Scandinavian Journal of Caring Sciences
EMPIRICAL STUDIES
doi: 10.1111/scs.12756

Putting life on hold: lived experiences of people with obesity

Britt Marit Haga BSW, Cand.san (PhD Candidate), **Bodil Furnes** RN, PhD (Professor), **Elin Dysvik** RN, PhD (Professor) and **Venke Ueland** RN, PhD (Associate Professor)
Faculty of Health Sciences, University of Stavanger, Stavanger, Norway

Scand J Caring Sci; 2019

Putting life on hold: lived experiences of people with obesity

Obesity presents challenges in everyday life, one of which involves the existential aspects of living life as a person with obesity. There is a need for understanding the existential experiences, but there is limited in-depth research about these experiences of people with obesity. The aim of this study was to gain deeper insight into the existential experiences of people dealing with obesity. We performed a qualitative study that included in-depth interviews with seven men and 14 women with obesity (body mass index $\geq$ 35 kg/m^2) aged 18–59 years. The study took a phenomenological–hermeneutic approach in which the participants' own experiences formed the basis for understanding their lifeworld. The lived experiences of people dealing with obesity were characterised by several existential challenges. One overarching theme—*Putting life on hold when struggling with obesity*—was developed based on three themes: *The body as an impediment to living the desired life, to being oneself* and *to moving on in life*. These findings illustrate the complex existential experience of life, body and existence faced by people dealing with obesity. Based on these findings, we discuss whether people with obesity who experience 'putting life on hold' are attuned to live their life to the fullest in some areas. Their embodied experiences seem to challenge them to experience the joy of life, to appear as a whole self and to live life in the moment. Reflecting on obesity in the context of life and life phenomena seems to provide deeper insights into the existence of people living with obesity and may help to advance a more comprehensive approach in obesity health care.

Keywords: obesity, Merleau-Ponty, phenomenology, life phenomena, existential experiences, lifeworld, lived experience.

Submitted 7 August 2019, Accepted 14 August 2019

Introduction

The number of people with obesity, defined as having a body mass index (BMI) $\geq$ 30 kg/m^2, is gradually increasing throughout the world (1), and this increase has attracted growing attention. In the time since the World Health Organization identified obesity as a global health challenge, obesity has moved from being a personal matter to now being considered as a condition that requires treatment (2). Given the ideal in Western culture of the slim body (3,4) attitudes towards people with obesity are sometimes characterised by disparagement and stigmatisation because of the associations between obesity with moral failing and lack of self-control (5,6). As a result, many people with obesity are prone to have a reduced quality of life (7), psychological problems (8,9), low self-esteem, poor body image (5,10), blame (11) and shame and guilt (10,12).

When considering how these challenges influence the health of people with obesity, it is relevant to include an existential perspective on living life as a person with obesity; that is, how we as human beings experience and understand our existence in the context of life (13). However, given the medicalisation of the obesity field (14,15), there is limited in-depth research on the existential experiences of people dealing with obesity.

Background

To date, much of the research on the experiences of people with obesity has focused on their experiences as recipients of health care for obesity (12,16–18).

The experience of lifestyle change is associated with great challenges (19,20), and only a few people manage to maintain a lasting change (21). Most drop out of healthy lifestyle programmes or return to their former living habits, and these people often end up gaining more weight than they lost during the lifestyle change (21). Undergoing weight loss surgery implies enormous changes in daily life (22) and risk of complications, both somatic and mental (23) and, for some, a markedly

Correspondence to:
Britt Marit Haga, Faculty of Health Sciences, University of Stavanger, Stavanger N-4036, Norway.
E-mail: britt.m.haga@uis.no

reduced quality of life (24). After achieving maximum weight loss, many surgically treated patients regain a considerable amount of weight, which contributes to a gradual regression in their quality of life (7). Some researchers have recently emphasised that weight regain (if weight is even lost) and weight cycling (repeated weight gain and loss) contribute to poorer health and further stigmatisation (25–27), and may even lead to greater weight gain over the long term (28).

Some studies have focused on the more general experience of people living with obesity. Within the phenomenological perspective of Merleau-Ponty, body weight appears in the forefront of all experiences in everyday life (2). This has been confirmed by other studies, which have also noted the continual experience of having a huge body and its effects on one's life (29,30). Living with obesity has been described as 'paradoxical living' through descriptions of a dualistic body image. Paradoxical living means that people with obesity seem to alternate between experiencing their body and weight as an object (an alien to who they perceive themselves to be), or a subject (an integration of body and mind which form the basis for getting access to the world) (2,29,31).

Body phenomenology was also used as the background for this study. According to Merleau-Ponty, people exist in the world primarily as a body. The body is relational in the sense that it is inseparably connected to one's surroundings (32). Merleau-Ponty noted the dualistic way of seeing the human being; that is, body and soul as two separable entities. He suggested that, instead, the body should be seen as a whole, both as a subject and object that coexist (32).

Research on patients' experiences, which surface in times of illness, has shown that healthcare professionals should not overlook a patient's life phenomena, as expressed by feelings of powerlessness, despair, life courage and hope (33). As developed by Delmar (33) within a Nordic caring philosophical discourse, the understanding of life phenomena provides the basis for considering the challenges of dealing with obesity. When a person becomes ill or is challenged, universal life phenomena become more evident (34). Depending on one's specific life situation, life phenomena might appear to have either life-limiting or life-facilitating characteristics (35).

We have found very little research that aimed to deepen our understanding of the existential experiences of people living with obesity. By asking people with obesity about their experiences and what the experiences mean to them in the context of their life, we reasoned it would be possible to gain valuable insight into the life phenomena of living with obesity. Understanding their experiences might be one way to advance the current approaches to obesity. Therefore, the aim of this study was to gain deeper insight into the existential experiences of people with obesity by addressing the key research question: 'What is it like for people to live with obesity?'

Methods

We chose an exploratory phenomenological–hermeneutic approach to understand the first-person perspective on the phenomenon 'existential experiences when dealing with obesity'. This approach is based on a lifeworld perspective. Dahlberg et al. (36) note that lifeworld theory can help to describe the existential world in which all humans live. Lifeworld is the world of lived experiences, the world in which we live our daily lives (37). The lived body and lived experiences should be examined as the subjects describe them. This is consistent with the classical phenomenological idea of returning to the phenomena themselves (38).

Recruitment and participants

We sought to identify the lived experiences of people who were willing to share their experiences dealing with obesity; 21 people, seven men and 14 women, volunteered to participate in the study. A convenience sampling strategy was used because we decided to include the people we had access to (39). Hence, the participants were recruited from two health promotion programmes shortly after their entry into the programme. The programme itself was not the focus of the interviews. The inclusion criteria were aged ≥18 years, either male or female, ability to communicate in Norwegian both orally and in writing, BMI $\geq$ 35 kg/m^2, and able to provide informed consent on their own behalf (Table 1).

The participants were informed about the study in writing and orally by the leading health professional in the programmes, and a written consent form was completed before inclusion. Those who consented were contacted by the first author, and an appointment for the interview was made.

Data collection

We chose to use qualitative in-depth interviews to capture the existential experiences of everyday life of people dealing with obesity because the phenomenon is tied to human existence (36,38) The interviews were conducted using a thematic interview guide with topics such as living everyday life with obesity, the significance of being a large body and being obese, viewing oneself from the perspective of others and thoughts about the future. To encourage the participants to reflect on their lived experience, they were asked to provide detailed descriptions of their experiences, situations and events, and what meaning these experiences had for them. The interviews were completed by opening a discussion to obtain additional comments.

Seventeen of the interviews were conducted in the health programme offices, three in the first author's

Table 1 Sample characteristics (N = 21)

Sex	
Male	7
Female	14
Age, years	
18–29	6
30–39	2
40–49	3
50–59	10
Marital status	
In a relationship	11
Single	10
Education (highest level)	
Primary school	1
Secondary school	12
University/college	8
Employment	
Active	10
Temporary unemployment	10
Lasting unemployment	1
Weight	96–155 kg
BMI	35–51
Health-related suffering because of obesity	15
Obesity-reducing actions	
On their own	19
Healthy life centre (municipal level)	10
Intensive lifestyle intervention (specialist level)	16
Bariatric surgery	1
Weight-reducing medication	2
Other (group therapy, psychological intervention, etc.)	1

office, and one in the first author's home, according to each participant's choice. The interviews lasted 40–90 minutes and were conducted by the first author.

Ethical considerations

The study was approved by the Regional Committees for Medical and Health Research Ethics (reference number 2016/1530), and the Norwegian Centre for Research Data (project number 50184), and was conducted in accordance with the Helsinki Declaration (40). The participants were guaranteed confidentiality and were informed about the implications of participation and that they could receive professional support for follow-up if needed. It was emphasised that participation was voluntary and that participants could leave the project at any time.

Analysis and interpretation

The interviews were audio-recorded. The first author transcribed 16 interviews, and a professional transcriber who signed a confidentiality agreement in advance transcribed five interviews. After repeated discussion with all authors, the first author then performed further analysis.

Through analysis and interpretation of the written text as inspired by the phenomenological–hermeneutic thinking of Ricœur (41–43), we identified one overarching theme and three themes. According to Ricœur, reading a text reflects the dialectic of two attitudes: explanation and understanding (41). We used the following steps in the analysis and interpretation: naïve reading, structural analysis, and critical interpretation and discussion. The analytical process is outlined in Table 2.

The overarching theme and the thematic findings together with quotations are presented first, followed by further interpretation and discussion.

Findings

The participants in the study described challenges related to everyday life and their body and existence when living with obesity. Participants had a lifelong history of obesity and being considerably overweight and reported their experiences with repeated dieting and weight cycling. The overarching theme obtained from our analysis—*Putting life on hold when struggling with obesity*—illustrates the complexity of the participants' life situation. The three themes describe nuances and variations of a life put on hold. Table 3 presents an example of the analysis process.

The wording 'putting life on hold' shows that the participants considered themselves to be in a waiting position. Their lives seemed to be lived in anticipation of what they understood to be their 'actual life' at some point in the future. However, 'putting life on hold' also implies that they considered their life situation to be temporary.

Table 2 Steps of the analytic process

1. Naïve reading	All the interview texts were read and re-read. The immediate impressions from the text were written down to gain an initial appropriation of the texts and a holistic understanding of what the texts were about. We paid attention to what moved us in relation to "what was said" and to the questions that emerged.
2. Structural analysis	Structural analysis seeks to clarify the dialectic between understanding ("what is said") and an explanation of the text ("what is spoken about") with the intention of making a deeper critical interpretation. Development of three themes was based on interpretation of the explanatory structure and an understanding of the content.
3. Critical interpretation and discussion	Critical interpretation aims at developing new understanding, which can be formulated as an overarching theme. The results from the naïve reading and the structural analysis give direction to the selection of and interpretation in relation to theory.

Table 3 Example from the analysis process covering one overarching theme and three themes

Putting life on hold when struggling with obesity					
The body as an impediment to living the desired life		*The body as an impediment to being oneself*		*The body as an impediment to moving on in one's life*	
Units of meaning (What is said?)	*Units of significance (What is being spoken about?)*	*Units of meaning (What is said?)*	*Units of significance (What is being spoken about?)*	*Units of meaning (What is said?)*	*Units of significance (What is being spoken about?)*
That is what I long for. Just an ordinary daily life where you manage to live like veryone else.	The always-present body limits the desired ordinary life.	"I don't listen to you because you are so damn fat" is something I've heard . . . this is not who I want to be. I want them to see the professional I am. I want them to be able to see the person I aspire to be. I want them to see that I'm there to help	The outer body blinds the "real" self.	Another summer has passed by, and another year gone. Will I be able to manage this until next year, if I begin to reduce sensibly? Hopefully, that will set me on a good path to next summer.	The body out of control makes the future unpredictable.

A 46-year-old woman described her life as a situation in which she is 'just *existing*' and is separated from the actual life where life is *lived*.

> I want to really live my life. I don't want to simply exist; that is what I'm doing now. I want to have fun, enjoy myself and live.

The body as an impediment to living the desired life

The participants described their 'large body' as always being present in their daily life. This attracted continuous attention and the effort appeared as an impediment to living the life they desired. They had to live their life differently compared with people with 'normal' weight. Because their body did not seem to fit into a 'normal' life, they were waiting for their body and life to 'fit in' so they could live what they referred to as an 'ordinary life', that is, a nonextraordinary, 'normal' everyday life.

> I long to go to work in the morning and, if I had kids, I'd pick them up from the kindergarten on my way home. I'd come home, cook dinner, go for a workout and then relax on the couch. That is what I long for. Just an ordinary daily life where you manage to live like everyone else. To date, this is something that I have not managed to achieve. Maybe it's a small dream, but it would be huge for me.

Participants also described in detail what they wished to do if they were slimmer. The different life they currently led made the participants wish to participate in 'normal' activities, such as hiking, skiing and travelling, activities 'everybody' can do. They had tried several times to participate in various desired activities. However, they at some point had to put these activities on hold, both because their bodies were unmanageable and because they felt self-conscious about other people's responses when they experienced difficulties performing these activities. This was described by a 58-year-old woman who provided several reasons why she had put skiing on hold even though she enjoyed it.

> If I were to go skiing, it would be really difficult if I were to fall. I imagine that I would not be able to get back on my feet and, even if I did, I'd look completely hopeless trying to do so. That's why I've stopped, even though I really liked it.

Living with obesity meant that the participants sometimes lost connection with the desired social group. Participants mentioned several examples of experiences in which their large body was an impediment to friendship and belonging to a group of significant others. Asking others to pay attention to them and adjust the activity to their capacity was not an alternative, and they chose loneliness instead. A 54-year-old man described his

experience of putting friendship on hold as a great loss because his body prevented him from doing activities with others.

> I feel that I have lost, or that I am losing, something in relation to … of course, I want to do things with friends, but I am unable to.

The participants longed for mutual love and closeness, but their experiences of having a large body also appeared to be an impediment to intimate relations. Among the participants who were single, both men and women were hesitant about starting intimate relations because they felt shy about showing their body. Despite longing for a close relationship, they felt not ready for the intimacy it would entail and had put such relations 'on hold'. A 58-year-old woman reflected on her vulnerability, which was linked to her large body because she felt it held her back from opening herself to anyone.

> I think that my fat body certainly inhibits me from entering into a new relationship. I don't really want to live alone. I wish I could be a little more open to meeting someone I liked.

The body as an impediment to being oneself

The interviewees reported that they constantly experienced the judging gaze of others on their body. They saw in other people's eyes, on first glance, the reaction to sensing their body's mere presence. The participants commented that they struggled daily to be seen as something other than simply a large body.

Both male and female participants expressed their frustration over their body's disruptive presence, as shown by the reaction of others to their body on first glance. Hence, the participants perceived that the sight of their body blinded others to their 'real' self. This contributed to a feeling of having their authentic self on hold as they waited to become the person they knew themselves to be. An 18-year-old woman commented:

> The first thing people see is how you look, and many, without much thought, will simply not bother to talk to you. It's very sad that I can't develop close friendships with these people because they don't really get to know me.

The participants noted that, normally, their large body attracted glances and not oral utterances. However, some participants had also experienced judgemental words from others, including children, elderly people or people affected by alcohol or mentally ill people, who did not hold back 'telling the truth'. A 24-year-old woman who worked as a nurse in a mental hospital commented that she was told several times by patients that they would not listen to her 'because she was fat'. In one situation involving setting boundaries for a patient who abused drugs, she perceived that the mere presence of her body blinded the patient to her actions. This left her with a feeling of powerlessness because she felt she could not reach the patient as the person she aspired to be.

> 'I don't listen to you because you are so damn fat' is something I've heard … This is not who I want to be; I want them to see the professional I am. I want them to be able to see the person I aspire to be. I want them to see that I'm there to help.

The participants experienced that their body appeared to be an impediment to a dialogue about important issues with their general practitioner (GP). They felt they were not fully able to express what they wanted to convey to their GP because any symptoms they described were interpreted as side effects of obesity. The participants worried that their GP was not sufficiently open to a discussion about potentially serious conditions and feared they could die because their concerns were not being taken seriously by their GP. These kinds of experiences revealed a sense of powerlessness at the realisation that not even their GP could see beyond their appearance.

A highly educated 58-year-old woman who worked in a leading position commented that she had trouble expressing her worries about having serious heart disease to her GP. Despite her highly developed communication skills, she felt that something held her back from being able to express her inner worries to her GP.

> I think it gets in the way of getting a referral. I do not understand it completely, for I am completely capable of claiming a referral. But, I just don't do it —the result being that I end up as an underdog, unable to say anything.

The body as an impediment to moving on in one's life

The participants struggled with the challenge of having an uncontrolled body as they had tried to lose weight several times but had then regained the weight. The participants expressed frustration and shame about living a life situation characterised by a sense of having failed, especially because they knew what to do to succeed. A 59-year-old man described his situation as 'stagnated', which it seemed impossible to move on from.

> In many ways, regaining weight is a defeat. It feels like I have failed to address the problem sufficiently and to do something about it when I have the blueprint to address it. It's like taking an exam and you have the answers, right?

However, the participants commented on the possibility of rejecting the role of one's body in life. Moving on

in life felt difficult because they had to deal with a bothersome part of themselves, an appendage, which hampered their life. Some expressed that they were so tired of carrying their body around that they claimed they did not *need* their body at all in their life. A 58-year-old man described his body as not necessary to live his life.

> We don't really need our body. I'm not joking. I realised this when I was unable to walk more than 50 m, but I still managed to give 130% at work. I could only use my arms, neck and head. And I could go on like this for the rest of my life. The rest of my body did not exist; its existence wasn't necessary.

As the years went by, the participants continued waiting for the day they finally were successful at losing weight. Regardless of the number of times they had failed to lose weight or to retain the weight loss, they never seemed to stop hoping that their dream of a new body, and thus a new life, would come true. They expressed their hope by picturing a slim version of themselves at special occasions, for example as a healthy and slim elderly person playing with their grandchildren. These images allowed them to continue to wait and hope. However, given their prior experiences and uncertainty, they remained cautious about their expectations for the future.

> Another summer has passed by and another year gone by. Will I be able to manage until next year, if I begin to reduce sensibly? Hopefully, that will set me on a good path towards next summer.

The experience of having a large body that was out of control and unpredictable constantly occupied their attention. Special life events and feasts were experienced as troublesome because they were reminded of their unsuccessful life when encountering others. In that way, pleasant events became filled with ambivalence. A 46-year-old woman expressed this as wanting to postpone meaningful and valuable events to the future.

> I hope my sister doesn't get married soon. Of course, I want them to marry, but I hope it won't be for a while because I really want to feel lovely at the wedding.

Discussion

The aim of this study was to gain a deeper insight into the existential experiences of people with obesity. The developed overarching theme—*Putting life on hold when struggling with obesity*—illustrates the complex experience of life, body and existence of people struggling with obesity, and the three themes describe further the nuances and variations: *The body as an impediment to living the desired life, to being oneself* and *to moving on in one's life*.

Our study shows that the participants *experience their body as an impediment to living the desired life*. Having a large body is experienced as an obstacle to living an ordinary everyday life, which has also been shown by other studies (2,44). According to Merleau-Ponty, one's access to the world goes through the lived body, and serious illness and bodily pain influence the way people, as 'body-subjects', perceive their lifeworld (32). Any change in the body also means a change in the access to life (36). Obesity might reflect a breakdown in the body, which can keep a person from immediate engagement with the world and their life.

When feeling unable to participate in the desired everyday life, activities and relations, the participants in our study reflected on the movement between the life-facilitating phenomenon missing someone and the life-limiting life phenomenon loneliness. Comparing themselves with other people, the participants also wanted to experience equality and recognition through belonging with significant others and confidence and acceptance through being loved in an intimate relationship. However, they were not ready to reveal their vulnerability to others. Therefore, living with the always-present large body seemed to make them put their desired life on hold. Delmar distinguishes between 'being alive' and 'living'. Being alive refers to survival and needs, whereas living is about life courage and life happiness, and the ability to reach beyond oneself towards others with openness and appreciation (34). As we have seen, the participants felt they just existed in life and were not really living. In our view, being attuned to experiencing joy in life might be a challenge for people dealing with obesity, as the participants in our study seemed to renouncing or postponing their desires for life. When not attuned towards the joy of life, a person may not either become aware of possibilities that show up and may let them pass by. Thus, the existential challenge of putting the desired life on hold seems to involve not being attuned to experience the phenomena of life-facilitating character as they present themselves in everyday life.

The present study also reveals how the participants experience *their body as an impediment to being oneself*. The participants experience their body as an obstacle to what they perceive as their real self and therefore feel a sense of putting their inner self on hold. Our participants described several situations in which they encountered people they wanted to make an impression on but felt that the other person was blinded—even alienated—by their appearance. Our findings are similar to those of Westland Barber (29) who described the discrepancy between the feelings of having a real self inside the body and the outward visible self, which is judged by others. According to Merleau-Ponty (45), as a body in the world, one sees oneself through the eyes of others. Therefore, one's self-understanding always involves perceiving what

others see in oneself (46). By looking at themselves as others saw them, the participants perceived that their body becomes an object that is not socially accepted but instead is an object of social devaluation and abjection.

The findings of our study describe the participant's experience of rejection because of their bodily appearance and how this rejection leads to a feeling of powerlessness. The phenomena of life, such as powerlessness, can have a greater effect during times of illness or changes in life (35). These might cause a sense of disorientation, or 'homelessness' or even alienation towards one's body, and may lead to challenges in developing relationships with other people (47). This was particularly evident when the participants experienced rejection by a trusted person. Such a rejection can become overwhelming in situations of vulnerability, such as in a doctor–patient relationship (18,48,49). In addition, Martinsen confirms that a person's existence may be at stake when trust is rejected (50).

When urged to reveal their real self, the participants probably have a deep desire for immediate engagement with the world (36). Delmar claims that life is given its full meaning when being present with one's whole self (35). From the same viewpoint, an existential challenge for those living with obesity may be to present as a subject anchored in their own body, that is to be able to step forward as a person consisting of both body and self, a whole self (51), Hence, allowing the body and self to become a whole can restore the lifeworld that is lost through the body's breakdown (52).

This study revealed the participants' experience of *the body as an impediment to moving on in one's life*. The always-present large body can be overshadowing and may constantly influence life. The participants described that living their life with an uncontrolled body hampered their ability to move on in life. Being able to move on in life seems to be closely related to the achievement of weight loss. However, the present everyday life with obesity means a story of repeated failure at weight loss, which leads to the experience of a life on hold for participants who felt they lacked bodily autonomy to take on life and change their situation.

Our study also reveals the perception of the body being out of control, which was expressed as a rejection of the body's relatedness to life. In the context of Merleau-Ponty's work (32), the body should be seen as a whole, as the coexistence of body and soul. The experience of bodily dissonance—that is, the conflict between wanting to but not being able to—seems to be a common experience also uncovered in research about people's experiences of living with a chronic illness (36) because the illness experience involves a split between the subjective and the objective body (47,53,54).

With time, people with a chronic illness often move towards acceptance and reconciliation of their situation (55). The findings of our study suggest that people with obesity do not consider their life situation to be permanent, as shown by the phrase 'putting life on hold', which implies that they consider their situation to be temporary. They pictured themselves as slim in future life situations and emphasised their wish to defer important events to the future. These findings seem to indicate that the participants are holding on to the life-facilitating phenomenon hope and that the act of waiting may have a positive effect on the life situation at the present time. Hope can bring a feeling of freedom and control, and the sense that the present situation is temporary and that normality will be recovered in the future (34,55). However, living with a constant possibility and a constant impossibility can increase uncertainty and unpredictability in life (30). The lack of predictability when experiencing obesity may, therefore, influence the phenomenon of hope. Hope is dependent on access to the future but presupposes that there is a future of possibilities (34). The feeling of autonomy seems to be closely related to the control of time. With time, an uncertain situation might appear to become permanent, and it may become more difficult to maintain hope.

As the pendulum moves towards hopelessness, time might be perceived as a threat if freedom and control are replaced with restrictions and uncertainty. As we see it, the experience of the body as an impediment to moving on in one's life might, therefore, lead to a change in the temporal experience (54). Hence, even though chronological time passes, the existential flow of the lifeworld stops (36). This means that the existential experience of not being able to move on in life could be experienced as waiting outside the stream of life and considering that life at the moment is time wasted.

Methodological considerations

To ensure trustworthiness, we applied the conceptual approach of Lincoln and Guba (56). The credibility of the data collection was maintained by having the same researcher conduct all the interviews, but we are aware that the credibility may have been challenged because the interviews were not conducted in the same surroundings. Hence, it is possible that the participants had a different degree of confidence in the interview situation.

To create a comprehensive understanding, we interpreted the findings critically in the context of the existing literature and the theoretical framework presented. The diversity of the sample of 21 participants of different ages, both men and women, and from different backgrounds reinforces the credibility because the participants

offered rich and nuanced descriptions of the phenomenon of interest.

We have presented the findings along with the participants' quotations and a detailed description of the analytical steps (Table 2) and an example from the structural analysis (Table 3). This provides the reader access to both the data and the abstraction process used in the analysis. This information supports the demand for an inner logic because it should be possible to follow a researcher's reasoning throughout the whole study (36). However, the validity of the content in phenomenological writing can also be verified by the degree of recognition made by the reader of the lived meanings of the lifeworld. The writer's ability to create reflections that touch, stir and evoke the reader's recognition may, therefore, contribute to one's perception about the validity of a study (57).

Confirmability has been provided by giving a detailed description of the methodology and process of data collection to allow the reader to judge the applicability of our findings. Our findings may be transferable to other situations by considering the culture and context, along with the methods of data collection and analysis.

One possible limitation is that the participants were recruited not long after entering a health promotion programme. It is possible that their views may have been influenced by their involvement at a time they were seeking help to manage a lifestyle change. However, this selection was considered to be the most appropriate way to find participants whose perceptions could help provide insights into the questions of interest. From other studies, we knew that it could be difficult to recruit people with obesity from the general population (29) given the sensitive topic (58). We acknowledge that different results may have been obtained using a more 'open' recruitment process, for example, by advertising in a newspaper to find participants not involved in any treatment process.

Conclusion

Dealing with obesity involves a complex relationship between everyday life and one's body and existence. This has been interpreted as 'putting life on hold'. The lived experiences of people with obesity are characterised by several existential challenges. The participants' bodies were perceived as impediments to living their desired life, to being themselves and to moving on in life. The findings suggest that people with obesity are not attuned to living their life to the fullest in some areas because of this experience of putting life on hold. One reason may be that their experiences challenge them in experiencing the joy of life, appearing as a whole self and living life at the moment. We suggest that this information may have implications for the life-facilitating potential hope has, as people with obesity trying to overcome the experience of putting their life on hold. Further research should focus on how people *handle* their struggle with obesity.

Implications for practice

Reflecting on the phenomenon of living with obesity in the light of lifeworld theory and life phenomena seems to be important for gaining deeper insight into the phenomenon and constitutes a good basis for understanding the challenges faced by people living with obesity. It is important to understand the experience of putting life on hold. Health professionals should question the implications of unambiguously recommending weight loss to their patients. We suggest that care for people struggling with obesity should encompass life phenomena together with a lifeworld-directed way of caring. This requires an existential view of being human and well-being. Lifeworld-led care can provide a comprehensive and broad context for understanding life experiences and may help to advance the approaches towards people struggling with obesity.

Acknowledgements

We thank the respondents who shared their valuable reflections about their lived experiences concerning obesity. Thanks also to the two health promotion centres for their assistance in the recruitment process.

Conflict of interest

The authors declare no conflict of interest.

Author contributions

Haga, Furnes, Dysvik and Ueland designed the study. Haga conducted the interviews and transcribed most of them. Haga, Furnes, Dysvik and Ueland analysed the data and Haga drafted the manuscript. All authors made critical revisions to the manuscript's scientific content during the process.

Ethical approval

The study was approved by the Regional Committees for Medical and Health Research Ethics (reference number 2016/1530), and the Norwegian Centre for Research Data (project number 50184), and was conducted in accordance with the Helsinki Declaration (40).

Funding

There has been no contribution to this study as a result of financial or personal relationships with other people or organisations.

References

1 World Health Organization. *Global Health Risks: Mortality and Burden of Disease Attributable to Selected Major Risks*. 2009, World Health Organization, Albany.

2 Rugseth G. *Overvekt som livserfaring: Et empirisk–teoretisk kunnskapsbidrag [Obesity as a life experience: An empirical–theoretical knowledge contribution]* [doctoral thesis] 2011, Faculty of Medicine, University of Oslo, Oslo.

3 Lewis S, Thomas SL, Blood RW, Castle DJ, Hyde J, Komesaroff PA. How do obese individuals perceive and respond to the different types of obesity stigma that they encounter in their daily lives? A qualitative study *Soc Sci Med* 2011; 73: 1349–56.

4 Murray S. *The 'Fat' Female Body*. 2008, Palgrave Macmillan, London.

5 Puhl RM, Heuer CA. The stigma of obesity: a review and update. *Obesity* 2009; 17: 941–64.

6 Spahlholz J, Baer N, König HH, Riedel-Heller SG, Luck-Sikorski C. Obesity and discrimination – a systematic review and meta-analysis of observational studies. *Obes Rev* 2016; 17: 43–55.

7 Karlsson J, Taft C, Ryden A, Sjostrom L, Sullivan M. Ten-year trends in health-related quality of life after surgical and conventional treatment for severe obesity: the SOS intervention study. *Int J Obes (Lond)* 2007; 31: 1248–61.

8 Chen Y, Jiang Y, Mao Y. Association between obesity and depression in Canadians. *J Womens Health* 2009; 18: 1687–92.

9 Bean M, Stewart K, Olbrisch M. Obesity in America: implications for clinical and health psychologists. *J Clin Psychol Med Settings* 2008; 15: 214–24.

10 Pila E, Sabiston CM, Brunet J, Castonguay AL, O'Loughlin J. Do body-related shame and guilt mediate the association between weight status and self-esteem? *J Health Psychol* 2015; 20: 659–69.

11 Kirk SFL, Price SL, Penney TL, Rehman L, Lyons RF, Piccinini-Vallis H, Vallis M, Curran J, Aston M. Blame, shame, and lack of support: a multilevel study on obesity management. *Qual Health Res* 2014; 24: 790–800.

12 Borge L, Christiansen B, Fagermoen MS. Motivasjon til livsstilsendring hos personer med sykelig overvekt [Motivation for lifestyle change in people with morbid obesity]. *Sykepleien forskning* [The Nursing research] 2012; 7(1): 14–22.

13 Dahlberg K. *Att Undersöka Hälsa och Vårdande [To Explore Health and Caring]*. 2014, Natur & Kultur, Stockholm.

14 Throsby K. "There's something in my brain that doesn't work properly": weight loss surgery and the medicalization of obesity. In *Critical Feminist Approaches to Eating Dis/orders* (Malson H, Burns M eds), 2009, Routledge, London, 185–95.

15 Jespersen RM, Xxxx VM. Det sykeliggjorte fettet [The diseased fat]. In *Det Diagnostiserte Livet: Økende Sykeliggjøring i Samfunnet* [The Diagnosed Life: Growing Medicalisation of Society] (Brinkmann S, Holthe MEG, Røen P eds.), 2015, Fagbokforl, Bergen, 211–30.

16 Følling IS, Helvik A-S, Solbjør M. Previous experiences and emotional baggage as barriers to lifestyle change: a qualitative study of Norwegian Healthy Life Centre participants. *BMC Fam Pract* 2015; 16(1): 17.

17 Groven K, Engelsrud G. Negotiating options in weight-loss surgery. *Med Health Care Philos* 2016; 19: 361–70.

18 Merrill E, Grassley J. Women's stories of their experiences as overweight patients. *J Adv Nurs* 2008; 64: 139–46.

19 Natvik E, Råheim M, Andersen JR, Moltu C. Living a successful weight loss after severe obesity. *Int J Qual Stud Health Well-being* 2018; 13(1): 1487762.

20 Groven K, Råheim M, Braithwaite J, Engelsrud G. Weight loss surgery as a tool for changing lifestyle? *Med Health Care Philos* 2013; 16: 699–708.

21 Look AHEAD Research Group. Eight-year weight losses with an intensive lifestyle intervention: the Look AHEAD study. *Obesity* 2014; 22: 5–13.

22 Lier HØ, Aastrom S, Rørtveit K. Patients' daily life experiences five years after gastric bypass surgery – a qualitative study. *J Clin Nurs* 2016; 25: 322–31.

23 Jakobsen GS, Småstuen MC, Sandbu R, Nordstrand N, Hofsø D, Lindberg M, Hertel JK, Hjelmesæth J. Association of bariatric surgery vs medical obesity treatment with long-term medical complications and obesity-related comorbidities. *JAMA* 2018; 319: 291.

24 Groven KS, Råheim M, Engelsrud G. My quality of life is worse compared to my earlier life. *Int J Qual Stud Health Well-being* 2010; 5(4). https://doi.org/10.3402/qhw.v5i4.5553.

25 Rugseth G, Groven KS, Engelsrud G. Nye grep i fedmefeltet[New moves in the obesity field]. *Fysioterapeuten: Tidsskrift for Fysioterapeuter* [Physiotherapist: Journal of Physiotherapists] 2015; 1: 26–7.

26 Samdal GB, Meland E. Helse uansett störrelse [Health regardless of size]. *Tidsskr Nor Laegeforen* [Journal of the Norwegian Medical Association] 2018; 138(4). https://doi.org/10.4045/tidsskr.17.0863, 334-36

27 Tylka TL, Annunziato RA, Burgard D, Daníelsdóttir S, Shuman E, Davis C, Calogero RM. The weight-inclusive versus weight-normative approach to health: evaluating the evidence for prioritizing well-being over weight loss. *J Obes* 2014; 2014: 1–18.

28 Coutinho SR, Rehfeld JF, Holst JJ, Kulseng B, Martins C. Impact of weight loss achieved through a multidisciplinary intervention on appetite in patients with severe obesity. *Am J Physiol Endocrinol Metab* 2018; 315: E91–8.

29 Westland Barber S. *Being Large: An Interpretive Phenomenological Enquiry into the Lived World of Problematic Weight [doctoral thesis]*. 2017, Middlesex University, London.

30 Glenn NM. Weight-ing: the experience of waiting on weight loss. *Qual Health Res* 2013; 23(3): 348–60.

31 Overgaard D. Being obese is paradoxical living: an exploratory study of five persons' lived experiences of being overweight. *Theoria* 2002; 11: 3–12.

32 Merleau-Ponty M, Smith C. *Phenomenology of Perception*, 2nd edn. 2002, Taylor and Francis, Hoboken.
33 Hoeck B, Delmar C. Theoretical development in the context of nursing – the hidden epistemology of nursing theory. *Nurs Philos* 2018; 19: e12196.
34 Delmar C. Beyond the drive to satisfy needs: in the context of health care. *Med Health Care Philos* 2011; 16 (2): 141–9.
35 Delmar C. The phenomenology of life phenomena – in a nursing context. *Nurs Philos* 2006; 7: 235–46.
36 Dahlberg K, Dahlberg H, Nyström M. *Reflective Lifeworld Research*, 2nd edn. 2008, Studentlitteratur, Lund.
37 Van Manen M. *Researching Lived Experience: Human Science for an Action Sensitive Pedagogy*, 2nd edn. 1997, Althouse Press, London.
38 Kvale S, Brinkmann S. *Interviews: Learning the Craft of Qualitative Research Interviewing*, 2nd edn. 2009, Sage, Los Angeles, CA.
39 Malterud K. *Kvalitative Metoder i Medisinsk Forskning: En Innføring* [Qualitative Methods in Medical Research: An Introduction], 3rd edn. 2011, Universitetsforl, Oslo.
40 The World Medical Association. *WMA Declaration of Helsinki – Ethical Principles for Medical Research Involving Human Subjects*. 64th General Assembly Fortaleza, Brazil October 2013. Retrieved from: https://www.wma.net/policies-post/wma-declaration-of-helsinki-ethical-principles-for-medical-research-involving-human-subjects/ (last accessed 8 January, 2019).
41 Ricœur P. *Interpretation Theory: Discourse and the Surplus of Meaning*. 1976, Texas Christian University Press, Fort Worth, TX.
42 Furnes B, Dysvik E. Results from a systematic writing program in grief process: part 2. *Patient Pref Adherence* 2011; 5: 15.
43 Delmar C, Bøje T, Dylmer D, Forup L, Jakobsen C, Møller M, et al. Independence/dependence – a contradictory relationship? Life with a chronic illness. *Scand J Caring Sci* 2006; 20: 261–8.
44 Christiansen B, Borge L, Fagermoen MS. Understanding everyday life of morbidly obese adults-habits and body image. *Int J Qual Stud Health Well-being* 2012; 7: 17255.
45 Merleau-Ponty M, Tin MB. *Øyet og Ånden* [The Eye and the Spirit]. 2000, Pax, Oslo.
46 Leder D. *The Absent Body*. 1990, University of Chicago Press, Chicago, IL.
47 Svenaeus F. *The Hermeneutics of Medicine and the Phenomenology of Health: Steps Towards a Philosophy of Medical Practice*. 2000, Kluwer, Dordrecht.
48 Malterud K, Ulriksen K. Obesity in general practice. A focus group study on patient experiences. *Scand J Prim Health Care* 2010; 28(4): 205–10.
49 Thomas SL, Hyde J, Karunaratne A, Herbert D, Komesaroff PA. Being 'fat' in today's world: a qualitative study of the lived experiences of people with obesity in Australia. *Health Expect* 2008; 11(4): 321–30.
50 Martinsen K. *Fra Marx til Løgstrup: om etikk og sanselighet i sykepleien [From Marx to Løgstrup: About Ethics and Sensibility in Nursing]*, 2nd edn. 2003, Universitetsforl, Oslo.
51 Zahavi D. *Phenomenology: The Basics*. 2019, Routledge, New York.
52 Toombs S. Illness and the paradigm of lived body. *Theor Med* 1988; 9: 201–26.
53 Carel H. *Illness: The Cry of the Flesh*, 3rd edn. 2018, Routledge, New York.
54 Toombs SK. *The Meaning of Illness: A Phenomenological Account of the Different Perspectives of Physician and Patient*. 1993, Kluwer Academic Publishers, Dordrecht.
55 Delmar C, Boje T, Dylmer D, Forup L, Jakobsen C, Moller M, et al. Achieving harmony with oneself: life with a chronic illness. *Scand J Caring Sci* 2005; 19: 204–12.
56 Lincoln YS, Guba EG. *Naturalistic Inquiry*. 1985, Sage, Beverly Hills, CA.
57 Van Manen M. *Phenomenology of Practice: Meaning-giving Methods in Phenomenological Research and Writing*. 2014, Left Coast Press, Walnut Creek, CA.
58 Liamputtong P. *Researching the Vulnerable: A Guide to Sensitive Research Methods*. 2007, Sage, London.