama - At the marae – Mum was a marae person. She was not from around here.

Connections to places and people matter. We talk about mum being from the north, about her being taken home to be buried after fifty years with 'Dad's people' – about her express wishes to be taken home. We also talk about Marama's connections to her husband's people down the coast. "We have very strong ties with them, very strong". The talk moves back to food.

Clare - So what was the food? What was the standard fare?

Marama - Boil-up, lots of meat; meat, potatoes - salads when we could, but the basic everyday food was roast

Clare - So back then – eleven children – Mum & Dad – was everyone what we would call a normal weight?

Marama - Yeah everyone was normal – no one was fat.

Clare - What about around you in the community?

Marama - We were all basically the same, nobody was fat. The normal was your average type weight. Everybody was into sport; you were always active, played sport. You just did. Everybody did.

Clare - Can you think of a time when food was changing or was it just a gradual thing? For example, I do think more stuff started coming from supermarkets.

Marama - Yes we had basic food, basic food from scratch. There was no packet stuff for us. Mum did everything from scratch – packet food was like, ‘woo hoo!’ a real treat. She was home – there was no need to have fast food. Even fish and chips Mum did from scratch. If we had it in newspaper it was wow! It was a treat. Mum did her own filleting, her own battering and home-made chips.

Clare - Would you have caught the fish?

Marama - Yes, Dad or in our little village, if there was an abundance it was shared out, especially with our old people. Not so much nowadays.

Clare - Someone was telling me about eeling in the old days – down around the creeks but a lot of them dried up or they are polluted.

Marama - We still have eeling. I remember Mum taking me and my little brother and the ones just above us and we had to go eeling with her. We had to pick watercress once a week, we had to do all of that – puha hunting – to supplement our table. Dad would be at the beach getting mussels and stuff. You know that was just a standard – you had to because money was tight.

There is a gentle summer breeze and we are both remembering now. Nostalgia has a way of creeping in, thoughts of people long gone, feelings of what it was like to be children under the sky beside the sea – of rushing home to eat. Bodies moving in nature – into the natural world – laying down deep connections between the bodily and place, between the gut, the ground and the sea.

Georgina and I also reminisce. Somewhere in the midst of that interview I catch a glimpse of her in my peripheral view and get a flash of my late mother. It catches me unawares. The crop of snow white hair perhaps, but maybe there’s something more. A

similar toughness of character and lined face, similar intellect and signs of a life hewn from the same landscape – the wild places and the intermingled cultural and social fabric of Aotearoa New Zealand. Maybe I am a bit daughter-like wary when I am with Georgina. I know I will be enlightened and entertained but I also know that she suffers no fools and can spot the bullshit train coming from a mile away.¹⁹ I become acutely aware of how trust is foundational to this research and not to be taken lightly. We talk about her childhood. Georgina says that as a child she was big in comparison to other children but never felt diminished by her weightiness.

Georgina - You know, I remember when I was a kid, I can remember the food that we used to eat – our father used to hunt.

Clare - Straight off the land – straight off the sea

Georgina - Yeah, [*her sister*] and I, we were known as the bush kids because her and I grew up in [*the central North Island*] which is where my mother comes from. So we grew up right in the interior and our father used to go hunting all the time. We used to have wild pig and venison. We used to come up here every year [to the coast] and of course there's all the kaimoana and we used to love the kaimoana so we'd bring all the stuff from the bush and everyone used to love it and they would have wild pork and venison ... and we'd be 'let's have fish, let's have fish, fish and figs'. There used to be a fig tree here and our mother used to preserve all the fruit, veges and you know she would make chutneys and this that and the other thing. She used to make cakes and that as well but most of my memory of the food we had... a lot of it didn't come out of the supermarket. You know; puha, watercress, stuff like that eh.

I hear the active verbs – hunting, fishing, gardening, filleting, and picking – and imagine a flow of food from land to hand; food which then fuels metabolisms – bodies that metabolise in order to gather more food. It becomes easy to think in terms of

¹⁹ Ghassan Hage notes that: “we can reasonably say that racialized people have acquired a historical habitus which makes them good at ‘sniffing out’ racism when it comes their way” (2010: 120). I believe that Georgina has an embodied ability to ‘sniff out’.

equilibrium²⁰ between bodies and place – places yet to have calorie-dense industrialised foods surging through them.

Suzanne’s childhood was also connected to nature – in her case the beach. She is one of those people that seem luminous, shiny – she finishes most sentences with a laugh – tall and slim – so slim now that I find it hard to picture her before her operation. At our first meeting she was worryingly thin – off work, and clearly unwell. Months have gone by and she has gained a little weight and now infuses our discussions with energy. I started the interview by asking her about her childhood in the north as one of six children.

Clare - Were you in the country?

Suzanne - We lived at the beach so the beach is our background and we were just out and about all of the time ... We lived mainly off the sea; fish, seafood and all that sort of stuff and obviously your vegetables. It’s not that we were poor; it’s just that we had enough and we survived. You know, we got through so we weren’t considered poor. We didn’t think of ourselves as poor. We had what we had and that is just the way it was.

Clare - You weren’t overweight as a child?

Suzanne - No, no because we were so active, we ran around all of the time, literally, so no, not as a child.

Somehow my research into bariatric surgery twists and turns inward and for a moment becomes about my childhood. I write in my journal (fieldnotes 23/11/2017).

*Remember Little Waihi, Maketu
Barefoot, jandals maybe
Roast chicken in the electric frypan
New potatoes
Condensed milk & vinegar dressing
Tomatoes, lettuce & cucumbers*

²⁰ Gadamer speaks of natural ecologies as being dependent upon equilibrium and applies this idea to human health and wellbeing: “the phenomenon of human health ... cries out to be understood in terms of the natural condition of equilibrium’ (1996: 35,36).

*Cliffs, sand and mudflats
Jelly Tips
Making small whirlpools by dipping the oar just right
Fishing lines and nets
Maketu fish n chips & a bottle of Coke
Twisting feet down and down until you feel a pipi
Dad eating our pipi and the rest for bait
The salt, the sea, the sea air
Food appeared and hunger was there*

Pākehā and Māori deeply connected to the same land felt under foot, the same ocean, seafood, plants, forests, rivers, mountains, lakes, and eeling creeks. Our childhood memories both fold together and separate. Together in 'place' but separate in history and in ways of knowing. Stories of mahinga kai which reveal maps of Māori food matrixes networked across whakapapa ties that connect people to their ancestral food gathering sites (Phillips *et al.*, 2016). Kai (the noun – food, and the verb – to eat) is at the heart of these old entanglements between people and place and mahinga kai – still foundational to Māori culture.

Kai – with Love & Respect

Kai is much more than the noun – food, and the verb – to eat; as Georgina explained: “food is the pinnacle of everything, the end of everything, the rounding off of things”. Kai becomes a paradigm with many interlinking ideas; a touchtone infused with tradition and imbued with aroha. Suzanne and I talk about food.

Clare - Food is such a big part of our lives and I've been thinking a lot about food lately.

Suzanne - Oh it's huge in Māori culture! When we welcome people, whether it is a formal occasion or an informal occasion, we offer them a cup of tea and something to eat. You go to hui and you come and you get your pōwhiri done, you have a kai, you sit down and share a kai together, then you do your business, your mahi and then you say farewell. It's just what you did, you know, it's part of our culture, you feed everybody, meet and greet – feed, do your thing and go home. So it's all about food.

Georgina and I also talk about kai.

Clare - So I don't want to make a sweeping generalisation, but my picture of the marae is big food, big quantities of food – feeding people

Georgina - What happens today is a lot different than it used to be. The old Māori way of food, there is a whole lot of korero around that. Like you know one of those things about food, if you look at the really, really, old ways of doing things, when we used to have people coming in [onto the marae], the whole thing of pōwhiri, it would take days (not three hours) even three hours is quite long for today. When you imagine sitting in a Pa and you know there are people coming but you don't know who they are but you can see them coming because your scouts have let you know that these people are coming... So one of the old ways of doing things is that a lot of the people that would be doing the pōwhiri and stuff like that, they'd be eating a lot of things like protein that would sustain them. To sustain them for when these people came because when they came, you wouldn't eat.

Clare - Oh you wouldn't eat?

Georgina - No and neither would they because they would've done the same thing on their side. There is no eating, because then when you come in and pōwhiri, if you understand the proper concept of pōwhiri, and it takes days, days and days and days just before you get into the wharenuī ...It doesn't take five minutes; it will take days and all during that time you don't eat because eating makes you sleepy.

Clare - Oh so you stay alert?

Georgina - It's the only way to stay alert. So you stay awake and you learn as much as you can and then when you're satisfied that everything is ok, then you welcome them as manuhiri ...In a lot of ways modern day's food is about the end of things, the finalisation of things, for example the tangi when you have the kai hākari. Really in a tangi, the whānau tangi which are the people that are immediately to do with the person who has passed shouldn't eat.

Clare - All the way through the tangi

Georgina - All the way through the tangi because once that person has been buried they then come out of their sacredness and they become noa and the way to do that is through food...

And the other thing of course is when you invite someone to your house, you give them the best of things, you know, you always give them the best cuts of meat etc. You always give them the best because you want to be hospitable to them.

As Georgina's thoughts turn to the distant past my own turn to the present where bariatric surgery starts to manifest as a disruption to centuries of tradition and cultural practise. The gut no longer connected seamlessly to place but rather, fraught and malfunctioning and partially alienating people from the world they know. This world however, has also dramatically reshaped over time and is now one in which kai has become entangled with obesity and disease. Marama and I talk about food.

Clare - I'm starting to think that it is very hard to be slim in this world. It's a constant battle because all around us there is way too much food, way too many calories – it's almost like it is much easier to be big than slim. And your world is – I'm going to make an assumption here – in your world there is a lot of eating going on.

Marama - It is a cultural thing. With people, you show your love by giving something and it is usually food... You show your love. You prepare this beautiful meal and you present to your loved ones. You feed them. That's how you're showing your love. But is it love really? We're killing them with food. But in my family and culture that's how we show our love I suppose – by feeding you. You know – sharing something.

Clare - Quantity, quality

Marama - Yeah so that's how I think we show our love by feeding and feeding and feeding and feeding. That's a cultural thing too...

And our people are getting diabetes and our kaumatua and kuia are dying young, why, you know. Māori are looking at this because we are predominantly

in the statistics for being overweight. So why is that? We have got to change or we are going to die early and I'm sorry, I am not.

Marama pivots and turns on a paradox. Kai infused with aroha and whanaungatanga changes and becomes a source of whakamā and concern. She walks proudly in her culture but simultaneously distances herself in order to make a stance: “we are going to die early and I am sorry, I am not”. ‘We’ becomes ‘I’. Marama sets herself apart in order to step towards better health. I get an inkling of post-colonial power seeping through and keeping Maori in place.

Feeling for my friend and feeling knocked about by the capacity of colonisation to lay down such deep roots, I remember two things and take heart. Firstly Marama is also energised and agentic in that moment, expressing a desire that will potentially propel her towards a better outcome including extending *life* itself. Secondly, kai is both food and beyond food and serves community as an enduring practise that weathers change. Kai surges through the hearts and minds of the Māori women I spoke to, and infuses the space between people with aroha – with conviviality, texture, smells, taste, sound, comfort, chatter, hospitality, nourishment, and together-ness. Kai as a practise anchors feet to soil, brings voices from the past into the present, and turns the eye outward towards the land and sea. Food alone however, stripped of its cultural context, is problematic in these calorie-dense contemporary times.²¹ Our conversations move into this context – from childhood memories to getting big, being big, and dis-ease.

Getting Big

There is one thing that you do when you're with Billie and that is smile a lot. I remember her when she worked behind the counter at the local petrol station. You would enter to pay and leave with a smile. She's small now but this is not what defines her – she was and is the light that lights the room. She makes me a milky cup of tea and we talk about her childhood and getting big.

²¹ Brewis (2010:1) notes that “...[f]or the first time in human history, in the year 2000 it is [was] estimated that there were more overweight people than underweight people globally.”

Clare - Can you just tell me a little bit about your background? How old are you and when did weight become an issue, has it always been an issue?

Billie - Well I'm thirty and weight has pretty much been an issue for me since I was a kid. Actually my weight gain started when we moved to [name of town] when I was about nine years old. Up until then we lived up North and everything was fine and when we moved down here it was kind of like a change of atmosphere and a new life and everything so it pretty much started for me when I was about nine.

Clare - So what do you reckon about the new life, what changed for you and your family?

Billie - I think the main change was not knowing people so I wasn't active, I wasn't as active as I used to be and I was always out and about with my friends and things like that and when I first came here, initially, I was quite shy and reserved so I would just stay home and not go and spend time with family and friends.

Clare - So is there something different about the eating, in the change from [...] to [...], any difference in the type of food you were eating or was it just around the whole social thing?

Billie - No not just the social thing, it would've been around the eating as well.

Clare - Can you think what that would be?

Billie - What I think was different, was that Mum started to work full time to support us so when it came to food, it was just make whatever you could and by the time she finished work she was tired and because she was working at the Bar'n'Grill at the time. She would bring home food that she made there and it would be like, hot chips and things like that, burgers. Whereas before then we would have completely home cooked meals and all that kind of stuff.

Clare - And when you were up north, did you have a big whānau up there or were you connected to Marae or anything like that or was your whānau based down here?

Billie - My family up there was my poppa and my nanna so with your poppa and your nana you always have really yummy home cooked and there was me, Mum, Dad, and my brother.

We take the time to map out her family connections. She is in one place but her being moves beyond the bodily and connects across whakapapa to people and several marae across the North and North West. Her narrative is embedded in whanaungatanga and it is easy to get a sense of the love she has for whānau.

Clare - So just talking about the weight gain; was the whole family experiencing weight gain when you moved down here or was it just the kids? I remember you saying your brother had some weight issues.

Billie - Yeah, at that time my brother was really sick so he went the other way. He went really, really tiny and I think it was about four years later, he got rheumatic fever and then after that, he started to balloon.

Billie's narrative is inflected with the normalness of bigness and she remains upbeat throughout the conversation. I wonder if this reflects her age and the prevalence of big bodies across her lifespan; being large perhaps being simply par-for-the-course. With the older women however, their becoming big is viewed as more insidious and calamitous in retrospect. Getting people to talk about getting big becomes about asking them to dig into the past and reveal their (perceived) list of failures. Their narratives then become shaped by these negative experiences. I feel complicit in taking them down this path, particularly as they had initially agreed to talk about the success of their weight losses. This sits unresolved for me. I asked Marama about getting big.

Clare - I'm just wondering if you could tell me a little bit about yourself. When did you start becoming a bigger person?

Marama - I think when I left home and I was 17 when I left home. I had to cook for myself, went into a hostel first and then went flatting with boys from other hostels; started that boozy thing. Wasn't eating right, never had that control anymore. Um, first fulltime job - thought my figure would always stay the way it was.

Clare - So if you don't mind telling me, can you remember what you were at your biggest weight?

Marama - 132 or 133 kilos

Clare - Was that as a young person?

Marama - No. After my first child – I remember I was pregnant – I was 92 kilos – fully pregnant. Then you know I never sort of lost the baby fat. Then the worst time was when I gave up smoking. I was smoking too and smoking kills your hunger and then when I gave up smoking – it just sort of went boof. And then I thought, I'm still looking good – I'm in denial I think. Then I had my second child and that fat never left. Then just kept eating and eating – changing jobs, death of my parents – you know 'life' I think, and I just thought 'I'm alright'.

Marama also spoke about her husband's insecurity back in the days when she was slim, when she used to get a lot of attention from other men, and he would worry that he would come home and find her gone.

Clare - Oh, he thought you would leave?

Marama - Yeah and then when we got married he felt more secure – he told me this years ago, and then I got bigger and bigger, and the bigger I got, I felt that he felt the more secure.

Stories about getting big shift from food to relationships, moving from home into the wider world, from old ways of gathering food to the supermarket aisles, from food unfettered to food overloaded with calories, super-infused with fats, oils, and sugars.²² I asked Marama if her family still gathered food from the beach and she said yes they still do if they have a big social gathering, but adds:

²² Brewis notes that although the global rise of obesity is complex, scientists generally agree on several exacerbating factors; 'diets emphasising sugars, fats, and high-calorie liquids; lifestyles tending to the sedentary; increasing and more stable access to low-prices processed foods, and urbanisation' (2010:2). Brewis also notes that particular fat-making substances have been surging and spreading through the food supply for several decades such as; high fructose corn syrup, cheap fats and oils, fast-foods from proliferating fast food outlets, and the 'massive up-swing in high calorie drinks' (2010:2).

Marama - yeah but half the trouble with *us* – [she then shifts to the personal] – I’ll just talk about myself, I’m lazy – I’ll go to the supermarket, it’s faster.

Marama has raised many children over the years, including whāngai children and others in need. At the time of considering surgery, she was running a household of eleven. She has worked fulltime for over three decades in the social services and as a younger child of eleven, has supported older siblings and her parents in their later years. Her home sits close to her marae and obligations that come with being a key member of that community are ever-present in her everyday life. Yet she calls herself lazy. Another of the women recently said to me: “us Māori see ourselves as a problem, as we’ve been told that we are a problem for years and years”.

I am struck by the toll of stigma – the way in which promulgated (perceived) deficits saturate, burden and potentially become embodied – felt and believed. Subjectivity seems swamped, weighty, prone to defensiveness in the face of derision, and imbued with a creeping self-doubt – like a whisper – ‘you are a problem’. I begin to think in terms of racialised subjectivity but Biehl and Locke (2010) caution against thinking with ‘inevitably’. They note that: “[e]thnographic realities are never fully reducible to the books and theories we bring to the field” (2010: 320). An individual’s actions may be contingent on subjectivities but are not necessarily inevitable as per those subjectivities (2010: 321). From this perspective, people are therefore fettered to a degree but not intrinsically bounded. Māori-ness emerges amidst the complex morass that is ‘being big’ as the presence that holds and nurtures, no matter the shape, no matter the size.

Being Big

I asked Billie about being big in differing contexts:

Clare - Some people are very self-conscious about their size. I was just wondering if culturally it is different, if in the Māori world size doesn’t matter so much or whether it’s just the same whether it’s down at the mall or up at the Marae. Do you experience any differences around the way people think about body size at all?

Billie - I think that's a little bit harder [in the mall] because when you are on the marae it's all family and you are who you are and they just accept you for that. It doesn't matter whether you are big, small, and weird – you know. It's just like that's you, you've always been that and we love for who you are ... That's what I have grown up with. I never had my family, you know, 'saying you should lose weight, you look funny.' that kind of stuff. I've never had to experience that...

They just always accepted and supported. So just in general, I've had a lot of support throughout my life anyway. So I haven't had a mental challenge when it comes to my weight because that is who I was and my family supported me.

Clare - Are there any places out there in the world that you would avoid that you felt most uncomfortable in as a big person?

Billie - Oh, not really, because I am such a kid at heart. Last year before the surgery when I was bigger, I would take my nephew to the park and I would be going down the slide with him and swinging on the swings with him ... So for myself, personally, if I'm gonna be a kid and go and do kid things. I have no issues with it but some people would have issues with it because it's like, 'oh look at you, you shouldn't be out, you should be like at home sleeping or something'... being bought up with my Mum and my Mum being such a positive person and always having a positive outlook, I didn't really see other people's negatives – their negative views in regard to who I was.

Billie as big seemed to shimmer and shine and swing on swings with her young nephew seemingly oblivious to the slanted gaze of others. I imagine her supported by the collective – enlivened by an enduring current of whanaungatanga strong enough to push back the fat-bias of others. I grapple with the women's apparent ability to disrupt the widely held belief that losing weight is motivated by a desperately poor body image coupled with the desire to reshape in order to achieve the perfect shape. I asked Marama if she had a hang up about her size:

Marama - No! (She laughs)

Clare - The assumption is that people have a real problem with their body image but I wonder if that's the case.

Marama - No, no, no! If I couldn't fit a dress, I'd buy a bigger one. If I looked good in it, that was fine. Every now and again, I'd say to my husband - oh I know I'm big and he goes, I love you no matter what.

Georgina was also strident about how comfortable she felt in her big body.

Clare - That whole thing about size - was there a point in that journey when you started to think more about your size, a time when you felt less comfortable in your body or more comfortable in your body?

Georgina - I have never felt uncomfortable in my body. It wasn't about size.

Clare - So it's never been about size?

Georgina - In my mind's eye it hasn't. I've never been a mirror person.

Self-image is not reflected back from the mirror (of our times) but rather drawn from the interior, the deep pool of the collective. Self-image is not two dimensional - a line drawn around the breaching curves of a voluptuous body - but rather a deeply rooted sense of self where the body has neither a 'before' or a desperately needed 'after'. Consciousness, anchored by whanaungatanga, ripples outward from this fullness of being and issues with size are brushed off with a flick of the wrist, as Marama noted - "if I couldn't fit a dress, I'd buy a bigger one" - as simple as that. These big bodies however, swing and sway and take up space; breeching borders of skinny seats, knocking into things, and brushing up against strangers while tentatively manoeuvring through crowded spaces.²³ Billie remembers scoping seating and moving through the mall:

Billie - Like there's nothing worse than going out and thinking there's a plastic chair and I don't want to sit on it because it's plastic and I could possibly break

²³ Brewis et al. call this 'public mis-fitting' noting: "the need [for the obese] to plan and scan constantly while navigating too-small public spaces" (2017:257). Fat stigma is exacerbated by both 'public mis-fitting' and experiencing a lack of sympathy from others.

that ... 'I don't want to break that seat!' The worst space was trying to get through crowds and stuff and just being conscious of the fact that you might bowl somebody over and knock into people and annoy them.

Big bodies struggle to fit into the material world and also potentially carry the burden of weightiness within; surging blood-sugars, malfunctioning organs, breathless lungs, aching joints and for many – the near impossibility of a good nights' sleep. I'm not sure how much to talk about these things with my participants. It feels like prying. At times we brush over, at others, disease memories well up and become pivotal in narrative threads that eventually lead to bariatric surgery.

Dis-ease

Georgina and I talk about her struggles with gout.

Georgina - Do you remember the times I used to be in so much agony?

Clare - I remember the gout.

Georgina - I used to be in so much agony! I could not walk; I just could not walk at times. And I would be crying on the way home and couldn't barely drive at the time but I did and I'd come home and I'd literally drag myself through the door. I was literally on my stomach sometimes because I couldn't walk. And I thought, 'oh my God this is terrible'.

I asked Marama what her main health problems were.

Marama - I had diabetes, sleep apnoea.

Clare - So with the diabetes – how was that affecting your health?

Marama - Things were not healing, skin rashes; things not healing straight away like I used to when I was younger. The worst thing was my eyesight changed and you know I just put it down to age, getting older. Sleep apnoea, the constant headaches – falling asleep. By Wednesday – I'd be falling asleep at the wheel driving to work, and I was driving to Queen Street then.

Sometimes disease was just bundled together – “this, that and the other thing” or spoken of in lists: heart disease, liver disease, asthma, diabetes and leaky kidneys. Disease also came up as part of whānau life.²⁴ Suzanne’s whānau narrative was, in part, a story of limited life spans:

Clare - I remember when we met earlier in the year and you talked about – was it your mother’s family or is it your father’s family – where there had been really short life expectancy?

Suzanne - Yep, so my Mums family have had a short life span.

Clare - Is that all of them?

Suzanne - Yep pretty much all of them, the females particularly.

In my mums family I think her four sisters, they all passed before her. Also the generation ahead of her – they were all dying – they weren’t making it past forty, fifty sort of thing. So my Mum was the very first to last longer than 60 years.

Clare - Did they have cancer or something?

Suzanne - Yeah cancer – just all sorts of diseases, my mum had a heart disease – kidney and liver diseases.

Clare - Not obesity related – just general

Suzanne - No, but they were reasonably big people anyway, as well, so they had a lot of illnesses.

It becomes hard for me to move my thinking beyond the ravages of our time: like an apocalyptic reckoning where big bodies reflect the toll of dispossession, consumerism and immense changes to the food landscape. I feel for the people that grapple with illness and who often feel solely responsible for the burden that they carry but who also live in a world which facilitates countless opportunities to gain weight. I imagine commodities stripped back and regulated – whole aisles in the supermarket gone for good and people moving again in bodies equipped to move in the world much like they did ‘back when we were thin’.

²⁴ As noted earlier: “[i]t seems at times that the development of these [obesity related] disorders has become a part of the aging process for Māori” (Warbrick, 2011:175).

Concluding Thoughts

It felt good to reminisce with the Marama, Georgina and Suzanne, to remember times that were seemingly pre-problem food and pre-problem bodies – times when those bodies moved in the natural world; in sea, sand, bush, creeks, rivers, and garden beds. Shifting the conversation to ‘being big’ however, was like trying to pin down a moving target. ‘Bigness’ defied categorisation. A large Māori woman, it seemed, could be both stigmatised and fully accepted, a racialised subject, and culturally strong, mis-fitting in certain public spaces and ‘at home’ in many others. Van Manen notes that “[a] human being is not something you automatically *are*, it is also something that you are also trying to *be*” (emphasis in original, 1990: 5). In Deleuzian terms, ‘to *be*’ is an ongoing process of *becoming* within the “immanent fields that people, in all their ambiguity, invent and live by” (Biehl and Locke, 2010: 317). The women are *of* their immanent fields but also emerge *from* these fields with nuance and modulation, shade and variation, capacity and incapacity and openings and foreclosures. One foreclosure that was hoped for (implicitly) was the end of a lifeworld entangled with obesity-related ill health. Disease talk seemed to drain the energy from the room whereas stories of success animated discussions and lifted spirits. Success did not begin with weight loss but with being accepted into the bariatric surgery program; a process so profoundly experienced it emerged as a *rite de passage*, beginning with ‘decision time’ and a separation from a life as they knew it.

Chapter Five: Entering the Weight Loss Surgery Program: A Rite de Passage

Decision Time: Agency within the Collective

'Decision time' is an act of resurgence from imperilled bodies and precarious lives. Combative, individuals emerge from the collective ready for change but never fully stand nor act alone. Decisions are atmospherically²⁵ charged by myriad factors; medical norms, concern, desire, discourse, knowledge, power, and the influence of others that sit close to the heart. Tim Ingold calls this: "[a]gency that is inside the undergoing of life" (2016). I asked Billie:

Clare - What made you decide to have surgery; was it family, was it your health, what sent you off down that path?

Billie - Well four years prior to me having surgery, my mother had surgery as well. And I was talking to my aunty who had surgery as well and was like 'oh my God' you're looking so good and she was like 'you know what bub, I wish I had decided to do this surgery earlier because it's just made it so much easier for me to stay on the right path.'

And that got me thinking - ok - If my mum is telling me to do it and I'm not listening and my aunty too, trying to tell me that if she had decided to do it earlier, it would've been better, then maybe I should look into it. And so that's pretty much how I decided to look into it and maybe it is the right path for me to take.

Clare - So when you were watching Mum and Aunty go through it, were there any misgivings around their experience?

Billie - My Mum struggled. Yeah after her surgery, it took her a while to bounce back. So she really struggled with the healing process afterwards and my auntie also struggled with it as well ... I think the bits that weren't good were watching them trying to recover.

Clare - Oh ok, the recovery period.

Billie - The recovery looked really, really, scary.

²⁵ Teresa Brennan's (2004) notes that 'atmosphere' is created through the 'transmission of affect'.

Clare - And when you're talking recovery – you're talking over months or weeks?

Billie - Maybe like one to two months and I thought – that's way too intense for me but what changed my mind was obviously talking to my aunty about it and her thing. 'I wouldn't suggest this if I didn't think it wouldn't help' and you say 'what I went through and how hard it was but I would do it again'.

Billie's thinking spills over and mixes with her aunt's and mother's. Others inhabit her world deeply and closely, especially her aunts. Joan Metge (1995:190) in discussing the upbringing of Māori notes that aunts and uncles play a significant role and "share the authority of parents". Billie's agency is entangled with others; tributaries that connect and flow through heart and mind. Simultaneously, agency is enlivened by whanaungatanga and desire while still being gripped by the stuff of life – like a surging wave in a stormy and powerful ocean.

I asked Marama what led her to making the decision to have surgery:

Clare - So what made you go down that path? Was there any one particular thing?

Marama - There were a few things, the birth of my granddaughter. I had a check-up, my blood pressure wasn't good and I had never had blood pressure problems, even though I was a big girl. Everything was going out of whack. My eyesight was getting worse. I wasn't feeling good about myself. I started feeling yuck. But my biggest motivation was that [my granddaughter] and my husband I think. I thought he was not interested in me anymore.

Clare - Oh, did you really?

Marama - Yeah, because he gave me a choice too. And my granddaughter – those were the two major things and I thought, 'what are you going to do about yourself? Are you just going to lie around feeling sorry for yourself?' What are *you* going to do about it? So I went to the doctor – well she called me in any way for a check-up and she said, 'this is going to have to stop, you are going to

be a type one soon – diabetic’. She said – ‘your lifespan is going to cut severely if you carry on like this’.

Clare - That was very forward of the doctor.

Marama - She was amazing. She saved my life...

And I thought ‘blow it’, and things with me and [husband] weren’t going too well at this stage and I thought, I’ve given all this time for you and your family and now it’s about me.

Trying to understand the ‘me’ in ‘about me’ moments is like shining a light on a multi-faceted surface. The ‘me’ is desperate and devastated by failed diets and ill health. The ‘me’ is also energised and purposeful in the act of deciding to have surgery – courageous not weak. The ‘me’ acts for her own sake but also acts relationally as part of the whole. The ‘me’ imagines a future through surgery – a better life, a longer life. The ‘me’ also knows deep down that there may be a price to pay but ‘decision time’ is not focused on risks but rather opportunities. Emboldened, the ‘me’ steps into the weight-loss clinic and towards an opportunity to experience success; success which begins at the point of being accepted into the bariatric surgery program.

Acceptance and the Embodiment of Success

Getting in to the bariatric surgery program is significant and getting in and making it through is experienced by all of the women as a turning point – a triumph. Criteria have to be met. Prospective candidates are required to have a Body Mass Index (BMI) greater than 35 kg/m², a background of being unable to lose weight through dieting, and at least one obesity related comorbidity that can potentially be reversed through surgery. Those who are too big can be declined, as a BMI greater than 50 kg/m² may pose significant surgical risk (The Ministry of Health, 2009; Taylor *et al.*, 2018: para 12). Once accepted, a new process begins with candidates being interviewed by members of the bariatric team, including a dietitian, health psychologist, and nurse specialist. The next step is particularly difficult, with candidates being expected to lose 10% of their bodyweight above a BMI of 25 kg/m² and three to six weeks out from surgery they are put on low calorie (Optifast) diet to reduce hepatic steatosis (fatty liver disease) (Taylor *et al.*, 2018: para 13). Many who start out do not make it onto the

program which has an attrition rate of up to 54% (Taylor *et al.*, 2018). Talking about making it in and making it through shifted the emphasis from living with the burden of disease to doing well and moving ahead. It felt good to stop talking about obesity and disease. Articulating success has the power to lift the spirit, reframe the narrative and draw people back from despondency. Energy comes back into the room. I ask Marama about getting into the program:

Clare - What were the criteria?

Marama - His [the surgeons] criterion was basically that I had tried. He asked me what sort of diets I had been on before. What was successful, what wasn't successful, what was my best result, why did I stop etc. – basically what you are asking me, even down to sexual abuse. That was in the questionnaire. He accepted me anyway because I hadn't just thought 'oh this is an easy way out'. My reasoning for wanting this – so I told him straight up.

Clare - So what happened next?

Marama - So a month later, I had to go in again. He examined me again and said: 'this is what I want you to do. You have to lose 10kgs before I operate' and I thought, 'of course I can' and in three months, I'll have the operation and it will be all over. Well it didn't work out like that at all.

Clare - What happened?

Marama's life becomes subsumed by family responsibilities as she agrees to take on the care of four young nieces and nephews. After 18 months, and having not lost any weight she faces losing her place on the program but her GP advocates on her behalf.

Marama - I couldn't concentrate on what I needed; it was about what they needed [her young relatives], about concentrating on them. And I thought – get them settled and I will get back on track. But every month you're meeting with these people and my weight wasn't dropping off.

After about 18 months I was told at the last check-up, either lose this weight by a certain time or you're out and they sent a letter to my doctor who called me in and hit the roof – not at me – at them.

Clare - Oh did she?

Marama - Yes she did – she's amazing.

After the hospital received the GP's letter another appointment was made and it was suggested to Marama that she go on an optifast diet.

Marama - I'm getting sicker and sicker and now it's about *me*. And then my son had another child – she was pregnant and I thought, 'I'm not going to see this child'. Nah stuff it, it's about me.

Clare - And you did it – you lost ten kilos?

Marama - I did it! I lost 25 kilos. I loved it Clare!

The more I hear the more I realise that entering the program is a substantial offering up of mind and body, of meeting goals, clearing checks, succeeding not failing, being strong and being committed. Acceptance is a turning point, but nevertheless other people can still heap scorn and look upon surgery recipients as cheats, as Marama explained:

Marama - One colleague said to me, and she's a big girl and she's always sick in some way and I said to her, 'if you were offered this operation would you take it?' and I meant it in a nice way. And she says, 'no I wouldn't, because I think it's a cheat's way'. And I said 'oh I don't see it like that, 'I did this for my health'. And she said, 'no, that's cheating'. And I felt annoyed and I said, 'well you can stay fat then', that's being bitchy now.

Clare - Do you feel it's a cheat's way? Do you think that people think that of you?

Marama - Some do. They don't know my reasons, they don't need to know my reasons, that's my personal 'why I did what I did'. If that's how they think, that's them.

I spend some time clarifying my own thoughts.

Clare - The way I see it, I can see how people, if they were being honest, how they could possibly think – ‘Oh you needed to have weight loss surgery because you have no will power’ and how people like yourself, who have had it, may feel deep down that ‘I couldn’t do it by myself and I needed help’, but the more I talk to people, the more I realise how it is a huge achievement *in itself*.

Marama - It is Clare. It is a *big thing* in itself.

Clare - It’s like climbing a mountain or something.

Marama - It is like climbing a mountain, it really is!

Clare - It’s not an *easy* option eh?

Marama - It really *isn’t*, it is one of the biggest choices and it’s a commitment Clare. It’s not the easy option. The easy option would be to do nothing.

I asked Suzanne about being accepted into the program.

Clare - So how do they work that out, do they just talk to you, how do they test your commitment?

Suzanne - So they give you goals to reach – so I might have been a 100 and something kilos and I had to lose 10% of my body weight or, you know. And that in itself was quite hard and they give you some help ... Yeah so you’ve got to show you have what it takes mentally, psychologically and physically to lose that first bit of weight and then be able to maintain it for a certain amount of time to show that you are serious about it.

Clare - Its hard work

Suzanne - It is, it is hard work – really hard work – you’ve got your surgery you’ve got to recover from, you’ve got the mental side of it that you’ve got to recover from and accept, and then there’s the adjustment to your habits, eating and looking at exercise that becomes a daily routine as opposed to something that you have to make yourself do – you know – and they whole change of mind-set.

I get a sense that the participants are being strengthened by a process that helped to facilitate their success. Success is embodied, tenacity strengthened – like a muscle, disposition shifted and perhaps other potentialities begin to form on their

horizons. Like a *rite de passage*, the program moves and shapes candidates towards significant change with eventual re-entry into society anew, precipitated by a drastic intervention – bariatric surgery.

Surgery: Threatening Life, Giving Life

Sometimes a word simply does not convey enough. *Surgery* sits for me like an iceberg on the surface with hidden depths in the same way that understanding what happens physiologically becomes murky beneath the skin. In order to garner an understanding of what happened to my participants; the range of surgeries is covered briefly below: ²⁶

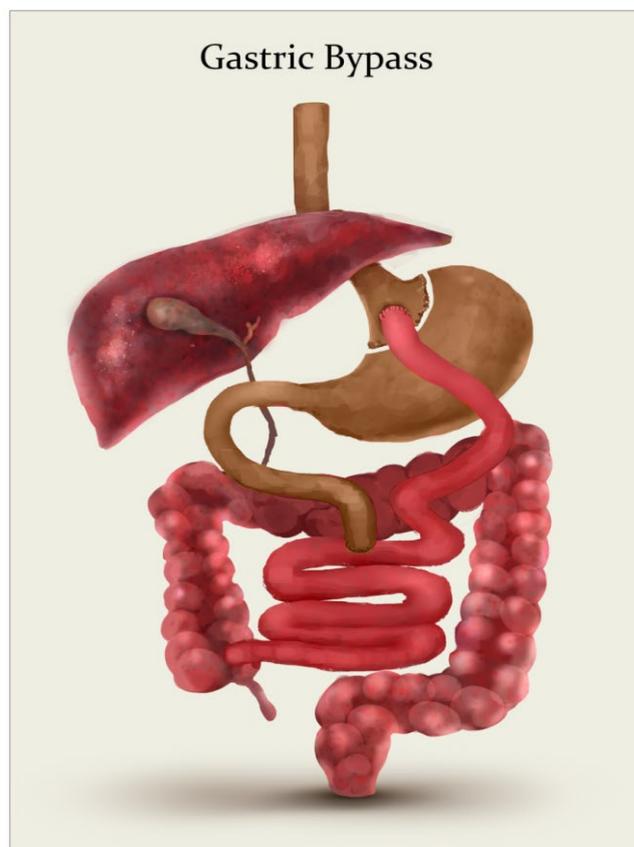


Figure 1

The gastric bypass involves separating a large section of the stomach and leaving a small pouch the size of an egg. The small intestine is cut and this is connected to the pouch. The remnant stomach is then reconnected to the end of the small intestine forming a Y. This is to allow digestive juices to flow from the remnant

²⁶ All images are used with the permission of the artist RD Hayward 2019

stomach and aid digestion. This surgery relies on a greatly reduced ability to eat, a reduction in the absorption of nutrients through the small intestine and the reduction of hunger hormones that are normally produced in the stomach (Mayoclinic, no date b). One participant called this – ‘having two stomachs’.

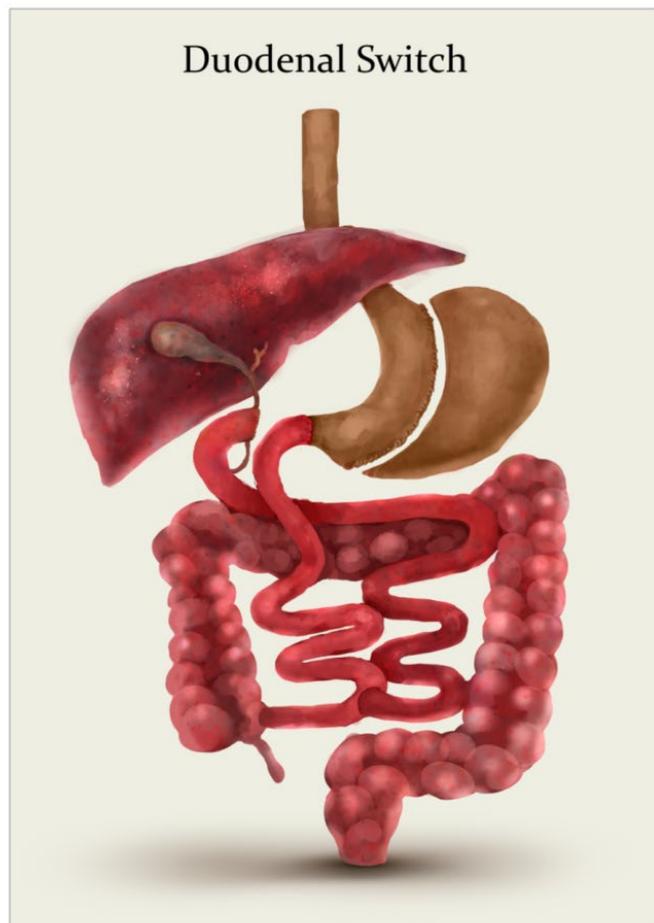


Figure 2

The duodenal switch is also known the biliopancreatic diversion with duodenal switch (BPS/DS). This involves removing a large portion of the stomach and connecting the remaining sleeve to a limited portion of the small intestine called the duodenum (the duodenal switch). The remaining part of the small intestine is reattached to the end of the intestine to allow bile and pancreatic juices to flow into this part of the intestine (the biliopancreatic switch) (Mayoclinic, no date a). Weight loss occurs through food reduction and malabsorption. This surgery is considered to

have the greatest risks including gastrointestinal side effects and nutritional complications (Kumar, Gomes and Palanivelu, 2017).

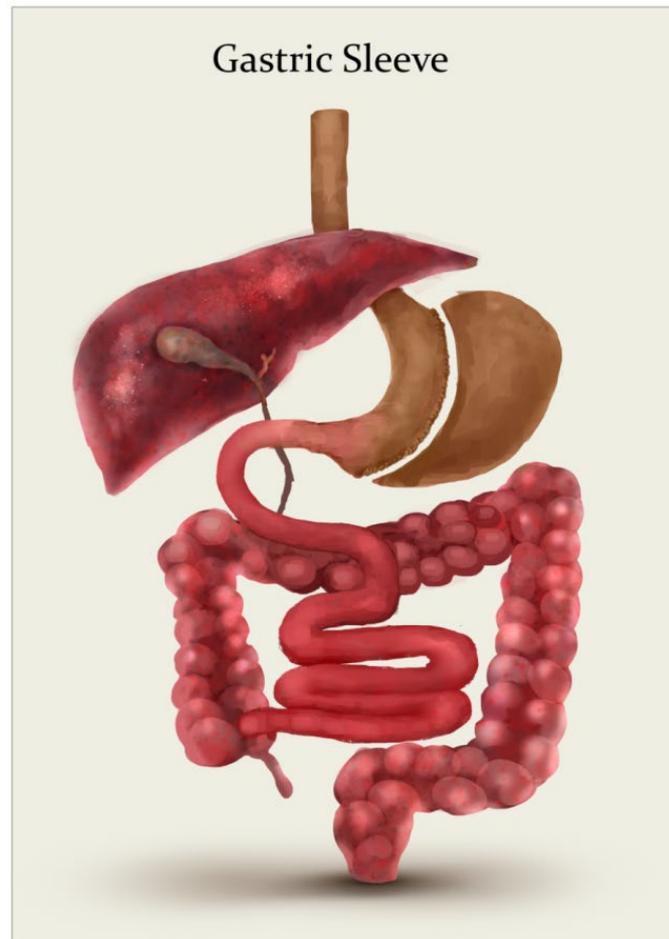


Figure 3

The gastric sleeve, which is also called a sleeve gastrectomy, involves removing a large portion of the stomach and leaving a sleeve. Weight loss occurs through a reduced ability to eat and a reduction in the hunger hormones normally produced in the stomach (aucklandweightlossurgery, no date).

Billie bounced back from her sleeve gastrectomy:

Billie - I think I went into the surgery quite healthy because I bounced back so fast.

Clare - Oh good on you!

Billie - Like it was completely opposite to what I had seen my Mum and Auntie go through. I rang my brother the next day and he was like – oh you sound good – I feel good, I was walking around. He was like, ‘oh ok’, and I was like, ‘yeah they’ll probably let me out tomorrow so after the surgery’. I was really good, I healed really quickly.

This was not the case with the others however, two of whom ended up in intensive care (ICU) and one returning to hospital after surgery. Marama and I talked about her gastric bypass.

Clare - So what sort of surgery did you have?

Marama - I had a gastric bypass. There were three choices – a duodenal switch, a gastric bypass and a sleeve. And the surgeon said to me “what would you like?” and I said to him ... “I’m not an expert in bariatric – you tell me which one I’m gonna have and why it would suit me and I’ll go from there”. So with my history, he suggested a gastric bypass.

Clare - So when you came out of surgery and you had your liquid diet and then you start eating again, were there some difficult times around trying to eat again?

Marama - You know the most difficult time wasn’t the food Clare – it was that instead of having the five slits, I got slit from here to there [points from the chest to the bottom of the stomach]. The rest of my friends – they had five slits. They tried but because I’ve had so many surgeries before, it took two hours to get rid of the scarring inside of me before they could do the operation. So they slit me open, they cleaned me up inside because of the scarring and did what they had to do and stitched me back up. So it wasn’t the food so much, it was all the stitches I had, I had heaps. I looked like I had had a heart operation. So it was being dependant on my partner to wash me and that ... we’ve been together for forty years but there are just some things. I mean, he has seen every part of my body but being powerless and not being able to help myself. That was the biggest mental thing that I had in my head and I would just stand there crying.

It wasn't because of the food or because I couldn't do this or eat that, it was him having to bath me; being helpless, being reliant on him and he's a *good* man. I'd be crying and he would say, 'what are you crying for – you would do this for me wouldn't you?' He was excellent; it was me and my thinking. That was the hardest thing. Not the food.

Clare - Just jumping back to the physical stuff for a moment, are you one of those people that could stop taking the diabetes meds after surgery?

Marama - Well funny thing – three days in – unfortunately for me, I don't know what happens but my heart gets a bit of a fright. My heart got a bit of fright 24 hours later and I ended up being rushed to ICU for a short period of time. You know, and these bloody people said to me – they wake me up at 1.30 in the morning and I'm rushed away and they are holding up my arm for monitoring and they are asking my name and I'm going 'look up my fuckin' record', the sixteenth time I've been woken up. 'Are you in pain?' and I'm going; 'what do you think Sherlock?'

Georgina spoke about her duodenal switch and the issues that emerged during surgery:

Clare - How long ago was the surgery – four years?

Georgina - It'll be four years since I had the surgery and nearly six years since I made the decision and had to do something about it.

I had two things done. I had the stomach stapled; well actually it was sewn so it was made a lot smaller. And the top of the stomach and the bottom of the stomach – the holes are made smaller. So the whole stomach was made about the size of my finger and the other part was called a – can't remember off the top of my head, a duodenal switch and I guess the easiest way I can describe it is that they shorten your intestine. So they sort of bypass one area and switch into another.

You know when I first had it done I could barely eat a teaspoon of yoghurt.

In fact probably a week after I came home I had to go into hospital again because I wasn't eating and I had no energy and anything like that, so they just took me back in.

Clare - I remember you saying that you went into renal failure in the surgery?

Georgina - No it was after the surgery, the next day.

Clare - Oh yes that's right.

Georgina - They kept telling me these things and I'm saying yeah, yeah whatever, because I am a very strong minded person as you know. And I kept thinking they've got it but my body went into renal failure, absolutely nothing to do with the surgery. It was my kidneys stopped functioning and that was probably heading that way anyway. So that's what happened - they nearly lost me.

Clare - So are they alright now, the kidneys?

Georgina - Well I have to keep an eye on it. I have to go every so often and of course the other problem that surfaced was my heart.

Clare - Oh your heart?

Georgina - So I've gotta go and get that checked all the time.

Suzanne talked about her gastric bypass and the precarious time post-surgery:

Clare - Would you mind describing the actual surgery that you have had?

Suzanne - So the bariatric surgery I've had was a bypass, so not knowing my anatomy very well, my understanding is that the tube that comes down that we eat through and then goes down into the first stomach and then gets processed or broken down and then goes down into a second layer stomach before it goes out the other end...

Clare - So you have little pouch thing then?

Suzanne - Yep it bypasses the big stomach and goes straight down into the small stomach. So hence the food needs to be chewed properly so it can go down and get processed otherwise it just sits.

Clare - Yes, so how long has it been now?

Suzanne - So coming up November, it'll be two years, so it's taken a good while for me to be comfortable in my new skin I guess you could call it.

I think not long after the operation and everything, I think I remember thinking 'If I had known then what I knew now' about the effects and after effects of the whole process, I don't know if I would've have done it.

Clare - I think you said that to me when we met in March. You actually made that comment and I wondered about it.

Suzanne - Yeah because, you know, they explain all about the surgery. They explain about how hard it is going to be afterwards and the changes to your body, the changes to the way you eat and how you eat but I guess for me, and I don't know if it's the same for everyone, but for me, I don't think there was enough psychological work on the impact of those changes to me. Like there was one time there when I got sick when I literally could not eat, not because I didn't want to, but I couldn't because I was too sick and that was like a two week process, because I take a long time to get over being ill anyway.

By the time I came out of being that ill – I was right down to 56 Kgs [from 144 kilos – a loss of 88 kilos].

And that wasn't good for me, I was looking pretty bad, pretty terrible, very pale, very, very weak and I didn't know that I was that sick and should've been telling someone that I couldn't eat at all. I'd been to the doctor and they said, 'yes you're sick, here's your antibiotics'.²⁷ Try and keep your fluids up. If you can't eat you can't eat but...

When I went and had my specialist appointment and went and saw the nutritionist and she says, "Oh you're a little bit down on where we would like you to be, what's been happening?" So I told her and she said, "well actually – you should've gone into hospital". That wasn't helpful for me.

Clare - There's a real risk of malnutrition.

Suzanne - Exactly, exactly! So little things like that don't seem major but when they happen they end up being quite serious and now it's kinda like, if I'm not eating for more than a week I talk to someone about it.

²⁷ Suzanne has no immune system so has to take extraordinary care with her health.

My keyboard strokes become more strident recording these harrowing accounts of surgery. The temptation to theorise is strong but and I resist folding the narratives into a Foucauldian drama between the body and the medical system, the (god-like) surgeon's hands, the (victim-like) subject's innards and technology invading the 'body as machine'. To do so would 'pull the rug from under' and turn the stories into something other than those told to me. I think about Georgina's words regarding her surgeon:

Georgina - You know, the thing is, I love my surgeon. I love that man. When we're together we just laugh and laugh, he cracks me up.

And Marama's about her GP:

Marama - She was amazing. She saved my life.

Accounts of surgery are, in places, charged with drama; pain, discomfort, fear and things that could have been done better. There is also a precarity that comes with age and decades of living with health issues prior to undertaking surgery. The narratives however, are not framed as a complaint against the system or the people within it. As Yates-Doerr (2012: 139) suggests, "care happens in the spaces of personal relationships, in linkages between formerly separated bodies and selves, in the intimacies that form between one and an other". Surgery narratives are complex stories of people helping people within a system that offers up a choice riddled with compromise but nevertheless a choice that *will* help to shed weight and *may* help to extend life.

Concluding Thoughts

I have a small, niggling voice in my head saying that surgery is like a modern day (somewhat diabolical even) *rite de passage*, complete with knives and an initiation ceremony. I think about the force of personal pro-nouns; *her* surgery, *my* surgery, 'my brother is thinking about having *his* surgery', and the way in which they signify a

crossroads – a personal life changing event. Potential candidates are separated from the ordinary – the taken-for-grantedness of eating and transitioned into surgery (across the threshold). The social and physical entangle in a mire of innards – surgery re-orientating the self like a compass that changes its North. Recipients are then discharged – released back into society to re-integrate. Social re-integration however is fraught, liminal and on-going – not a full stop, not an ‘after’ following a ‘before’ as media representations suggest. Eating with radically altered viscera is an enforced liminality – a different way of *being* in the world.

Chapter Six: Kai & a Radically Altered Gut

Kai: Getting Stuck and Getting Through

Eating emerges as a fleshy and complex entanglement between bodies and the world. Minerals and vitamins which come via plant, animal, soil, sea, rain, and sunlight, are shaped by social, cultural, and political currents into what we eat (Abbots and Larvis, 2013). Food then moves from this worldly context into the digestive tract (and its accessory organs) – generally a permeable and accommodating meeting place. After surgery, food no longer fits so seamlessly but struggles to get through tiny openings and be digested in cramped spaces by digestive tracts with a stripped back ability to digest. I talked to Billie about eating chicken:

Billie had talked about being iron deficient (potentially permanently) post-surgery.

Billie – Yeah, so my body isn't absorbing iron like it used to. So I am eating meat and I'm making sure that I am getting enough iron-filled foods in my body but my body is not absorbing it because of the surgery...

Clare - So can you eat meat?

Billie - Oh yeah – most definitely. Just not dry meat.

Clare - How would you eat meat – would it be in a stew?

Billie - Stews are really good, just because it has the gravy so it is a lot easier to swallow. Like I said with chicken, I can't eat chicken like I used to.

Clare - So what happens when you eat chicken – does it get sort of stuck?

Billie - Because it's so dry, it works its way down slowly and because it's working its way down slowly, my mouth is salivating and I'm swallowing and that just builds up and then I feel yucky. Like a gastric reflux or just sort of a nausea. It feels like something is stuck.

Different foods get stuck for different people and I imagine the slightly tentative moment when a food is held before it enters the mouth – eating no longer taken-for-granted. Encounters between commensality (eating together) and materiality (food and food practise) (Abbots and Larvis, 2013) once enmeshed in

conviviality, are now disturbed by the impacts of surgery; sometimes unpleasantly so. While Billie spoke of some issues with food after her gastric sleeve, Georgina's duodenal switch seemed to come with harsher side effects. Georgina moves our conversation from immediately after surgery into the present (four years later):

Clare - How long did it take you to get eating again, was it a long time?

Georgina - It was a long time. I probably um, you know, you've gotta have soupy stuff for about six weeks because your stomach is still healing. You know you've gotta have bland stuff and you can't go on to solids and even now I have difficulty, you've gotta really chew your food and the worst part with me is that when I'm really hungry, I go really fast and I end up being a little bit bulimic.

Clare - Throwing up?

Georgina - I throw it up. And the other thing is, if it's too large it has difficulty getting in through the hole you know, that's why you've gotta chew your food really well.

Getting enough nutrients into the body becomes a daily focus and oftentimes – a struggle. Suzanne and the other participants all talked about the need to take supplements for the rest of their lives.

Clare - Do you take supplements and stuff?

Suzanne - Supplements, that's one of the downsides.

I'm going to be on supplements for the rest of my life because of the small amounts that I eat. The body isn't getting enough nutrients and minerals, vitamins and that sort of stuff so I'm on a supplement that's going to provide me with those for the rest of my life.

Clare - What about protein – you mentioned that?

Suzanne - You're supposed to eat the protein first, vegies later and anything you can fit in after that.

Thinking about nutrients means looking at food in a new way as Georgina explained:

Georgina - I really wasn't interested in food but what was really interesting for me was for the first time in my life I understood the relationship between food and my body. You know what I mean by that, I realised that, oh god, I realised that I have to have protein because if I don't have protein it's not going to build this that and the other. If I don't have my vitamins, you know if I don't have this and that it made me realise the relationship with minerals, vitamins, protein, carbohydrates and all that sort of stuff. Because before, I just used to just go, food you know? I didn't care what it was made up of. It was just something that filled my gut really. So that's probably what's been the change for me. You know I'm very aware of what I need. Like I know at the moment, I just have to have calcium and tons of protein.

Food as a 'whole' becomes dissembled to 'food in its component parts' – eyed for its nutrients, especially protein, and its texture – the ability to slip and slide through. Food dissembled as component nutrient parts becomes akin to bodies abstracted through measures and weights - a sort of 'reductionism' (Yates-Doerr, 2012: 64) that strips away context and the complexity of 'being'. Compromised digestive tracts can also lead to underfed bodies. Georgina and I remember the day her hair began to fall out:

Clare - I think as an observer you start to get quite worried when someone is shrinking that fast, and I remember the hair coming out and to me that was the worst moment in your journey, from my perspective, for all of us – that malnutrition thing was like – holy crap!

Georgina - It was terrible

Clare - It was terrible

Georgina - Because I didn't know what was happening and they're going – 'well you're not having enough protein' and I'm going – 'I can't put anymore in!'

Clare - ... you always had that beautiful shock of white hair.

Georgina - Yeah, and it just started coming out and I remember I made that decision to go and get it shaved off by Bazza [a hairdresser].

Georgina lives a life steeped in tikanga and subsequently the hair on and from her head is tapu. For many years she has entrusted Bazza as her hairdresser. Thankfully, he refused to shave her hair off and gave her a trim haircut instead.

Malnourished, Georgina could not get enough protein into her shrinking body - a fundamental nutrient now desperately difficult to ingest and digest. Bodies changed on the inside become like trees with unstable roots; struggling to stand firm, leaves fading and falling as nutrients are no longer drawn effortlessly from the world. This struggle also means giving up on some foods - foods that were once integral to *being*, foods that will be missed.

Kai: The Things I Miss

Kai as 'more than food', viscerally connects the heart and mind to myriad things - land, people, memories, love, family, childhood and in particular - home. Decades ago I wrote to my father in Aotearoa New Zealand from his country of birth, the Faroe Islands, and told him I'd had halibut for tea. He wrote back, "I was very jealous when I read you had eaten the halibut. I haven't eaten halibut for over fifty years". I cried for my dear old Dad - an accidental immigrant cast adrift by WWII, never making it back home. My dinner-talk took him back and I felt his longing for those sea-swept islands and the deeply missed people of his distant past. These embodied attachments between food, place, and people are disturbed post-surgery - some displaced for good. Suzanne and I talked about the things she missed:

Clare - Do you miss your old relationship with food or are you settled into a new one?

Suzanne - No, I still miss some things and I don't know if it's a mental thing or if it's just my body rejecting it, but sometimes I'll miss something and I just want to eat it, so I'll eat it anyway knowing what the consequences will be - that I'll probably be sick and that it'll probably come back up... I love rice. I could eat rice all day, any kind of rice; boiled rice...

Sometimes I just boil rice and throw in some corn and peas and just eat it like that. I just love rice, sushi - all that sort of thing, me and rice now... [Tapers off]

Clare - You would think it was so innocuous.

Suzanne - Yeah, it's quite heavy and it just sits, and if it sits too long it just comes back up. But every now and then, I just miss it so much, you know what, I'm gonna have it, so I have just a couple of mouthfuls...

Clare - What are your thoughts around that – around the change?

Suzanne - I think the biggest thing that I found was one day – and it was a little while after I'd been through the process and I was sitting there talking to the nutritionist. I suddenly realised that I never, ever, ever, ever, was going to eat a steak again like we do. You know cause we're in New Zealand, we're New Zealanders. A barbequed steak is part of our lives. You know, any true New Zealander, steak is what we eat. It's what we eat. It's like a nice big thick steak on the barbie with a bit of sauce or whatever, salads and stuff and if I can have two slivers of that steak now I'm lucky.

Clare - What happens if you eat steak now, does it get stuck or doesn't it digest?

Suzanne - At the moment for me – as I say everybody's really different – big food like that I have to really, really, really, really, chew... [Conversation tapers off]... one day I realised that I'm never ever gonna be able to have that [big piece of steak]... and it was quite sad in its own little way. It is interesting, as I never thought that the relationship with food was even relevant, you eat what you eat, and you don't eat what you can't eat.

I never once imagined that I would miss having a steak or a hot slice of bread.

Food choice, post-surgery, is like a different type of picking from the supermarket shelves – I can't have that, I shouldn't have this, I need to eat this – or else. Steak, for Suzanne, has become a 'can't have' – slipped away, perhaps for good. Food that once connected her to *her* is now sequestered as a part of her past and feeling slightly dislodged – she now needs to (re)imagine a future without it. She feels a sense of loss. Food emerges as not outside of us but as a part of us – its nutrients absorbed into our bodies, its meanings shaping our identity and its taste, texture and

smell sensuously replenishing consciousness and re-producing identity.²⁸ Perhaps the giving up of certain foods is much easier said than done. Reconfiguring life post-surgery also extends into social spaces as strategies are needed to cope with eating amongst others – particularly at eating-places away from the home.

Social Strategies in Eating Places

Georgina and I talked about social life post-surgery:

Clare - So having had surgery, you have a very limited capacity to eat and you are back in the social world. How do you navigate that world?

Georgina - I'm still navigating it [four years after surgery].

I still don't understand what foods are good for me, or what will affect me. I suppose it's a bit like when you have Delhi belly and you have curry. I've gotta be very, very, aware of what my stomach is going to do. Some days, it's like aw god, am I going to have diarrhoea or not? You don't know what food's going to do to you and things like that...

Clare - What's it like in the Māori world or are the issues the same?

Georgina - Same everywhere I go.

Clare - Do people understand?

Georgina - You see when people look at me, especially when I go to a new Marae or whatever, they don't see what I was before because they don't know, so I'll rock up there with my plate and I'll usually put a little dollop of everything on my plate because the other thing that they see is an old lady, you know? A lot of old people don't eat a lot. Usually I go up and I can put a little bit of something on my plate just to be a good guest really, and that's enough, and I'll always just go in and have a little bit of something to eat. One of the things I'm not supposed to do is drink and eat at the same time but I do, not a lot. So um, if I have a cup of tea I'll have a little biscuit or something like that. But I won't have a lot because I know if I'm not near a loo and I don't know

²⁸ Abbot and Lavis (2011:83) discuss the way in which eating, "informs the way in which bodies, relatedness and places are socially (re)produced".

where it is ... I don't want to embarrass myself. So you know, I just have a little bit of something just to say thank you for the effort and time you had put in to prepare this food. But I don't go crazy.

I think about how a well person can sort of throw themselves at the world; walking, talking, eating, laughing – moving ahead – all at once and with stuff to do. Georgina's movements are more tentative, she scopes her environment for the closest toilet, she strategically assembles her plate and she takes steps not to offend. With disturbed innards, she is compelled to keep one 'eye' on the stomach and the other on the social – resulting in a different kind of *being* there.

Marama explained what it was like having to be a different kind of host at her family bach down the coast on her husband's tribal land.

Clare - It must be quite hard when you're all together as a family and one person changes.

Marama - Well it is because when we get together, like this Christmas down the coast, there is all this food around and I purposely – well it is at our bach anyway, everybody comes to our place – I'm setting up the food, 'come on, start' and I purposely make myself super busy. I purposely go 'Clare sit down, here, have a drink' and they go 'Marama come and have something' and I'll have a little nibble and then I see something else and I keep going now, whereas before I would just sit [gestures eating]. I say 'yep, yep the sauce is forgotten' and I get up and start moving and they go 'have you eaten Marama' and I go 'yes'.

Clare - So they don't notice so much

Marama - Not so much, because I am up making sure that they have got everything and I've had a little bit. Or they go 'is that all you're having?' and I say, 'nah, I've been picking'. You have to have something because they'll try and make you eat and drink as much as they are and I just...I really can't...

Clare - And I guess it makes them feel comfortable thinking that you are just busy rather than not eating. So it kind of keeps the social thing going...

Marama - That's right. It keeps them comfortable. And I feel good because I don't have to pretend that I am eating.

Clare - And you're still doing your manaakitanga, you're still the hostess.

Marama - Yes! Mixing in, yes they don't notice.

Suzanne and I talked about the pitfalls of dining out.

Clare - I've been thinking about how hard the adjustment must be after surgery.

Suzanne - Yeah when I think about it, when I came out of the haze and was well enough to start socialising it's kinda like I double think before I say yes because, 'what am I gonna eat?' You know I can't eat anything and I can't just sit there and eat nothing because that just looks stupid. So my poor husband – we've stopped doing it now – but he would order his meal and I would order my meal and I'd order a small one and I would kind of pretend that I was eating it and nibble away and have a little bit and then I would just shuffle it to him. So he would have two meals and then he started not fitting his jeans and it's like, ok, we're not doing that anymore, (we both laugh) we'll have one meal between us and I'll just nibble off your plate, how about that.

Suzanne has found a way to front up to dinner, nibble at her husband's plate, and be with family and friends. Marama keeps moving, serving, and hosting to distract attention from her lack of eating. This smoothing over of 'the social' works for them. They are there but differently there. Food no longer flowing inward as conviviality flows outward – the social footing left less secure – like a boat without an anchor caught in a changing sea.

Concluding Thoughts

Settling into a stable and taken-for-granted place with food has slipped beyond the grasp – seemingly unfairly so. Eating prior to surgery was often problematic; both pleasurable and morally fraught – food like forbidden fruit; tempting, sinfully over satiating and within far too easy reach. Eating post-surgery is also problematic. Food is

still desired and desperately needed but imposter-like in its journey through the body. After surgery, life stumbles ahead somewhat precariously on a new trajectory with shaky co-ordinates. Barnett (2017:25,26), in discussing the work of Judith Butler notes that, “[p]recariousness entails a certain fragility, not as a kind of weakness or failure but, rather, as a constitutive component of what it means to be a living body exposed to the world in which one finds oneself”. Bodies, once exposed to the world in one way, are now exposed in another and this is what needs to be contended with. Leder (1990) argues that an outwardly deployed person engaged in the world is dependent upon a ‘taken-for-granted’ interiority. The re-mapped interior of a surgery recipient cannot be ‘taken-for-granted’ and nor can eating. Moving about the place is like a double act – I’m here and so is my digestive tract which sits somewhere in my peripheral view. This altered tract also disrupts the space between people who eat together – like an unsettling background noise – saying you’ve had enough, no more, the food is stuck, and at times – more dramatically – find a toilet! Others are also impacted by weight-loss surgery. I think back to the day Georgina’s hair began to fall out and our concern for our colleague who was clearly upset. We had seen her rapidly lose weight, we knew she was struggling to keep her food down and now her hair lay on the staffroom floor. The impacts of bariatric surgery ripple out, move beyond the body and begin to affect others.

Chapter Seven: A Smaller Body Now

Ripple Out: Friends, Whānau and the New 'Me'

As we move about the place as (seemingly) bodily individuated selves, something is happening in the space between people, something perhaps felt but not necessarily known. An uncovering of this dynamic occurs, however, when surgery talk concerns relationships and the way in which change ripples out and unsettles others. 'Being' becomes about 'being with' and thinking about selves becomes thinking about how selves are constituted in relation to an Other (Crapanzano, 2014). As the small-once-big move amongst the familiar as unfamiliar, others potentially become rattled and in some cases 'put out' or even affronted by change. My interview turns to questions about friends and whānau and I asked Georgina whether she thought her weight loss had affected other people:

Georgina - Yeah, tonnes. It was really interesting because I didn't realise how badly it would affect so many people... [Friend] was so jealous and I couldn't understand why, couldn't understand it... Everybody was happy that I was having this surgery done because it would improve my health. But it made me realise that people are so into that, you know, vain shit eh.

Clare - The look thing?

Georgina - Mm the look of things...

Clare - ...the weight loss unsettles in some way

I too was unsettled by her weight loss. In a reflexive exercise for a writing class, I unintentionally ended up in confessional, releasing thoughts and feelings that crept up from below – somewhat embarrassingly so. I wrote about my own weight loss (abridged):

...I realised that my own weight loss had in part been motivated by my pending trip but also in part by my need to remain thinner than my friend. She had always been the big one. These thoughts were submerged beneath a veneer of good

intentions and I was disturbed by my ulterior motive when I faced up to the facts...

...While I like to think that hierarchies of power do not belong in friendships, perhaps relationships are embedded (almost subconsciously) in structures of status. My personal revelation has opened my eyes to a potential dynamic (murky undercurrent) between individuals (friends/family) in which change in one 'ripples out' and requires the 'other' to reposition and regain status (27/9/2017).

The fieldwork lens inverted and pointed at me – I was also into that 'vain shit'. Feeling vulnerable, thinking about intersubjectivity became about tapping into emotions or “emotional recall” (Ellis, 1999) and a sort of “feeling the world” (de Quincey, 2005). My own feelings and subsequent actions uncovered a (competitive) desire to maintain a position within a relationship.²⁹ Selves can be re-imagined as porous and molecular; co-constituted and shaped by the flows that move between bodies. When threatened, these flows may give rise to less desirable emotions. Georgina talked about how she felt she was treated by others:

Georgina - I'll have to say that the thing I didn't realise was the impact it was having on other people because I was so concentrating on what was happening to me, I didn't realise the impact it was having on other people. And then suddenly it was almost like I got kicked out of the fat club for some unknown reason – and I didn't know I was in it. I'll tell you what the feeling was – exactly the same thing as I felt the day I left the [services]. Suddenly I wasn't a [...] anymore and I wasn't wearing a uniform and they were all going yep, yep, seeya, you know.

Clare - And it's like there's this patch in-between, a whole bit in the middle, where your weight is going down and down and down and everybody's adjusting.

²⁹ Groven, Raheim and Engelsrud (2013:24) note the “value of letting one's own bodily experiences “count” in the process of determining how to explore the phenomena in question”. Turning my attentions to my own feelings and actions led me to understanding how one person can almost unwittingly be shaped by an-other.

Georgina - They're adjusting with me.

Clare - They're adjusting in their own way and it's not always positive?

Georgina - It's not always positive... it's a thing around envy...

Clare - What's going on with all of us?

Georgina - All I can tell you is what happened with [my friend].

From the deep pool of human encounter, the snake of envy rears its ugly head. Others' emotions entangle with judgement and surgery recipients can find themselves both under surveillance and occupying a difficult moral space. Having been judged as 'obese', they also potentially carry the stigma associated with needing to use (tax payer funded) surgery in order to lose weight. Post-surgery, others scrutinise their behaviour.

Marama talked about being watched:

Clare - How do you think your weight loss has affected the people around you?

Marama - Attitude wise, there has been a bit of jealousy... That's their hang-up, that's what I have to think about. They also watch what I eat and they comment.

Clare - In what sort of way do they comment?

Marama - Are you allowed to eat that? Is that any good for you? Oh she's eating that.

Clare - Oh, so you have food monitors around you?

Marama also talked about the shifting dynamics of the workplace and dealing with people who still had weight problems:

Marama - ... so I've got to be really careful not to make them feel the way they do. But I'm not going to take on their crap either. That's not my problem.

Clare - You don't have to apologise for yourself.

Marama - No! I've made this decision and this is what I have chosen to do - how you take that is your problem.

The space between 'I and them' is unsettled by dramatic weight loss. The liminality of post-surgery life manifests, in part, as a sort of slippery living with an unsure footing and unpredictable reactions from others. Layers of currents flow through the women's daily lives. An uplifting wave of compliment and encouragement for losing so much weight, a quiet murmuring about concern for their health, a ripple of derision for needing to resort to surgery in the first place, and a murky undertow of feelings re-shaping the shifting sands of co-subjectivity. Weight loss surgery becomes a shared experience and 'being with', a complex reciprocal re-ordering of 'I' in relation to the 'other'. Surgery recipients may also become objects of unwanted attention and may be treated differently; specifically, sometimes, as more competent – as *cleverer* now.

Sexier Bodies & Bigger Brains

Marama loves clothes and she really loves to shop. She always has. She is particularly pleased that she can now wear dresses – options before, she says, were basically tents. Big or small, she carries herself with finishing school deportment, style, and a touch of glamour – dignity firmly intact. Dignity, I come to realise however, does not come from style, shape, size, clothing or fancy shoes but from within and beyond, from Te Ao Māori, and flows through a person as mana. Marama has mana – some would say formidably so. Her past is in her present and she fronts up to the world accordingly – with a host of ancestors by her side. She also strongly identifies as the partner of her husband, a relationship that goes back across decades and which connects her to his people and their land. This identity – deeply woven within the collective – clashes with the shallow and the superficial post weight-loss; Marama talks about being affronted by such encounters:

Marama - ... people's attitudes have been very interesting, very interesting; being *looked* at again. Just every now and again when people make a fuss of me, I feel quite offended sometimes.

Clare – Oh you feel offended? In what way, why does that offend you?

Marama - I'm a married woman. I take my vows seriously. These aren't nice comments. Like one person said to me, 'wow you're looking hot' and I said thank you. And he said, 'if I wasn't married I'd *have* you'.

Clare - You're kidding me. He didn't know who he was talking to, did he?

Marama - And I said to him 'if you were the last man on earth, I'd turn lesbian'! I was so angry. That's what I find offensive. I don't mind if someone says 'gee Marama you're looking good today'. I say 'thank you'. I don't mind that, but when they talk to me like that, that's rude, I get really angry...I'm the same person, I never changed my inside. Why are you looking at me like that now? Just because I was fat, now you think ooh. It really angers me...I don't care if you're joking or not; don't talk to me like that, I *don't* find it flattering.

Billie also felt the unwanted attention of others. She remembers being looked at as big and now has to contend at times, with being leered at as small. When I asked her if she felt any difference in the way she was treated she replied:

Billie - Most definitely!

Clare - What comes to mind when I say that?

Billie - [*thinking back to when she was big*] When it comes to people who didn't know me, when I was out and about with friends and family, sometimes I would catch people giving me weird looks. And I've seen it with one of my big friends - we went out to dinner a couple of months ago and this old couple just stared at her with this disgusted look on their faces and I felt really bad for her because it was like, 'you have no right to judge her'. It was definitely her weight that they were judging - yeah, you can just tell.

Clare - So when you go out now, does it feel markedly different?

Billie - Now it is a lot different because I do know that people *stare* at me but in a different way, like people used to stare at me... and now people stare at me more intensely.

Clare - This is people that know you?

Billie - People that *don't* know me - 'ok, eye problem - much'. What are you looking at - is there something on my face?

The 'eye problem' in others is experienced uncomfortably and self-consciously – like thinking you have something stuck to the side of your face. The male gaze slides over Billie's (objectified) body causing her to squirm. The radical change in body shape has also given her a sort of three-way lens on the world. In retrospect, from the other side of weight loss, she now realises how she was regarded by others (particularly strangers) when she was big. This perspective reveals a contrast and leads to disconcerting comparisons with how she is treated now. She can also recognise the treatment her (large) friend is getting via the stares of others. This seeing is connected to feeling and these feelings unsettle and disturb. Like Billie and Marama, Georgina also spoke of the unsettling experience of being treated differently, being treated like a different person:

Georgina - And I think the thing that kind of annoys me in a funny sort of way, is well – I was asked out and I said to this person, 'why are asking me now, why didn't you ask me a few years ago eh?' You know, the person hasn't changed, the mouth is still there – nothing's changed. [They said] *you look..*, and I said, 'you look like what?' Don't say a million dollars because I haven't got it and neither have you. But it says to me one thing – that you are only interested in the look of a person not the person themselves, so I find that stuff really interesting.

Georgina and I went on to talk about perception, mana, and size. I asked her if size had anything to do with mana:

Georgina - No, size has got nothing to do with mana... mana is a big word you know...You know I remember one of the people I met. His name was Tipene Ngata. His father was Apirana Ngata and Tipene was the youngest son. I never forget meeting that man and he was a really, really, tiny man, but you could see the mana of the man. He didn't have to do or say anything and he was happy to be the ditch digger down the road, but he didn't have to do or say anything because when he moved his mana moved – now that's mana...

You know me ... you know what I was like before – has that changed?

Clare - No

Georgina - Case in point, I suppose that's my mana, nothing's changed. The only thing that's changed is what people see. If you were blind and I lost weight – would you notice any difference?

Clare - No

Georgina - And that's what I am saying about perceptions of things eh...
And so when you ask me how I see myself – well I don't ... I suppose it is because the biggest sense that I've had, that I have relied all my life is my sense of people. Not what they look like ... I actually feel that before I see it.

Seeing moves through the surface towards the essence of a person and senses and feelings are stirred. This way of knowing people however, does not necessarily happen in reverse. Large Māori women live with the multiple burdens of racialised, gendered, and (fat) stigmatised subjectivity (Pausé, 2017). As noted, these burdens mean having to negotiate through life with what Erving Goffman called a “spoiled identity” (1990 [1963]). This becomes more apparent when a dramatic downward shift in body size shifts the behaviours of others. Marama talked about losing weight, having blonde hair now and feeling like she had ‘grown a brain’:

Marama - I always blame it on the blonde hair now. I'm looked at differently, I get treated differently [*Marama dyed her hair blonde during her weight loss period*].

Clare - In what way

Marama - Like I've got brains now and that angers me.

Clare - Are you talking about in the workplace?

Marama - Yes, in the workplace – especially by clients. Not colleagues because they know me, but clients.

Clare - Why did you say ‘the blonde hair’?

Marama - Because you know – the (pause) whole package I think. I look different with blonde hair, slimmer package, so I must be cleverer. You know, when you're fat, a big girl – even though I felt like I took care of my grooming

and everything – it was like ‘well you must be lazy or you must be thick because you’re *fat*. If you weren’t so dumb you wouldn’t be so fat’.

Clare - So what about being Māori, does that come into the equation at all – about whether you are dumb about the way you are treated?

Marama - Nah – I’m from here and they know me.

Clare - Yeah, so you’re a local. I remember you telling me years ago, about what was happening with [*her Māori husband*] – where he worked and people would walk up to him and ask to see the manager.

Marama - Yep, even that happened to me when we first came – me and [*a Pākehā colleague*]. We were the only two in the office. They would go straight up to her and go blah blah.

Clare - Why were they doing that? Were they doing that because you were big or because you are Māori or because you are a big Māori?

Marama - I think both.

Clare - You said that thing about the blonde hair and being slimmer and it seems like – suddenly you’re more intelligent?

Marama - Yes! Once I said to somebody – and they should’ve known by the flashing of my eyes or the slitting of my eyes that they were on dangerous ground – I said, ‘you’ve known me for so long now, what’s changed other than my body shape and the colour of hair?’ And they got a fright, and I said ‘I am still the same person inside; same brain, same everything. Why are you treating me like this now, I haven’t changed’.

Clare - What was happening with the way they were treating you?

Marama - Like they respected what I was saying more. ‘Oh, you know what you are talking about...’ – that sort of thing, like I had grown a brain overnight...

And I got annoyed.

Georgina also spoke about being treated as if she were now more intelligent:

Georgina - And another thing I’ve noticed is that they seem to think that you’re more intelligent.

Clare - How’s that?

Georgina - They ask you probably more, they want to have a bit more of a conversation with you and they go, 'oh you really are an interesting and intelligent person' and I says, 'what do you mean, I was always an interesting and intelligent person. What's changed?' 'Oh well, no you wouldn't have spent five minutes with me before because of what I looked like and things like that eh?' But now you're finding me interesting, eh'

Acceptance and respect, (particularly from strangers) are experienced in bigger doses in a smaller body; a small-bodied valorisation as opposed to big-bodied invisibility. These experiences could be framed in the positive – as further accounts of success following successful weight loss – but rather, are couched in a frustration that comes from reflecting on the way in which the very 'same person' was treated before. Thinking about the experiences of weight loss surgery recipients evokes an image of walking through a hall of mirrors with multiple points of view. Despite being in a smaller body, they see themselves as the 'same person' while others see them differently. These others have perspectives that are refracted through societal prejudices which fog the lens and shape judgement. As Māori women, their own 'seeing' may be cast towards, and drawn to, different points in an-other; below the bodily surface, beyond the shape and towards the essence of a person – the mana. From the position of having experienced radical change these multiple reflections, refractions, and perspectives come to light. These perspectives in turn may tell larger stories about society while also revealing the complexities of the life of an individual (Biehl and Locke, 2010) post bariatric surgery. These lives are complex – living can be a mix of feeling fit and well, entangled with sick days and at times weaker bodies. These trajectories for living can also take unexpected turns towards the new – including the stretching out of horizons and the extension of *life* itself. In conclusion, I turn to the women in the study and some of our conversations about wellbeing beyond surgery, including future being and reimagined potentialities.

Wellness, Weakness, & Being Alive

Suzanne

Suzanne, at the time of the interview, had dropped from 144 kilos to 65 – a loss of 79 kilo's. I asked her about the benefits of surgery and how she felt now:

Suzanne - I think the overall benefits for me are great. My life expectancy – I've added apparently, I don't know – another fifty years to my life, and I'm not gonna complain about that at all. And I feel better for it.

Clare - Do you feel better – because that well-being thing is interesting to me? Compared to the person before and the person now – do you feel better?

Suzanne - Oh good question...um (pause). I'm not sure – yeah, I haven't really thought of it in those terms. Like in some ways, I think, I am better – I do feel way better. My energy levels are actually good. I'm still trying to develop my strength back. Like, I've lost a lot of muscle tone throughout the process and I'm not used to being a weak person physically. So part of my size before was my strength as well – you know I could do a lot of manual stuff.

Clare - On the farm

Suzanne - On the farm, anything – on the farm – shifting, lifting furniture – when I decide I don't like the look of my house – things like that. I can't do a lot of that anymore – I can't lift things, and a part of that is just lack of muscle so getting that muscle development back and that strength [is important]. Unfortunately part of that is linked to exercise and the protein diet – because I can't eat large amounts of protein – protein is a big issue... If I wanted to get something done, I would move heaven and earth to make sure it would get done... But there's a lot of stuff I can't do physically now, so no amount of my stubbornness is going to change the fact that I am just not going to be able to lift that damn rock ... My inner strength and my sense of self is still there – but my physical strength is gone and I am learning mentally and psychologically to cope with the fact that there are just going to be things that I physically cannot do and I have to accept that ... I'll slowly get stronger.

Clare - You just have to keep that protein going in

Suzanne - I just have to keep up the protein and get the muscles happening ... I'm happy that I'm not big, I'm coming to grips with the whole food thing even though part of it is me having to adjust and sort out how I think about it. I'm really, really happy about the benefits to my health but am I comfortable with it? – I don't think I am yet. Not quite there yet.

Billie

At the time of our interview Billie weighed 79 kilos, down from 146 – a loss of 67 kilos. I asked her about her the overall quality of life now:

Billie - I definitely feel healthier. I can do a lot more things. Like, I go out and do things more. Whereas I used to be like, I'll stay at home, I didn't have the energy.

I also asked her if she would fully support someone having weight loss surgery:

Billie - For me – because of how well it's gone – it would be 100%... I would be completely honest with them about what I have struggled with ... But they are small prices to pay for how much difference it's made to my life and to health. I wouldn't try to paint it as all rosy. I'd just be like – this is me, this is how I've done...

Clare - Is there anything else that sort of stands out in your journey that you want to mention?

Billie - I'm going to say that even though when I was big I was quite a confident person, my confidence now has probably tripled. I mean I've got a new job and I'm working in Auckland now. I would probably be still at the [service station] - working there if I was still big just because it was my norm – easy – everything I knew – whereas now I step out more and I do different things rather than sticking to my normal routines, I like to experience new things now.

Clare - Has losing weight opened up any ideas around what you'd like to do in the future?

Billie - Yeah, it has, because I've always liked cars and so what I want to do with my brother is actually do a mechanics course and I don't think I would've decided to go through with it if I was still that big girl. Only because, with mechanics, just being a girl is hard enough. You've got the disadvantage of being a girl, they don't think you know as much as you do, but being a *big* girl is even harder, it's harder to maneuverer under the car, get your hand in the tiny spaces and stuff. Me and my brother, we have always worked on cars together. We do oil changes and do our services on our cars and stuff together. Now we still work on them together but [...] gets me to do the little niggly bits cause my arm's smaller... (*Billie's brother struggles with his weight and is being encouraged to enter the WLS program*). We would both like to be qualified mechanics. That's our five year plan – open our own garage...

I'm comfortable to do something out of the ordinary, whereas back then I would just stick to what I am used to. Now I don't mind – if I have to go somewhere by myself – I'll do it. So definitely there is a lot more confidence [even though] back then I thought I had all the confidence in the world.

Marama

When I met with Marama, she weighed 86 kilos. She had been 133 – a loss of 47 kilos. We talked about the difficulty of maintaining a certain weight:

Marama - I always seem to use something like Christmas as an excuse for why I've put on weight. I've got to stop doing that to myself. I really have to... I've got to get that out of my head.

Clare - And do you have a voice in your head going 'don't get big again'?

Marama - Yep or 'why did you go through all of this just to put on weight again?' 'Why are you doing this?'

Clare - So it's not like it's sort of settled, it's ongoing

Marama - Yes, I think for all women they have some sort of thing going on like that but for me it's, 'why would you go through all of this pain [pause] to put on weight again' and that's what I've got to get through to myself. When I'm

feeling like this, I think, oh yeah [gestures eating] because eating is comfort. Got to stop and go for a walk instead of eating.

We also talked about life in a smaller body and what had changed:

Marama - Shopping, you know I'm a shopaholic! [Both laugh]. Before I knew exactly which shops catered for me and I knew which sections in the shop to go to ... when I first went shopping [as a smaller person] I had no idea.

Sometime after the initial interview, I asked Marama what she had meant when she had said that 'she still felt fat on the inside'. She replied:

Marama - At the time of our meeting and even sometimes now (not so much now though), I couldn't see myself as my family and friends saw me. I could only see the old Marama - the "big girl". It has taken me this long to see myself as others see me. For a time, I didn't know where to shop for clothing as I would go to the "big section" of the store and pick up tops that were too big for me. I truly believed that I was still my old size. It felt like I had lost myself!

I asked her if she would recommend the surgery to close family:

Marama - Yes, from my experience, I would say 'go for it' if you are doing it for the right reasons. If you're doing it because, 'I need to lose weight because I want to look good' - don't, because you are not going to succeed. If you are doing it for health reasons, you've got to have the right reasons and the right attitude up here.

Clare - So you have to have the health problems to justify it?

Marama - No, not justify it, I don't think that's the word. If you're doing it for superficial reasons, nah I wouldn't do it. There are other ways. You've got to have tried the other ways too ... I don't think they just take you on because you want to.

I think back to Marama's decision to have surgery and her words in an earlier chapter:

We [Māori] have got to change or we are going to die early, and I'm sorry, I am not.

Georgina

Georgina had weighed 154 kilos at her heaviest. When I interviewed her she weighed 62 – a loss of 92 kilo's. I asked her about whether she felt stronger now:

Georgina - Physically I'm weaker, yeah it's taken me a while, it's quite funny, but then I don't know whether that's old age as well. Physically I was a very strong person, a very strong person, you know I used to be able to throw the wool presses around in the barn ... now, I have to take a running leap at it and I can only move it an inch.

So physically I am not as strong.

We talked light-heartedly about the fun side of life in a smaller body:

Georgina - I really enjoy shopping for clothes.

Clare - Oh yes, you're a great shopper.

Georgina - I love shopping because I find clothes that I like and I think, oh I like that, not because I give a shit what it looks like. It's just that I like it and can fit it. What's changed is the type of clothes. I can wear dresses now. I couldn't wear dresses before because there wasn't one big enough for me to wear.

We laughed out loud about her bony discoveries; butt bones, a rib cage, smaller feet and the perils of shrinking gums:

Georgina - I've got false teeth, your gums shrink. It's quite embarrassing – especially when you do a cough.

Clare - Oh you have to hold them in!

Georgina - It's really bad when I want to throw up; I have to take them out. What else did I notice, oh yeah my feet shrunk ...that is probably the one thing that I have found really neat because I promised myself that when I lose weight and I lose weight enough to be able to wear boots ... I think I got down to 100 kilos and my kids took me shopping and I got boots and I had never ever worn boots in my life because I couldn't. My calves were too big and that's when I realised that oh, I've lost a bit of weight.

Clare - You can walk places now?

Georgina - Yeah I can walk, I can bike, go to the gym.

We also talked about a recent plane trip to a Pacific Island with her niece:

Georgina - Her and I were chatting and we lifted up the arms of our chairs and her and I just cuddled on to the thing and we had our knees up, facing each other in our chairs, chatting away and I was thinking to myself, I could never had done this before.

I think back to an earlier discussion around why she decided to have surgery and what being healthy meant to her. She replied:

Living, I'm alive.

Conclusion

Reflection on Research Beginnings, Method & Shape

I began this research with a curiosity piqued by unsettling and astonishing encounters with Māori women who had had weight loss surgery. I'd seen the rapid weight loss, witnessed the quick dashes to the bathroom, and marvelled at the (quick) change in a body from big to slim and 'normal'. The big shapes that had once moved slowly about the office in which I worked were now hard to recognise – small and light-footed – flitting from here to there. I also wondered about food. I knew that, for Māori, so much of life circled around kai and so, eventually, I asked four Māori women to participate in this research. A large part of their motivation was the desire to assist, in any way they could, others who were contemplating similar weight loss surgery. I give my heartfelt thanks for that. Before expanding on the broader significances of the women's experiences and narratives, I step back for a moment and reflect on my research pathway and the way in which the narrative shifted and moved from the present into the past.

I had planned to begin with weight loss surgery and then move beyond, but part of just sitting and talking with the older women (who are around my age) turned our talk to the past and together we reminisced about childhoods that had more in common than not. Māori and Pākehā children with sun on the skin, sand under foot – slim bodies moving in nature, with lives ahead not yet lived. The twists and turns that led to being big, were similar to points in my own life that did not turn out quite as expected. In those moments we were simply middle aged women looking back across life and sometimes a sense of knowing just sat in the silence between us. Māori and Pākehā sitting side by side – contemplating the past, considering the present, and (re) imagining the future. This is the research position that I sat most comfortably in – felt more sure-footed in – after somewhat tentative beginnings.

Methodologically this research shows that there is, within Aotearoa New Zealand, a viable research space between cultures, in which new stories can be told and new understandings may unfold. These narratives and thoughts emerge out of differences and commonalities, commonalities which are embodied and fashioned to

some degree in the same context – Aotearoa New Zealand. These (inter) subjectivities however, also stretch apart. I, for example, as Pākehā, do not carry the psychological and economic burden of colonisation – its major impacts embodied for many Māori a mere memory or two ago. I have, however, walked similar paths in other ways and as with many Pākehā, the Māori world has always, in part, enmeshed with mine. I believe that it is within these commonalities that a respectful inter-subjective space can be found; it is between differences, that new trajectories for thinking can be sparked; and it is through this cross cultural conversation that intellectual curiosity can flourish.

Learning from Māori women was the objective of this research and they gave me information in truckloads. In order to honour what they have shared, I have endeavoured to foreground their words and our conversations in the ethnography and in doing so reveal ‘logics for living’ and ‘patterns of becoming’ (Biehl and Locke, 2010; Biehl, 2013). Their words became the touchstones for where to go and where not to go analytically, and this was particularly so when I was tempted to move towards an analysis/theory focusing on power, inequality and unreflexive victimhood as opposed to what was expressed to me – lives imbued with mana and agency.

Agency, on Foucault & Mana

I did set out thinking that I might well end up writing about structural power as this is what is prevalent in the literature on indigeneity and medicine. But Marama, Georgina, Suzanne and Billie opened my eyes to an energised form of agency in the making of courageous decisions and the experiencing of hard won success. These women did not put themselves forward to talk about how hard life had been but rather, how well they had done in getting accepted into the program, meeting the initial weight loss demands, making it through surgery (albeit precariously in some cases) and achieving significant weight loss. Their stories illustrate the tenacity and work involved in reaching this point and counter the popular assertion that weight loss surgery is an easy (cheats) way out.

It did seem counter-intuitive to talk about agency when speaking about the decision to have surgery (most often made from a position of precarity) but as Saba Mahmood (2001:206) argues, agency is not necessarily about standing up to oppression and power, as is often asserted in feminist politics, but rather, can be about

conforming to norms “constitutive at times of very different forms of personhood, knowledge and experience”. The conditions within which decisions to have surgery were made were influenced by normative procedures which promote WLS, and the participants were conforming to these norms, but they did so with agency – underpinned by courage and motivated by desire. While it could be argued that some of the participants were at a stage in which they had very little choice, they did, in fact, make an extraordinary choice and expressed that in their narratives as being an energised pivotal turning point in their lives; power-full, not power-less.

All the way through this thesis, I had to take extra care with notions of power and inequity. For example, Foucauldian ideas on a state’s power over its subjects typify a body of social science research into medical encounters. As noted, I attempted a peopling of the text by foregrounding these narratives and leaving structures of inequity just beyond the frame. This is not an attempt to whitewash but rather, move the lens up close to the singularity of a person’s life and consequently (as noted on pg.5) not let, “the ethnographic die in [my] account of actuality” (Biehl, 2013:583). It turns out the actuality I encountered was more often that of lives imbued with strength and prestige, presence and vitality, wisdom and common sense; the women having moved through life embodying mana.

At no point during the research did it ever feel right or appropriate to write about Māori women with mana as victims. This is not to say that they did not experience racism in social encounters – either implicitly, explicitly, structurally or even unwittingly – but it is saying that their inner being may not necessarily be diminished by these abject encounters. Mana more often provides the strength to push back, hold fast and deliver the trump card. Furthermore, these women disrupted the notion that (large) body size equates to self-consciousness, body shame and even self-loathing. As Biehl notes:

through ethnographic rendering, people’s own theorizing of their conditions may leak into, animate, and challenge present-day regimes of veridiction, including philosophical universals and anthropological subjugation to philosophy (2013: 575).

Through ethnographic rendering this research presents a challenge to the notion that large Māori women are quintessentially victims (of the state and/or medicine) and

secondly, the belief that a sense of self or self-esteem is inextricably linked to appearances. The participants all alluded to a sense of self emanating from deep within the body and, atmospherically, from beyond the body towards the collective; not from 'the look of things' as Georgina would say.

Identity, the Collective & Whanaungatanga

This research suggests that when a Māori sense of self is anchored in the collective and enlivened through whanaungatanga – identity is strong and self-image, positive. Māori-being spills over beyond the body and mixes, merges and enmeshes with that of so many others; lives entwined in a web of whakapapa, a flow of whanaungatanga, and an effervescent current of aroha that provides unconditional support; no matter the size, no matter the shape. Their being-in-the-world however, also mixes with all that flows through and shapes 'place' in a modern world; consumption, media, politics, economics, social norms. The women do live in this world; not in some sort of siphoned-off place of otherness. They shared experiences of being treated differently in different bodies and these stories pointed to objectionable aspects of society; fat bias, racism and a social hierarchy based on looks and entangled with envy. These experiences did not equate to body shame amongst the women I spoke with however, who were emphatic they had been very comfortable in their previously big bodies. I argue that this comes in part from a deep sense of belonging; as Billie noted, "on the Marae, it's all family and you are who you are and they just accept you for that." This way of being also shapes a way of seeing and perceiving others.

On Seeing as Māori

This research adds to phenomenological ideas on perception and the reconstitution of selves. The embodied self is "a certain setting in relation to the world" (citing Merleau-Ponty, Csordas, 1990:8). Consciousness moves from the body towards the world with perception ending in objectification or abstraction. I argue that the Māori 'setting in relation to the world' potentially shapes perception such that an Other is seen through differing reference points. Georgina alluded to this when speaking about a person "that moves with mana" where she contends that mana is something you can sense in a person; something beneath or beyond appearances. Further to this, the women

stated that they were very comfortable in their (previously) big-bodies. This gave me the sense that the participants (as Māori) saw in others what they expected others to see in them; the essence, the person, not the body shape.

Csordas (1990:39-40) notes however that perception is not fully determined by the body as a 'setting in relation to the world' as there is indeterminacy and arbitrariness in the flux between the body and perception, between subject and object, and it is within this flux that selves can be reconstituted. Perception also moves from abstraction back to the body, potentially reconstituting selves and to a degree (re)shaping culture. It is within this flux that Māori may draw down on the strength of their culture to build a strong sense of self and of being within the collective. Conversely, they may also draw down on a plethora of negative discourse that defines and redefines Māori (Tamanui, 2013) as lacking, and keeps indigenous minorities in place (Hage, 2010).

Māori Being in the Statistics & Becoming

While the embodiment of (Māori) culture may shape perception and strengthen selves, Māori are not impervious to negative discourses that move in society – most often in the form of negative statistics. These discourses, on the whole, take the form of race-based statistics intended to inform policy but nevertheless able to map back onto selves and into culture in toxic ways (Tamanui, 2013; Curtis, 2016); as Georgina noted: “us Māori think we are a problem as we’ve been told we are problem for years and years”. Negative statistics potentially feed into racism in broader society by, as Hage (2010:115) argues, “a process of ‘fixing’ the racialised in a negative particularity”. This research cannot resolve that problem but does attempt to give full bodied accounts of Māori experiences, which stand in contrast to those suggested by statistics that reduce people to numbers (Yates-Doerr, 2012, 2013) and infer underlying (negative) cultural cause (Curtis, 2016).

These full bodied accounts also reveal the complexities of the experiences of WLS recipients and provide a counter to discourse that typically frames WLS as a before and after experience; ‘after’ – a full stop leading to a new life with new beginnings. Rather, life after surgery is shown to be a state of ‘embodied becoming’; shaping, forming and reforming out of context in multiple ways. This research shows

that this life after surgery can be fraught with ongoing challenges manifesting as a form of liminal being-in-the-world with trajectories for living reoriented by an altered interiority. I found it useful to conceptualise these trajectories by thinking with Kai.

Liminality & Thinking with Kai

As noted, life after weight loss surgery is a different form of living in the world and this was often illuminated in this thesis by thinking with Kai. Kai as a childhood memory represents closeness to nature and movement into and amongst the natural world. Remembering Kai in the past also connects food to people, places, culture and identity. Kai at the obesity turning point is seen as problematic as high calorie food supplies entangle with more sedentary lives creating ill health and communities struggling with obesity. Across time however, Kai remains the touchstone for conviviality and connectedness. After surgery, Kai is re-imagined into its component parts in a desperate struggle to get nutrients into the body. Kai after surgery can also get stuck, make you sick and be expelled from the body as vomit or diarrhoea. Post-surgery, some Kai has to be given up altogether resulting in a sense of loss. Kai after surgery can also disrupt the conviviality of the everyday – eating with others. This is a different form of being-in-the-world; liminal, dislodged – a side step away from the ordinary.

Lives Longer Lived

Ordinariness however, is not what these women necessarily sought but rather a better state of health. This, they would argue, is what they have achieved; diabetes reversed, gout gone for good (hopefully!), sleep apnoea pumps returned to the hospital and joints no longer creaking under substantial strain. Underpinning all of this is a strong desire (especially from the older participants) for a greater life expectancy and the chance to see their mokopuna, nieces and nephews grow up. WLS may very well have propelled them towards a longer life and this is a great source of hope. These lives may be entangled with ongoing challenges and sit a little outside of the ordinary, but can now be imagined beyond a close horizon, in a landscape peopled with whānau and replete with new possibilities – like tantalising imaginings, coming into view.

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Glossary of Māori terms

This glossary of Māori words provides simple definitions devoid of the nuance and complexity that would be the privy of a speaker of Te Reo within their cultural context. I have compiled this glossary using the Māori Dictionary <https://maoridictionary.co.nz/>

Aotearoa – New Zealand

Aroha – love, compassion, empathy, charity, affection

Hapū – kinship group

Haere Mai - welcome

Hui - gather, meeting, seminar

Iwi - kinship group, tribe

Kai – food, meal, to eat

Kai Hākari - feast

Kaimoana – seafood, shellfish

Kaumātua - elder

Kaupapa Māori Research – Research approach using Maori values and ideology

Kōrero – speak, talk, converse, discourse, address

Korowai - cloak

Kuia – elderly woman

Mahi – work, job, employment

Mahinga Kai – food gathering place

Mana - prestige, status, supernatural force in a person, place or object

Mana Tūpuna – power through descent

Manaakitanga - hospitality

Manuhiri – visitor, guest

Māori – indigenous New Zealander

Marae – meeting area for iwi or hapū

Mokopuna - grandchild

Noa – free from the restrictions of tapu

Pā - village (in the past – a fortified village)

Pākehā – New Zealander of European descent

Pōwhiri – to welcome

Pūhā – perennial sowthistle

Pipi – shellfish – Paphies australis

Tangi – cry, weep, commonly used for funeral (tangihanga)

Tapu – sacred, restricted, set apart

Te Ao Māori – the Māori world

Tikanga – custom practise, rule, lore, protocol, convention

Whakamā - ashamed, shame, embarrassed

Whakapapa – lineage, descent

Whānau –family group, sometimes used to include non-kin friends and community

Whanaungatanga – relationship, connection, sense of belonging

Whāngai – foster, adopt, adopted child

Wharenui – meeting house

Appendix A: Email from Māori Cultural Advisor

From: **Kawharu, Margaret** Date: Mon, Apr 10, 2017 at 5:30 PM
Subject: Re: Research proposal To: Clare Hayward [REDACTED] >

Kia ora Clare

As the Senior Māori Advisor at Massey University in Auckland, with an MA in Social Anthropology myself, it has been very interesting for me to discuss your MA proposal with you today. Our discussion has covered the following points:

- the need to articulate your positionality and analyse the lens through which you are looking as a participant/observer
- to define the terms of your proposal – health, social performance and Māori – and explore those definitions with your participants
- to consider kaupapa Māori and decolonising methodologies in your theory, alongside theories of embodiment and performance
- to seek from someone Māori other than me, cultural advice, perhaps to accompany you on visits to potential participants, to consider Māori values and protocols on your journey
- to enquire into the Māori dimension or worldview for each participant and the extent to which that impacts on self-image and identity, health & well-being
- to consider the socio-economic-political context as well as personal choice and emotional feelings
- to explore collaborative work in part with your participants, in group work and/or collaborative writing perhaps
- to consider ways in which your work will benefit the participants, and others
- to consider ways to build real relationships and maintain them with your participants
- to allow time to reflect on your research and refine the focus of your MA thesis once data has been collected

I'm very happy to continue to take an interest in your thesis and provide any advice I can.

Ngā mihi
Margaret

Margaret Kawharu
Ngāti Whātua / Mahurehure

Senior Māori Advisor - Albany

Email: M.A.Kawharu@massey.ac.nz Office of the Assistant Vice-Chancellor Māori & Pasifika | Massey University | Private Bag 102904 | North Shore, Auckland 0745 | New Zealand |

Appendix B: Ethics Approval



Date: 06 June 2017

Dear Clare Hayward

Re: Ethics Notification - NOR 17/23 - Bariatric Surgery: The impacts of Weight Loss Surgery on the health and social performance of Maori women.

Thank you for the above application that was considered by the Massey University Human Ethics Committee: Human Ethics Northern Committee at their meeting held on Tuesday, 6 June, 2017.

Approval is for three years. If this project has not been completed within three years from the date of this letter, reapproval must be requested.

If the nature, content, location, procedures or personnel of your approved application change, please advise the Secretary of the Committee.

Yours sincerely



Dr Brian Finch
Chair, Human Ethics Chairs' Committee and Director (Research Ethics)

Appendix C: Participant Information Sheet



Participant Information Sheet

Title of Project

Bariatric Surgery: The impacts of Weight Loss Surgery on the Social Performance and Health of Maori women.

An Invitation

My name is Clare Hayward. I am currently a student at Massey University enrolled in a Master of Arts in Social Anthropology. I am inviting you to participate in my research project entitled: *Bariatric Surgery: The impacts of weight loss surgery on the social performance and health of Maori women.*

What is the purpose of this research?

The purpose of this research is to learn from the experiences of Maori women who have had bariatric surgery and experienced significant weight loss. I wish to explore the social and cultural aspects of weight loss and any potential changes to identity or a sense of self. I am also interested in health and what it means to be healthy. My research focuses on Maori women with the intent to highlight potentially unique impacts experienced by these women after surgery.

Participant Identification and Recruitment

- Participants will be recruited through established networks in the community.
- Participants will be selected on the following criteria – Maori women who have had bariatric surgery which resulted in significant weight loss.
- There will be up to five participants involved in this research

Project Procedures

- Interviews will be conducted with the participants. The interviews will be framed by the research focus but participants will be encouraged to tell their stories in their way.
- The interviews will be conducted in a venue chosen by the participants.
- It is anticipated that the initial interview will take two to three hours. There will also be a follow meeting to discuss the research, provide transcripts if requested. This meeting may take an hour.
- If participants experience any discomfort in discussing their weight loss journey they can choose to decline to answer any further questions.
- If issues arise that require further discussion, support is available through:
Homebuilders – Warkworth 09 425 7048
Te Ha Oranga – Wellsford 09 423 60914, Helensville 09 420 8523.
Te Korowai Aroha Pumau – Wellsford - 09 423 9481
A referral from your local GP

Data Management

- A summary of the research findings will be given and the full research report will be available on upon request.
- All steps will be taken to endeavor to keep the identities of the participants confidential including using pseudonyms and not identifying locations.
- Raw data will be stored securely in password protected electronic files or locked filing cabinets for five years after completion of the project, when it will be destroyed.



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Participant's Rights

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- decline to answer any particular question;
- withdraw from the study anytime up to four weeks from the completion of the research
- ask any questions about the study at any time during participation;
- provide information on the understanding that your name will not be used unless you give permission to the researcher;
- be given a summary of the final report and will be given access to the full report upon request.

Project Contacts

If you have any concerns please contact my supervisors;

Dr. Barbara Andersen
Email: B.Andersen1@massey.ac.nz
Telephone: +64 (09) 414 0800 ext. 43472

Dr. Carolyn Morris
Email: C.M.Morris@massey.ac.nz
Telephone: +64 (06) 356 9099 ext. 83632

Ethics Procedure

This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application 4000017567. If you have any concerns about the conduct of this research, please contact Dr. Brian Finch, Acting Chair, Massey University Human Ethics Committee, Northern, telephone 06 356 9099 x 86015, email humanethicsnorth@massey.ac.nz.

If you are interested in participating in this research and require any further information please contact Clare Hayward on [REDACTED] or [REDACTED]

Yours sincerely

Clare Hayward

Appendix D: Participant Consent Form



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Bariatric Surgery: The impacts of Weight Loss Surgery on the Social Performance and Health of Māori women

PARTICIPANT CONSENT FORM - INDIVIDUAL

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree/do not agree to the interview being sound recorded.

I agree/do not agree to the interview being image recorded.

I wish/do not wish to have my recordings returned to me.

I wish/do not wish to have data placed in an official archive.

I agree to participate in this study under the conditions set out in the Information Sheet.

Signature: Date:

Full Name - printed