A deeper understanding of service users' needs, self-management support and user involvement in Healthy Life Centres

A qualitative study on lifestyle change in persons with overweight or obesity

by

Elin Salemonsen

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University of Stavanger
NO-4036 Stavanger
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Elin Salemonsen

Summary

Background: Worldwide, including Norway, overweight and obesity present some of the greatest health challenges. Since the 1980s, the incidence has tripled, leading to a subsequent high prevalence of chronic lifestyle diseases or non-communicable diseases (NCDs), such as cardiovascular disorder, diabetes type 2, some types of cancer, muscle and skeleton disorders and mental health challenges. This has led to an increased focus on lifestyle interventions that emphasise self-management of the condition, as well as the need for users to be readily involved and participating. Therefore, self-management support (SMS) and user involvement have become two important concepts in health services in today's society. The Norwegian Directorate of Health recommended the establishment of Healthy Life Centres (HLCs) in all municipalities to help facilitate and empower people to obtain a greater mastery of the health challenges they face. HLCs assist persons at risk of NCDs or those in need of support for health behaviour changes or weight management. Behaviour change refers to efforts to change people's personal habits to prevent disease. The purpose of these self-management interventions is mainly to promote and improve people's physical activity and diets. There is no clear way of addressing overweight and obesity in primary care; knowledge regarding lifestyle interventions in HLCs and what works is still sparse and needs further investigation.

Aim: The overall aim of this PhD-study was to contribute to a deeper understanding of service users' needs, beneficial SMS and user involvement in lifestyle interventions in Norwegian primary care HLCs. The study explored adult service users' and healthcare professionals' (HPs) experiences and perceptions of these phenomena. Three sub-studies were conducted. The aim of the first study was to explore HLC service users' experiences of living with overweight or obesity and their perceptions of seeking help to change dietary and activity habits. The second study aimed to explore service users' experiences of beneficial SMS and user involvement. The aim of the third study was to explore how HPs provide SMS and what user involvement implies for HPs in HLCs.

Methods: This study involved a qualitative, explorative and interpretative design grounded in hermeneutic methodology and tradition. Semi-structured in-depth interviews with service users participating in lifestyle interventions in HLCs were conducted and analysed using qualitative content analysis. A total of 13 service users (five men and eight women), aged 30-69, from five different HLCs, participated (Papers I and II). Focus groups were used to collect data from healthcare professionals working in HLCs and this was analysed using thematic analysis. 10 healthcare professionals from eight different HLCs participated in two focus group interviews (Paper III).

Results: The analysis of the first study (Paper I) resulted in one main theme: *Searching for dignity*, which could be split into two themes: 1) *Needing to justify avoidance of personal responsibility* and 2) *A desire to change*. In the second study (Paper II), one main theme was identified: *Regaining self-esteem and dignity through active involvement and long-term self-worth support in partnership with others.* This main theme comprised four themes: 1) *Self-efficacy through active involvement and better perceived health,* 2) *Valued through HPs acknowledgement, equality and individualised support,* 3) *Increased motivation and self-belief through fellowship and peer support* and 4) *Maintenance of lifestyle change through accessibility and long-term support.* The analysis in the third study (Paper III) resulted in one overall theme: *A partnership based on ethical awareness, a non-judgemental attitude, dialogue and shared responsibility,* comprising four interrelated themes: 1) *Supporting self-efficacy, self-worth and dignity through an attitude of respect, acknowledgement and generosity,* 2) *Promoting self-belief and self-perceived health,* 3) *Collaborating and sharing responsibility* and 4) *Being flexible, adjusting and sharing time.*

Conclusion and implications for practice: A synthesis of the findings in the three papers can provide a deeper understanding of service users' needs, beneficial SMS and user involvement by means of three new themes. The first theme, *The dual face of responsibility in health – the burden and the value* is based on the service user's search for dignity and the emotional alternation between shame, guilt and pride. This duality can be understood as a burden of shame and weight stigma that influence the user's capability to assume personal responsibility. The value can be understood as a perception of dignity, pride, active involvement and assuming responsibility. HPs need to address self-

conscious feelings like guilt, shame and internalised stigma, as well as responsibility related to dilemmas about right and wrong lifestyles. The second theme, *The art of acting ethically* seems to be an integrated attitude of beneficence in HPs' practice and is demonstrated by their capability to engage in a person-centred approach and to see the service users' existential needs in a vulnerable situation. HPs' self-worth support is based on ethical awareness, a non-judgemental attitude, dialogue and shared responsibility. This may help the service users to increase their self-efficacy and self-management and regain their integrity, self-respect and dignity. The last theme, T*he challenges and possibilities in sharing responsibility*, is built on the findings related to HPs treating service users as equal partners in a collaborative partnership based on shared responsibility. The challenges are related to the need for long-term follow-up, emotional and social support, personal responsibility in an obesity-promoting environment and structural and political responsibility. An important therapeutic mechanism in beneficial SMS and user involvement may lie in the possibility of sharing responsibility, which may reduce the burden of personal responsibility, shame, guilt and weight stigma. This may also increase self-efficacy and help service users live a healthier life and experience a better quality of life and wellbeing. Accordingly, there is a possibility of sharing responsibility at a relational level and to highlight collective approaches from a socio-ecological perspective.

Oppsummering

Bakgrunn: En stor del av helseutfordringene som Norge og resten av verden står overfor i dag kan knyttes til en økning i overvekt og fedme. Siden 1980-tallet har forekomsten av overvekt og fedme tredoblet seg, og har ført til økning i livsstilsykdommer, såkalte kroniske ikke-smittsomme sykdommer (NCD), som hjerte- og karlidelser, diabetes type 2, noen typer kreft, muskelskjelettplager og psykiske helseutfordringer. Dette har ledet til et økt fokus mot livsstilsintervensjoner og pasient- og bruker opplæringsprogram som i stor grad vektlegger egenmestring av tilstanden eller sykdommen, samt nødvendigheten av at brukerne selv involveres og medvirker. Brukerinvolvering og støtte til egenmestring er derfor blitt to viktige begrep i helsetjenestene i dagens samfunn. Helsedirektoratet anbefaler etablering av Frisklivssentraler i alle kommuner for å hjelpe og styrke mennesker til en større mestring av helseutfordringene de står overfor. Hensikten med Frisklivssentralen er å hjelpe personer som er i risiko for kroniske lidelser, eller som har behov for støtte ved endring av helseatferd, levevaner eller vekthåndtering. Endring av helseatferd handler om å endre personlige vaner for å forhindre sykdom. Hensikten med intervensjonene er hovedsakelig å fremme og forbedre menneskers fysiske aktivitet og kosthold. Det finnes ingen klar måte å håndtere overvekt og fedme i primærhelsetjenesten, og kunnskap om livsstilsintervensjonene i Frisklivssentralen og hva som virker er fortsatt begrenset og trenger å undersøkes nærmere.

Hensikt: Det overordnede målet i denne avhandlingen var å bidra til en dypere forståelse for Frisklivssentralens tjenestebrukere sitt behov for hjelp, nyttig hjelp til egenmestring og brukerinvolvering i livsstilsintervensjoner. Studien undersøkte voksne tjenestebrukere og helsepersonell sine erfaringer og oppfatninger om disse fenomenene. Tre delstudier ble gjennomført. I den første delstudien var målet å utforske tjenestebrukernes opplevelser av å leve med overvekt eller fedme og å søke hjelp til endring av kostvaner og fysisk aktivitet i Frisklivssentraler (artikkel I). Målet i den andre delstudien var å utforske nyttig støtte til egenmestring og brukerinvolvering for livsstilsendring fra tjenestebrukernes perspektiv (artikkel II). I den tredje delstudien var målet å utforske hvordan helsepersonells utøver nyttig støtte til egenmestring og hva

brukerinvolvering innebærer for helsepersonell som jobber i frisklivssentraler (artikkel III).

Metode: Et kvalitativt, utforskende og fortolkende design med utgangspunkt i hermeneutisk metodologi og tradisjon ble utformet. Semistrukturerte dybdeintervju med tjenestebrukere som har deltatt i livsstilsintervensjonene i Frisklivssentralen ble gjennomført og analysert ved bruk av kvalitativ innholdsanalyse. Totalt 13 tjenestebrukere, fem menn og åtte kvinner i alderen 30-69 år deltok fra fem forskjellige frisklivssentraler (artikkel I og II). Fokusgrupper ble brukt for å samle inn data fra helsepersonell som arbeider i frisklivssentraler, og analysert ved bruk av tematisk innholdsanalyse. 10 helsepersonell fra åtte ulike frisklivssentraler deltok i to fokusgruppeintervju (artikkel III).

Resultat: Analysen av den første studien (artikkel I) resulterte i ett hovedtema: *Søken etter verdighet*, basert på to temaer: 1) *Å ha behov for å rettferdiggjøre unngåelse av personlig ansvar,* og 2) *Et ønske om endring*. I den andre studien (artikkel II) ble ett hovedtema identifisert: *Å gjenopprette selv-respekt og verdighet gjennom aktiv involvering og langvarig støtte fra andre.* Dette hovedtemaet omfattet fire temaer: 1) *Mestringstro gjennom aktiv involvering og bedre opplevd helse,* 2) *Verdsatt gjennom helsepersonells anerkjennelse, likeverdighet og individuelt tilpasset støtte,* 3) *Økt motivasjon og selvtillit gjennom fellesskap med andre deltakere,* og 4) *Opprettholdelse av livsstilsendring gjennom tilgjengelighet og langvarig støtte.* Analysen i den tredje studien (artikkel III) resulterte i ett overordnet tema: *Et partnerskap basert på helsepersonells etiske bevissthet, en ikke-dømmende holdning, dialog og delt ansvar,* som omfatter fire komplementære temaer: 1) *Støtte til mestringstro, selvrespekt og verdighet gjennom en holdning basert på respekt, anerkjennelse og raushet* 2) *Å fremme selvtillit og selvopplevd helse* 3) *Samarbeid og deling av ansvar* og 4) *Å være fleksibel, tilpasse og dele tid.*

Konklusjon og implikasjoner for praksis: En syntese av funnen i de tre artiklene kan gi en dypere forståelse av tjenestebrukernes behov, nyttig støtte til egenmestring og brukerinvolvering ved hjelp av tre nye tema: Det første temaet, *Dobbeltheten i personlig ansvar for helse- byrden og verdien,* er basert på at tjenestebrukene søker etter verdighet og veksler mellom en følelse av skam, skyld og stolthet. Tosidigheten kan forstås som en byrde av skam og

vektstigma som påvirker evnen til å ta personlig ansvar. Verdien kan forstås som en oppfatning av verdighet, stolthet, aktiv involvering og å ta ansvar. Helsepersonell må adressere selvbevisste følelser som skyld, skam, internalisert stigma og verdighet, samt ansvar relatert til riktig og feil livsstil. Det andre temaet, *Kunsten å handle på en etisk måte* ser ut til å være en integrert holdning til velgjørenhet i helsepersonell sin praksis og vises ved deres evne til å ha en personsentrert tilnærming og se tjenestebrukernes eksistensielle behov i en sårbar situasjon. Helsepersonell sin støtte til selvbilde og egenmestring er basert på etisk bevissthet, en ikke-dømmende holdning, dialog og delt ansvar. Dette kan hjelpe tjenestebrukerne til å øke sin mestringstro, bedre egenmestring og til å gjenopprette integritet, selvrespekt og verdighet. Det siste temaet *Utfordringene og mulighetene for å dele ansvar* er bygget på funnene hvor helsepersonell behandler tjenestebrukere som likeverdige partnere i et samarbeid som er basert på delt ansvar. Utfordringene er knyttet til behovet for langsiktig oppfølging og emosjonell og sosial støtte, personlig ansvar i et fedmefremmende miljø og strukturelt og politisk ansvar. En viktig terapeutisk mekanisme i nyttig støtte til egenmestring og brukerinvolvering kan ligge i mulighetene for å dele ansvar, noe som kan redusere belastningen av personlig ansvar, skam, skyld og vektstigma, samt øke mestringstroen og hjelpe tjenestebrukerne til å leve et sunnere liv og opplev bedre livskvalitet og velvære. Følgelig er det muligheter i å dele ansvar på et relasjonelt nivå, men også kollektive tilnærminger i et sosioøkologisk perspektiv må vektlegges.

List of Papers

Paper I

Salemonsen E, Hansen BS, Førland G, Holm AL. Healthy Life Centre participants' perceptions of living with overweight or obesity and seeking help for a perceived "wrong" lifestyle – a qualitative interview study. BMC Obesity 2018; 5:42.

Paper II

Salemonsen E, Førland G, Hansen BS, Holm AL. Service users' experience of beneficial self-management support and user involvement in Healthy Life Centres – a qualitative interview study. Under review.

Paper III

Salemonsen E, Førland G, Hansen BS, Holm AL. Understanding beneficial self-management support and the meaning of user involvement in lifestyle interventions – a qualitative study from the perspective of healthcare professionals. Accepted January 2020, BMC Health Services Research 2020.

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Abbreviations

BMI	Body mass index
COPD	Chronic obstructive pulmonary diseases
CVD	Cardio vascular diseases
FG	Focus group
GP	General Practitioners
HLCs	Healthy Life Centres
HPs	Healthcare professionals
HRQoL	Health related quality of life
MI	Motivational interview
NCDs	Non-communicable diseases
RCT	Randomised control trials
SMS	Self-management support
SMI	Self-management support interventions
T2DM	Type-2 diabetes
WHO	World Health Organization

Table of Contents

Papers I-III

Appendices 1-7

1 Introduction

1.1 General introduction

After 11 years as a public health nurse in primary healthcare, I became a research fellow at Western Norway University of Applied Science (HVL) in 2015. In 2016, I became a PhD student at the University of Stavanger and began this doctoral thesis. Throughout my work as a public health nurse, I experienced complex challenges related to overweight and obesity, weight management and change of dietary and activity habits in children, adolescents and their families. This developed my interest in understanding these challenges better. Overweight and obesity in children, adolescents and adults are dramatically rising worldwide [1], including in Norway [2]. These complex conditions are considered major risk factors for lifestyle diseases, so-called chronic conditions and non-communicable diseases (NCDs) [3]. In primary care, children and adolescents afflicted by overweight or obesity are followed up by the public health nursing service at local health clinics or in-school health services. Adults have traditionally been helped and supervised by their general practitioners (GPs).

According to Henderson [4], there is no clear way to address obesity in primary care. In Norway, primary care has increased its preventive services, a position supported by the Norwegian Government and the World Health Organization (WHO). Various laws and regulatory documents have created the opportunity for, and helped to facilitate, people to be empowered to a greater mastery of the health challenges they face. The Public Health Reports, *Good health – a shared responsibility* [5] and *Mastering and opportunities* [6], emphasise health as a resource in everyday life and place an increased, positive focus on lifestyle changes. The Public Health Act [7] is an important tool for achieving the intentions of the Coordination Reform [8], to ensure sustainable welfare for the future through increased focus on prevention

and public health. An important way to control NCDs is to focus on reducing risk factors associated with these diseases and to monitor progress in NCD risks for guiding policies and priorities. Both the WHO Action Plan [9] and the Norwegian NCD strategy [10] highlight the need for preventing NCDs. These documents show the direction of public health work in the primary healthcare services in municipalities. The epidemiological shift from acute to chronic illness and the increased commitment to improving public health have led to the initiation of patient and user education programmes or self-management support interventions (SMI). Obesity is particularly associated with increased use of healthcare services and healthcare providers are likely to benefit from implementing interventions to combat obesity [11]. In Norway, there has been an increasing focus on interventions to prevent and control NCDs [5, 7, 10, 12-14]. This has resulted in recommendations to all Norwegian municipalities on establishing Healthy Life Centres (HLCs). These provide help and support for coping with health-related challenges and provide support for changing living habits, with a main focus on dietary and physical activity changes [13].

HLCs and learning and mastering courses are relatively new concepts for health promotion in primary healthcare in Norway. New interventions often need more research to highlight their potential effects. This thesis addresses self-management support (SMS) and user involvement in lifestyle interventions for adults, delivered by HLCs in Norwegian primary healthcare. The study specifically explores the services users' need for support, beneficial SMS and user involvement for persons afflicted by overweight or obesity seeking help to change their lifestyle. In this study, lifestyle change is understood as changing dietary and activity habits, and does not concern smoking cessation.

In the following paragraphs, there will be a presentation of overweight and obesity and its prevalence and health risks, to describe the problem area and phenomenon under exploration. A description of lifestyle interventions offered in HLCs and their historical and organisational

development will be presented to contextualise this study. This will be followed by an overview of previous research from HLCs and this study's aim and research questions.

The public health perspective, including health promotion and illness prevention, as well as the holistic and humanistic approaches and perspectives, will be presented in the first chapter concerning the theoretical and conceptual framework. The concepts of user involvement, the service users' needs and SMS will be presented in the second chapter concerning the theoretical and conceptual framework, to avoid repetition. Traditional treatment and the effect of interventions in overweight and obesity treatment will be presented to give an overview of some of the knowledge in the field. This will not include surgical and medical or pharmacological treatment.

1.2 Background and problem area

1.2.1 Overweight and obesity – its prevalence and health risks

Worldwide, more than 1.9 billion adults are overweight and 650 million of these have obesity [1]. In Norway, 21% of women and 25% of men in their forties have obesity and over 50% are overweight, including obesity [2]. The worldwide prevalence of obesity nearly tripled between 1975 and 2016. The fundamental cause of overweight and obesity is described as an energy imbalance between calories consumed and calories expended [1]. Complex interactions between biological, behavioural, social and environmental factors are involved in the regulation of energy balance and fat stores [15]. Obesity is not simply a problem of will power or self-control, but a complex condition involving energy metabolism and appetite regulation [16]. Obesity is also associated with unemployment, social disadvantages and reduced socio-economic productivity, thus increasingly creating an economic burden [17].

Overweight and obesity are defined as abnormal or excessive fat accumulation that may impair health. Overweight is a body mass index (BMI) greater than or equal to 25, and obesity is a BMI greater than or equal to 30 [1, 18]. Overweight and obesity are major risk factors for a number of chronic diseases or NCDs, including type-2 diabetes (T2DM), cardiovascular disease (CVD), chronic obstructive pulmonary disease (COPD), some types of cancer and musculoskeletal disorders, with serious social and psychological dimensions [2, 3, 19]. These negative health consequences are well documented [20]. NCDs are one of the major health challenges of the 21st century; they shorten life-expectancy [20] and represent 71% of all deaths globally [3]. The high proportion of health services devoted to chronic diseases reflects the shift from acute to chronic illness as the major cause of health problems. Overweight and obesity have become significant national and international health concerns that place an extensive burden on healthcare services worldwide [1, 3, 21-23].

The risk of NCDs has primarily been driven by tobacco use, physical inactivity, unhealthy diets and harmful use of alcohol [3]. In Norway, like other parts of the industrialised world, there has been a change in the global food system, with increased access to high-energy food and a more sedentary lifestyle due to urbanisation, social changes, technological development and advancement [2, 17, 24]. Population-inactivity presents a major public health problem [20]. Physical inactivity is responsible for 9% of premature mortality rates; an increase in physical activity could substantially improve health [20] and increase quality of life [25].

Whether the responsibility to change these trends lies with the individual, healthcare professionals (HPs) or policy makers, is debated [17, 26-28]. Lifestyle change is difficult; however, it is not just individual behaviour that leads to these epidemics. Behaviours take place in a biological and social environment. Efforts to change these must take account of the social context and the political and economic forces that act directly on

people's health, regardless of any individual choices they may make [29]. One effective actions might be a policy change that facilitates individual choices for foods that have reduced fat, sugar and salt contents [17].

There is a dominant view that overweight and obesity is a matter of personal responsibility [30, 31], as well as alternative conceptions that consider obesity as determined by biological factors within an individual or as resulting from features of the broader environment [31]. Personal responsibility for eating healthy food and engaging in physical activity is traditionally seen as the important determinant for weight status [27, 28, 31]. When individuals experience failure in the ability to lose and maintain weight, personal responsibility becomes associated with a failure in personal willpower [27]. Studies of how service users and patients present themselves or position themselves in lifestyle change programmes show that people are trying to construct an ethical self by acting in line with the norms of lifestyle change, acting in compliance with the aims of the course and positioning themselves as morally accepting individuals [32]. Patients in clinical dialogue about lifestyle issues represent themselves with an orientation toward responsibility and honour of achievements. In problematic situations, when they were not doing well, some patients revealed shame for not acting as responsible persons [33].

The challenges related to overweight and obesity imply self-blame and shame [28, 31, 34]. Some individuals with obesity are blamed for their weight and many experience weight stigma (anti-fat stigma, weight-bias) [31, 34, 35]. Victim blaming, moral condemnation and the logic of motivating people to comply with official health guidelines by moralising behaviours and promoting the internalisation of weight-based stigma is highly questionable [36, 37]. Numerous studies have documented harmful weight-based stereotypes – that overweight and obese individuals are lazy, lack self-discipline, have poor willpower are unsuccessful, unintelligent and are noncompliant with weight-loss

treatment [28, 34, 38, 39]. These stereotypes give way to stigma, prejudice and discrimination against obese persons in multiple domains of living, including healthcare facilities, the workplace, educational institutions, the mass media and even in close interpersonal relationships [38]. Weight stigma affects coping behaviours and is a fundamental cause of population health inequalities [40]. Weight stigma adds both psychological and physiological stress to people who are considered obese [34, 38, 41-43], which threatens their health, generates health disparities and interferes with effective intervention efforts [38, 40, 42, 44, 45]. Weight-bias internalisation affects wellbeing and weight-related quality of life [37, 46] and is positively associated with body-image concerns, poor self-esteem, depressive symptoms and stress [47]. Stress and having a stigmatised body can affect physical health by affecting cortisol secretion and stimulating the production of biochemical hormones and peptides, such as leptin and ghrelin. Stress is connected to obesity and interferes with cognitive processes, such as executive function and self-regulation; it affects overeating and high-calorie food consumption, decreases physical activity and shortens sleep [43]. A vicious cycle of stress to obesity to stigma to stress is described [41, 43].

Many healthcare providers hold strong negative attitudes and stereotypes about people with obesity [48]. These attitudes may influence the care they provide and may cause stress and avoidance of care, mistrust of HPs and poor adherence to interventions. Stigma can reduce the quality of care for patients with obesity, despite the best intensions of HPs to provide high quality care [48, 49].

1.2.2 The Norwegian Healthy Life Centres (HLCs)

The first HLC was established in Modum municipality in 1996. In 2004, the Directorate of Health cooperated with several county municipalities in developing different models for referral and follow-up interventions for support in changing living habits (physical activity, diet, smoking-cessation). In 2008, 42 municipalities had established HLCs. In 2012 the

Norwegian government introduced a new Public Health Act and emphasised municipalities and local governments taking responsibility for public health, with the intention to promote health and prevent development of NCDs. All municipalities were recommended to establish a HLC. The first guidelines for HLCs were published by the Directorate of Health in 2013 and updated in 2016 [13]. By 2018, 263 municipalities had established a HLC [50].

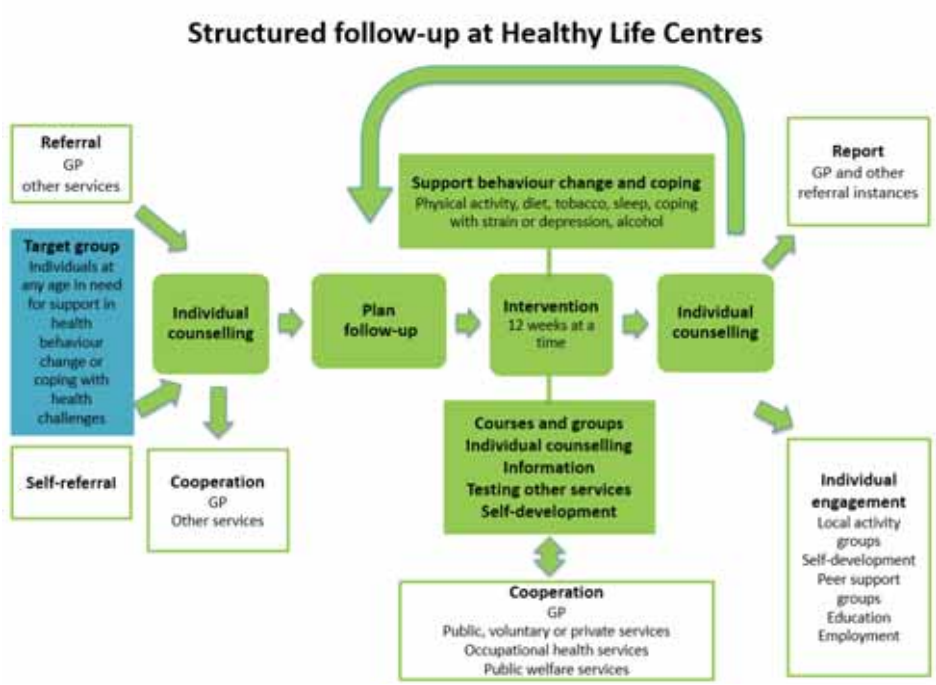

Figure 1. Structured follow-up at HLCs [13, 51]

HLCs are part of public healthcare services in municipalities and the interventions have a person-centred approach aimed at strengthening the individuals' control of their health. A HLC is an interdisciplinary primary healthcare service that offers effective, knowledge-based measures for people with a high risk of disease, who need support in health behaviour change and in coping with health problems and chronic

diseases [13]. The healthcare service offered at HLCs is part of the overall learning and mastering services in municipalities. The purpose of HLCs as a healthcare service is to support lifestyle change and promote self-management in people's everyday lives, where they live. The interventions offered have a salutogenic foundation [52], using motivational interviewing (MI) as one of the conversational approaches [13]. These behavioural interventions aim to help patients and service users better manage their own conditions (self-care) and healthcare needs [21, 53-57]. The purpose is to promote and improve people's physical activity, diet and behaviour – efforts to change people's personal habits to prevent disease [13]. Participation is not based on BMI measurements. This low threshold service is easily accessible through direct contact or by referrals from e.g. GPs.

Healthcare professionals working in HLCs include physiotherapists, public health nurses, psychiatric nurses, nutritionists and other providers (e.g. bachelor's in public health) who provide support through a structured follow-up programme of intervention. The initial health conversation, as part of the intervention, is based on the participant's perception and understanding of the challenges they are seeking help for. Individual goals are set in collaboration between the service user and the HP. Thereafter, HLCs offer group-based healthy diet courses and/or physical activity sessions (see figure1, p.7). The healthy diet course consists of four to five two-hour sessions with theory and practical tasks (including cooking and reading nutritional content declarations). Information on healthy diets and nutrition are provided. These courses focus on increasing the users' awareness of their habits, their own resources and making small steps. Relapse prevention and strategies are also discussed. Physical activity in the form of group-based indoor and outdoor activities is offered two to three times a week. If desired, individual health conversations and counselling is also available [13]. The organisation of the HLC differs between the various municipalities and small communities often have inter-municipal cooperation that

enables service users to attend courses across municipal boundaries. An intervention lasts for three months, with the possibility to extend it on three occasions. However, this is practiced differently in the various municipalities. The purpose of HLCs is to enable service users to maintain changes and continue with activities after the follow-up at the HLC has been completed, as well as encourage and guide participants to take part in feasible local activities in the municipality [13].

Many HLCs also offer counselling, support and education on issues related to mental health, sleep and alcohol. Within a municipality, the HLC functions as a resource, knowledge and contact centre for behaviour change, health promotion and disease prevention. Cooperation with other municipal healthcare services, hospitals, non-governmental organisations, private and public organisations and local authorities is of vital importance to provide continuous and integrated healthcare and help people establish independent and lasting health-enhancing habits [13].

HLCs are still new at delivering educational self-management interventions in Norwegian primary care and the scientific evidence and understanding of how HLCs work is sparse. In the following sections, an overview of research from HLCs will be presented.

1.2.3 Previous research in Norwegian HLC lifestyle interventions

On commencing this PhD project in 2015, very few studies on HLCs in Norway had been conducted and published. No studies describing beneficial SMS were found and research on user involvement in lifestyle interventions or weight management programmes in HLCs was also lacking.

A prospective study from 2013 found that participation in a group-based prescribed exercise programme for three months may improve physical

fitness and health-related quality of life (HRQoL) significantly, in both the short and long term [58]. A cross-sectional study in HLCs from 2014 found that exercising with others was the most frequent reason for increased self-activity. Participants with increased activity levels reported better physical health and a greater degree of interest and follow-up by the referent, often a GP [59]. An explorative study on HLC participants' backgrounds, experiences, reflections and descriptions of previous life experiences in relation to lifestyle changes was published in 2015 [60].

Eventually, more papers were published. In 2016, a paper on stakeholders' expectations concluded that HLCs are still a concept in development; they are trying to find their position in the public healthcare system [61]. In 2017, a study of HLC participant characteristics was published [62] and in 2018, one RCT of physical activity interventions in HLC primary care found that less active persons at baseline benefitted more from HLC intervention. However, they questioned whether HLCs and the emphasis on behaviour change on an individual level is a way of targeting general health and risk reduction at a population level [63].

Sagsveen et al. [64, 65] published two papers in 2018 exploring user involvement in HLC consultation, from both service user and HP perspectives. These studies do not describe or specify whether this involvement applied especially to people with overweight or obesity. However, one might assume that this is one of the reasons for seeking help at a HLC. Inclusion criteria were persons participating in individual health consultations, physical activity groups and/or diet courses. These explorative studies showed that respect, trust and continuity were essential. The service users felt their involvement led to trusting relationships, feeling ownership and responsibility through personal goal setting, trusting the professionals' decisions and experiencing involvement in group activities [65]. HPs described user involvement at an individual level as involving the users through MI, building a trusting

relationship, assessing and adjusting to the user's needs and life situation and strengthening the user's ownership and participation in the process of lifestyle change [64]. These results are similar to characteristics of SMS [53] and confirm the close relationship between user involvement and SMS.

User involvement is said to lead to better services and improved outcome [66, 67], and is enshrined in the Patients` and Service Users` Rights Act [68]. Service users' experiential knowledge is valued because it seems to provide information that will improve delivery of care. However, research on user involvement on effectiveness and quality is limited and there is a need for debate on the purpose of user involvement and what it means for whom [69]. Exploring beneficial SMS and user involvement in HLCs can be necessary for quality, improved effectiveness and guided approaches to lifestyle change support for overweight and obesity. There seem to be a need to develop effective interventions to support lifestyle change. There is also a need for more knowledge and understanding of what service users need, how they are involved in the process of lifestyle change (the significance of user involvement) and what and how the service users are best supported and helped (beneficial SMS). There is a lack of knowledge and understanding from the view of HPs in Norwegian HLCs, including how they create joint relationship with service users, how they promote user involvement and provide SMS for persons afflicted by overweight or obesity and what user involvement implies for HPs in HLCs. This knowledge-gap constitutes the rationale for this study.

1.3 Aims and research questions

The overall aim of this PhD-study was to contribute to a deeper understanding of service users' needs, beneficial SMS and user involvement in lifestyle interventions in Norwegian primary care HLCs, by exploring and interpreting service users' and HPs' experiences and

perceptions of these phenomena. The purpose of this study was to contribute to new empirical knowledge and understanding relating to the significance of user involvement and SMS for lasting lifestyle changes and how HPs can facilitate and provide a high quality healthcare service. Hopefully, this research will have implications for practice in primary care and the future development of HLCs, as well as interventions aimed at addressing the serious social, psychological and physiological health challenges that overweight and obesity may cause. Three sub-studies were performed, related to the overall aim and specific aims:

- To explore service users' experiences of living with overweight or obesity and their perceptions of seeking help to change dietary and activity habits (Paper I).
- To explore beneficial self-management support and user involvement for persons afflicted by overweight or obesity attending lifestyle interventions in Norwegian Healthy Life Centres (Paper II).
- To explore how healthcare professionals provide self-management support and what user involvement implies for healthcare professionals in Healthy Life Centres (Paper III).

The following research questions guided the study:

1. How do service users participating in lifestyle interventions in HLCs experience living with overweight or obesity?
2. What are the service users' perceptions of seeking help to change dietary and activity habits?
3. What do beneficial SMS and user involvement imply for persons afflicted by overweight or obesity attending lifestyle interventions in HLCs?
4. How do HPs in HLCs provide SMS in lifestyle interventions for persons afflicted by overweight or obesity?
5. What does user involvement imply for the HPs in HLCs?

2 Theoretical and conceptual framework

The general theoretical perspectives and approaches in this study are based on public health, including health promotion and disease prevention. This is in accordance with my theoretical and practical background as a public health nurse. A holistic approach to human existence, including a person-centred approach and beneficence, and a socio-ecological view of health is adopted. This is in line with WHO's definition and understanding of public health and health promotion [70, 71]. The theoretical perspective of public health will be presented first, including humanistic and socio-ecological approach to health, as well as health promotion and disease prevention and empowerment. This will be followed by a presentation of the main concepts of this thesis. This includes the concepts of user involvement, service users' needs and SMS (including self-management and self-efficacy). Each will be followed by relevant national and international research on user involvement in lifestyle interventions, service users' needs and SMS interventions in lifestyle change. Both theoretical and conceptual frameworks are used in this thesis to interpret and understand the findings.

2.1 Public health perspective

This study uses a public health perspective and a socio-ecological approach to health. Public health is defined as 'the science and art of promoting health, preventing disease, and prolonging life through the organized efforts of society' [71] (p.1). Public health is a social and political concept aimed at improving health, prolonging life and improving the quality of life among whole populations, through health promotion, disease prevention and other forms of health interventions. Public health should ensure that society creates conditions that allow the attainment of health by all its members [71]. From the beginning of the 19th century until the 1950s, there was a shift in the disease panorama from infectious diseases towards chronic diseases (or NCDs). In the mid-

1980s, WHO presented strategies towards combatting NCDs and the Ottawa Charter [70] was the first international political document for promoting health and the foundation for the new public health (NPH) movement. This movement emphasises psychosocial, humanistic and holistic views and values rather than a biomedical approach [72]. The fundamental policy of NPH involves self-care by the individual and community, as well as national and local governments being responsible for the health and wellbeing of society, voluntary organisational and private sectors, and the need to address health inequalities [72, 73].

2.1.1 Humanistic, ethical and socio-ecological approach to health

The NPH movement emphasises social and ecological holistic approaches to health and health promotion [72]. Humanistic psychology emphasises understanding the individual on their own terms, where experiences, perceptions, values and choices have a central position. Humanistic psychology is inspired by existentialism and phenomenology. Rogers and Maslow, together with Satir, are often seen as the founders of this movement. Phenomenological psychology emphasises a person's descriptions of themselves and the environment, and the psychological perspective has adopted a holistic approach to human existence [74]. Person-centred approach has long associations with nursing, with a focus on treating people as individuals, respecting their rights as human beings, building mutual trust and understanding and developing a therapeutic relationship [75]. Healthcare should be coherent and based on each individual's comprehensive needs. The focus should be on people's abilities, and empowering and engaging the person as an active partner in their care and treatment [76, 77]. HPs should always work from an ethical perspective and approach patients with dignity, compassion and respect [78]. Rogers [79] described person-centred therapy as necessary for establishing a psychologically therapeutic environment, in which a person feels free from threat, both

physically and psychologically. The therapist must be able to listen with understanding and empathy, be accepting and genuine and having a positive approach. This is an important and often crucial factor in motivating change and development [79]. The benefits of person-centred care are evident, presenting a major opportunity for improving health outcomes [80].

Providing healthcare and support implies being reflexive and acting ethically [78]. Beneficence is a concept in moral and ethical philosophy and theory and a relevant aspect in this study. Morality require us to treat people autonomously, avoid harming them and contribute to their wellbeing. The principle of beneficence refers to the moral obligation to act for the benefit of others. There is an implicit assumption in all medical and health care professions and healthcare institutions to act in beneficence [78]. As HPs, entering a profession and taking on professional roles, we have an obligatory duty and responsibility to act in beneficence. We are morally prohibited by rules of nonmaleficence from causing harm to anyone at all times. Preventive medicine and public health research embrace values of public beneficence [78].

A socio-ecological approach and understanding of health and health promotion can be found in Bronfenbrenner's ecological model and theory of development [81]. This theory explains how the individual is part of a larger ecological system and how interactions between systems from the micro-level (the individual) to the macro-level (culture and society) influence each other in all aspects of life [81].

2.1.2 Health promotion and disease prevention

The first international conference on health promotion in 1986 presented the primary source for health promotion and a charter for action to achieve health for all [82]. The Ottawa Charter defines health promotion as 'the process of enabling people to increase control over and to improve their health… Health is created and lived by people within the setting of

their everyday life; where they learn, work, play and love' [70]. Health involves caring for oneself and others and is seen as a resource for everyday life. Health is a positive concept emphasising social and personal resources and goes beyond healthy lifestyles to include wellbeing. An individual or group must be able to make decisions and have control over their life circumstances, to change or manage the environment and identify and realise their desires to satisfy their needs [70]. The Ottawa Charter has five action areas in health promotion. These include building healthy public policy, creating supportive environments, strengthening community actions, developing personal skills and reorienting health services. Four of these action areas are structural matters. The fifth action area – developing personal skills –has an individual orientation [70, 82]. According to Nutbeam, developing personal skills is important for people's opportunity to participate and to be empowered [71, 83]. In 2009, WHO decided to replace the term 'personal skills' with 'health literacy' and 'health behaviour' [84]. Empowerment, user participation and involvement, equity, justice and a holistic approach – including social, cultural, political, ecological and environmental factors – are guiding principles in health promotion [71].

'Disease prevention covers measures not only to prevent the occurrence of disease, such as risk factor reduction, but also to arrest its progress and reduce its consequences once established' [71] (p.4). Rose [85] made a distinction between high-risk strategy and population strategy in disease prevention and described the 'prevention paradox' as a contradictory situation. That is, the number of people at high risk of a disease is small and only a minority of cases come from the high-risk population. The majority of cases of a disease come from the population at a low or moderate risk of that disease, where the number of people is high [85]. Fundamental differences between health promotion and disease prevention is described, where the latter has a basis in biomedical and natural science [86].

2.1.3 Empowerment

The concepts of empowerment and user involvement seem to have the same origin and are intertwined, as people are empowered through user involvement and participation [87]. In health promotion, empowerment is defined as 'a process through which people gain greater control over decisions and actions affecting their lives'[71] (p.6). Empowerment is a fundamental value and goal in health promotion [71] and is recognised by WHO and health agencies as a core concept in health promotion, integral to the achievement of social equity [88]. 'Empowerment may be a social, cultural, psychological or political process through which individuals and social groups are able to express their needs, present their concerns, devise strategies for involvement in decision-making, and achieve political, social and cultural action to meet those needs' [71] (p.6).

One of the most famous and quoted authors in terms of empowerment is Freire. He discusses a mutual and open-minded dialogue about being a subject in one's own life and not a powerless object [89]. Freire sees empowerment both as a process and as a goal. It is a process when the purpose of a teaching intervention, such as information on healthy and good food, increases the person's ability to think critically and act autonomously. Healthy choices are facilitated through knowledge. Empowerment is a goal when an experience of increased self-efficacy occurs as a result of the process [89]. Participants find that they are able to choose healthier food types or they experience skills in implementing and conducting increased activity. According to Freire, raising awareness and focusing on the individual's own responsibility for changing their life situation is necessary. Individuals who do not feel personal responsibility for their problems will not endeavour to find solutions to them [89]. Relating this to lifestyle interventions that offer help and support to change health behaviour, healthcare providers need to contribute so that participants themselves become conscious and aware of what must be done before change can occur.

Askheim [90] describes that the term empowerment accommodates both an individual and a structural dimension. The individual addresses processes that aim to increase their control over their own life, their self-esteem and their skills and knowledge, so that they can identify barriers themselves. The structural dimension includes barriers, power relationships and social structures that maintain inequality, injustice and the lack of ability to take control of their own lives. The key to empowerment is to see the connection between the life situation that the individual is in and the problem the person has on one hand and the social or structural relationships on the other. If there is a one-sided emphasis on individual aspects, it may mean that the collective, system-oriented and political aspects of the empowerment process are not taken into account [90]. Malterud [91] suggests that the prevailing meaning of educational empowerment should be questioned. Within an empowerment framework, the responsibility of the healthcare provider is to recognise the suffering of patients, identify their strengths and prevent further marginalisation due to power inequality. Social structures and healthcare policy may neglect the power inequalities by determining the distribution of risk factors and the moral pressure of well-intended lifestyle advice, as opposed to the original notions of empowerment [91].

2.2 User involvement

Empowerment and user involvement are both central elements in health promotion [71]. User involvement is connected with the disciplines and discourses of political philosophy, power and democracy and of citizenship rights and responsibilities [67, 92]. In the 1980s, a new focus for participation reflected the desire to move away from service- or provider-led public provision to more user-centred and user-led services. User involvement became the unifying idea underpinning this development. By increasing user involvement, it would be possible to move beyond traditional top-down paternalistic approaches associated with the welfare state, to a more user-centred provision [92]. It is

universally acknowledged that patients and users should be involved in their own care [66]. A fundamental problem affecting user involvement and participation is that the terms tend to be poorly defined and carelessly used; treated in isolation as technical rather than ideological matter [92]. However, participation and user involvement are far from value-free. The ideology underpinning them is unclear and disputed and there is a need to understand user involvement in the political, ideological, cultural and historical contexts [92].

SMI and patient education is undergoing a paradigm shift, whereby patient perspectives are increasingly incorporated into learning programmes. Dialogue and collaboration between service providers and users is essential for effective user involvement and access to users' experiences is now considered a prerequisite for the development of quality health services [66, 93]. Patient involvement in managing chronic conditions (e.g. lifestyle change) is, for some people, synonymous with Lorig's work on structured self-management training programmes focusing on building patients' self-efficacy [57, 66]. According to Greenhalg, this gave rise to the concept of the 'expert patient' [66].

Askheim [90] states that empowerment thinking challenges the professional's traditional authority and power position. Professionals who want to work from an empowerment perspective must be willing to redefine their traditional expert role to become a resource that works on the user's premises [90]. Patient involvement in European healthcare is characterised in three terms: voice, choice and co-production [94, 95]. In user involvement, the term 'co-production', which may be the ideal and which, according to Askheim [96], has been widely spread in Western world health policy, means the patient must co-produce the health service individually and/or collectively with healthcare professionals. Askheim poses some questions for this new concept of user involvement that has been incorporated into Norwegian government documents, including whether it obfuscates or revitalises the empowerment

perspective, or whether it is a concealment of power relations [96, 97]. In this study, user involvement is characterised in terms of the co-production of healthcare services [94, 95] and understood as a clinical partnership between service users and HPs [66].

Greenhalg [66] argues that we need a wider approach in patient involvement, to go beyond the expert patient model and construct an ecological model for supported self-management of chronic conditions and to embrace a more holistic model that considers a person's family, social and political contexts [66]. An ecological model or understanding like this is also seen in Bronfenbrenner's theory [81] and in collectivistic perspectives, which highlight the understanding that individuals are part of social groups and social systems [98]. An ecological approach in diabetes self-management helped identify key resources and supports for self-management, including individualised assessment, collaborative goal setting, skills enhancement, follow-up and support, access to resources and continuity of quality clinical care [99].

Collaborative care models, such as patient-centred care, shared decision making, recovery and patient participation incorporate user involvement and patients' perspective on their treatment and care [100]. There is limited empirical research about the effectiveness of these models. There are also issues related to the person's capacity for user involvement, the role patients wish to play in decision-making and the lack of competence and awareness among providers (mental care) [100]. User involvement and participation are incorporated in the municipal healthcare services and the rights of patients and service-users to participate in issues regarding their health are provided for in the Patients' and Service Users Rights Act [68].

Patients have a legal and moral right to autonomy and self-determination [66, 68, 78]. In HLCs, user participation on both the individual healthcare and system levels should be safeguarded and implies active

participation from the service users [13]. Patient and public involvement in hospital (somatic and mental) healthcare is founded on mutual respect achieved through dialogue and shared decision-making [101, 102]. However, service users and HPs assign different values to its aspects [69, 102]. What user involvement means for service users in SMI, like the lifestyle interventions in HLCs, is not clear. Therefore, this study aims to explore what user involvement imply for service users and HPs in HLCs.

2.2.1 Research on user involvement in lifestyle interventions

Research on user involvement in lifestyle interventions or weight management programmes is sparse in primary care, and no studies have been found in relation to the significance of user involvement in adults afflicted by overweight or obesity. One study on user involvement in planning, implementing and evaluating a weight management programme for antenatal women with obesity was found [103]. A Study of user involvement in patient education in hospitals show that the collaboration between the users and HPs takes place in an asymmetric relationship, and the relationship was based on knowledge sharing (participant engagement and dialogue) and information exchange (absence of dialogue) [93]. In a study of user involvement in community mental health care, both service users and HPs reported that service user involvement had a positive impact [104]. Studies of user involvement in HLCs are described in the introduction chapter [64, 65].

2.3 The service users' needs

Service users' needs are the characteristics and needs of the person seeking help to change their lifestyle or to lose weight. A person-centred practice and approach may be useful for understanding the concept of both the service user's need for support and as a part of user involvement and SMS, as well as a humanistic view of health and care. To be able to

help and provide support, it is important to know the person behind the service user.

2.3.1 Research on service users' needs

A lack of literature in the field of service users' needs in overweight and obesity makes it necessary to include studies from general lifestyle counselling and other chronic conditions. These studies show that lifestyle counselling from GPs in a primary care practice underscores the necessity of a patient-centred approach. This includes exploration of patients' lifeworld, advice adjusted to concrete life situations, a good relationship with time to listen and personalised care with friendliness and openness where emotions were acknowledged. The patients emphasised the need for time and repeated consultations [105]. In a study of what coronary heart disease patients perceive as a good patient educator, individualisation to patients' needs and contexts is important, as well as the capacity to build a trustworthy relationship. Building trust was dependent on the patients perceiving the educator to be knowledgeable, to treat people with respect and equality and be good at connecting with the individual patient [106].

Reasons and motives for lifestyle changes and weight loss may reflect psychological differences that have an impact on successful weight loss. This may also provide insight into potential barriers for achieving weight loss success [107, 108]. Until the start of this project in 2015, only one previous study on HLCs has explored the background (characteristics), experiences and reflections of participants seeking help to achieve lifestyle change in HLCs. This study shows that the service users felt stuck in their old habits and had substantial emotional baggage. The service users found it difficult to initiate and manage lifestyle change without help and supervision and wished for emotional support [60].

Factors such as health concerns, past dieting success, self-reported weight status or BMI, self-esteem and body image may be important in

tailoring dietary and psychological elements to the individual [107, 108]. Some studies describe health risks, comorbidities and high BMI as a reason for seeking help [60, 61, 107]. In a previous study of reasons for wanting to lose weight, appearance (35%), health (50%) and mood (15%) emerged as categories [107]. High BMI was correlated with more total perceived barriers, such as the feeling of being too heavy or the fear of being treated unfairly or badly [108]. Experiences of or expectations of poor treatment may cause stress and avoidance of care, mistrust towards doctors and poor adherence among patients with obesity [48]. People need help to achieve lifestyle changes because they find it difficult to manage on their own [29, 109, 110]. Findings provide initial evidence that overlooking psychosocial factors, such as weight stigma, may hinder weight-loss maintenance and hamper help-seeking [48, 49, 111]. The implications for addressing emotional distress and stigma in overweight and obesity-focused clinical interventions are highlighted [60, 112].

Newly available studies describe characteristics and needs in persons seeking help to achieve lifestyle change. In 2018, Samdal et al. [62] published a paper on the characteristics and needs of HLC participants. The most frequent reasons given for attendance at HLCs were being overweight, increasing physical activity, improving diet and having musculoskeletal health challenges [62]. Evans et al. [113] claim that there is a lack of research into overweight and obese participants' characteristics and the weight management practices of these patients. 62% of the participants in their study were actively trying to lose weight. Only 20% had sought GP support for weight loss, with most efforts to lose weight being self-guided. Those who sought support from their GP were likely to use it and found it motivating. Participants had attempted weight loss on multiple previous occasions and, overall, felt less confident and successful at maintaining weight loss than losing weight. They lacked the understanding of effective strategies to do so. Participants with higher BMIs and more health conditions (those at

greatest clinical risk) reported low confidence and multiple barriers, but were highly motivated to lose weight and keep it off [113].

2.4 Self-management support (SMS)

SMS aims to equip service users and patients with the necessary information and skills to manage their own healthcare (independency), maintain optimal health and minimise the consequences of their conditions [13, 53, 54, 57]. The purpose of HLCs is to establish independent and lasting health-enhancing habits and to guide the participants into suitable local programmes that they can continue with on their own after the participation period has ended [13]. Self-management is defined as 'an individual's ability to detect and manage symptoms, treatment, physical and psychosocial consequences, as well as the lifestyle changes inherent in living with a chronic condition' [114] (p.178).

Health literacy is a useful concept for understanding health and people's personal resources. The 7th Global Conference on Health Promotion [84] highlight health literacy as critical to empowerment. Improving people's access to health information and their capacity to use it effectively to promote and maintain good health is important [84]. This is supported by Kickbusch et al. [115] who incorporate empowerment into people's daily lives and define health literacy as ´the ability to make sound health decisions in the context of everyday life – at home, in the community, at the workplace, in the health care system and in the political arena. It is a critical empowerment strategy to increase people's control over their health, their ability to seek out information and their ability to take responsibility` [115] (p.8).

SMS approaches emphasise a clinical partnership and collaborative care, promote service users identifying and achieving realistic goals and teach problem-solving skills [53, 116]. SMI is also described as patient education intervention, health education intervention, behaviour change

intervention, a lifestyle education programme, an educational programme, self-management education [57] or therapeutic patient intervention (TPE) [54]. Other terms used are interventions to promote self-efficacy and coping [117]. According to Bodenheimer [53], self-management education focuses on self-management skill development, while SMS and SMI describe clinicians reinforcing self-management skills to encourage daily decisions that improve health-related behaviours and clinical outcomes [53]. The potential benefit of SMS includes quality care tailored to the service users' preferences and situation [118]. Self-management may be one means of bridging the gap between patients' needs and the capacity of healthcare services to meet those needs [114]. SMI in primary healthcare has been one option used to enhance positive outcomes in chronic disease management, including overweight and obesity [119]. However, there is sparse knowledge related to SMS in overweight and obesity interventions [113, 120, 121]. There is also a lack of clear reflection on what, how and why patient education works [122].

Raising self-efficacy, an individual's belief in their ability to manage different tasks [123], is one key goal of SMS and educational interventions for persons living with chronic conditions [53, 57]. The desired outcome of SMS is behavioural change [116]. Self-efficacy is related to what a person believes they can manage; expectations of efficacy determine the initiation and sustainability of behaviour [123]. Self-efficacy focused interventions are highlighted in diabetes interventions [124] and are one of the best predictors or psychological mechanisms for successful outcomes in obesity-related lifestyle change interventions [125].

2.4.1 Research on self-management support interventions (SMI) in overweight and obesity treatment

Lifestyle interventions are named differently and patient education interventions and SMI can be used interchangeably, as described above. Very few studies describe the full intervention content and process. This makes it difficult to search for self-management support interventions in overweight and obesity in primary care. Analysis of integrative reviews, systematic reviews and meta-analysis in the literature of patient education on obesity suggests that patient education could improve health outcomes, including self-management skills and quality of life [120, 121]. However, the literature in the field of obesity is poor with regards to patient education programmes or self-management interventions, especially in adults [113, 120, 121]. Most of the literature is related to specific diagnoses, like diabetes, metabolic syndrome, CVD, asthma and COPD. Educational programmes have benefits in areas such as diabetes, asthma, epilepsy and mental health [55] and improved patient wellbeing in COPD [126]. However, there is no clarity of the active ingredients in successful interventions [55].

Generic programmes targeting educational interventions related to overweight and obesity are few. Some of the explanation may lay in the lack of recognition of overweight and obesity as chronic disease/conditions. In Europe to date, only Portugal recognises obesity as a chronic disease, with the American Medical Association (AMA) recognising obesity as a chronic medical disease in 2013 [127] and the Canadian Medical Association (CMA) in 2015 [128]. The World Obesity Federation considers obesity as a chronic relapsing disease process [1, 129]. However, recognition of obesity as a disease is by no means universally accepted [130].

Due to the limited research on SMS in overweight and obesity in particular, lifestyle interventions, treatments and outcomes for other

chronic diseases (diabetes, metabolic syndrome, CVD) will be included to give an overview of some of the knowledge in the field of SMS, SMI and similar lifestyle interventions.

2.4.1.1 Treatment in overweight and obesity and outcomes of lifestyle interventions

Guidelines for obesity management in adults define obesity as a chronic metabolic disease. Physicians have a responsibility to recognise obesity as a disease and help patients with appropriate prevention and treatment [15, 131]. On an individual level, WHO suggests that people limit energy intake from fats and sugars, increase consumption of fruit and vegetables and engage in regular physical activity [1, 19]. Systematic reviews and meta-analyses show that interventions designed to target dietary and physical activity behaviours are recommended counselling strategies for lifestyle change [109, 132]. In traditional treatment and counselling for overweight and obesity, a combination of physical activity, diet and behaviour change therapy is recommended and is the most effective strategy for weight loss and weight loss maintenance [16, 109, 132-134]. European guidelines support appropriate goals of weight management, emphasising realistic weight loss to achieve a reduction in health risks. Balanced hypocaloric diets result in clinically meaningful weight loss and aerobic training for reducing fat-mass is optimal. Cognitive behavioural therapy should directly address behaviours that require change for successful weight loss and maintenance [15].

A systematic review and meta-analysis of randomised controlled trials provides evidence that behavioural treatment strategies (goal setting, MI, relapse prevention, cognitive restructuring) improve adherence to lifestyle intervention programmes in adults with obesity [135]. These strategies should be routinely incorporated into lifestyle intervention, obesity management and weight loss programmes with the aim of improving engagement and adherence. If adherence were improved, treatment effectiveness, health outcomes and the ultimate burden of chronic disease could also be improved [135].

Psychological mechanisms, like higher autonomous motivation, self-efficacy and self-regulation skills (such as self-monitoring) are the best predictors of beneficial weight loss and physical activity outcomes [125, 136] and strategies to build self-efficacy are supported and recommended [109, 125, 137, 138]. A study from learning and mastery services in hospitals, show that persons with morbid obesity had increased self-efficacy and self-esteem after attending patient education programme [139]. Weight maintenance is also associated with better coping strategies and the ability to handle life stress. Autonomy, assuming responsibility in life and overall psychological strength and stability is important. Factors that may pose a risk for weight regain include a history of weight cycling, disinhibited eating and eating in response to negative emotions and stress [136]. Health risks, pride in holding on to new habits and experiencing an effect motivated individuals to maintain changes [112, 140]. Weight management programmes and lifestyle interventions have shown to improve HRQoL [141, 142]. Social support is believed to contribute to weight loss success and motivation to maintain changes [140], yet the type of support received is rarely assessed [143].

The use of person-centred approaches, such as MI and individual tailoring, with a focus on participants' needs and everyday lives, is important [105, 119, 144]. Person-centred approaches and the use of MI appear to enhance weight loss and maintenance [132, 137, 145-149]. Establishing a trusting relationship between the provider and the service user is essential [105, 150, 151]. A cluster of cognitive behavioural strategies are recommended, such as goalsetting, problem-solving, self-monitoring [109, 132, 138, 145, 152, 153], information and instructions [132, 140, 154], skills training, relapse prevention [109, 132, 152] and providing feedback [109, 140, 145, 150]. A study of overweight or obese adults with a metabolic syndrome showed that participants reported the most useful programme components as including food-label reading, cooking sessions and learning new and different physical exercises. The

authors suggest that active training in lifestyle modification is more effective than passive provision of guidelines [153].

Positive body image and flexible eating restraint may also improve outcomes [125]. Multidisciplinary approaches [138] and interdisciplinary cognitive-behavioural-nutritional therapy, with long term treatment and psychological follow-up, have improved the therapeutic success [155]. Increased effectiveness was also associated with increased contact frequency [109, 132] and long term support [109, 138, 152, 153, 156-158]. Group support and training with others are highlighted in several studies as increasing weight loss success, enhancing lifestyle changes and managing chronic conditions [59, 119, 150, 153, 159-161].

Studies from Sweden and Denmark, which, to a certain extent, can be compared to HLCs, show that patients and service users increased their physical activity and quality of life after attending a 'physical activity on prescription' in primary care [162, 163]. Exercise prescribed by GPs may be an important health-improving intervention for inactive individuals with lifestyle diseases. However, dropouts in these studies were considerable, with 48% at 6 months [162] and 44% after 16 months [163].

Guided self-help treatment on the internet, based on cognitive behaviour therapy, has shown positive results (in binge eating disorder) [164]. A RCT study on educational programmes or therapy focusing on psycho-educative approaches, including healthy eating and physical activity (such as 'Kg-free', an acceptance, mindfulness and compassion-based group intervention) for women struggling with their weight and internalised weight stigma, showed positive outcomes for mental health and reduced weight stigma [165]. Several behaviour change theories (e.g. social cognitive theory, the health belief model, the transtheoretical model, the theory of planned behaviour and self-determination theory) have been proposed to understand health behaviour change, with

research showing a global positive effect of these theory-based interventions [166].

Patient education interventions can be offered in various forms [161]. Recommendations for intervention processes and delivery strategies in counselling individuals to promote dietary and physical activity changes involve both individual and group-based strategies [109]. Group-based self-management patient education programmes are seen as beneficial [167]. There is evidence that group-based weight management education is more effective than usual care or individual approaches, in relation to improvements in clinical, lifestyle and psychosocial outcomes, empowerment, self-efficacy and self-management skills [161, 168]. The group process during patient education might be more important for improving coping skills than the content of the program [159]. Patient education programmes are an effective tool to reduce costs and provide benefits in terms of quality adjusted life years [169].

Conventional prevention and treatment for weight loss (behaviour modification aimed at reducing energy intake and increasing energy expenditure) often fails over the long term [17], but is sometimes successful in the short term, while bariatric surgery has been shown to be successful over the long term [170]. The probability of a person with obesity attaining normal body weight is low [171]. It is a problem that most efforts to change health behaviours have had limited success [29, 172] and more effective management strategies are needed for the treatment of overweight and obesity [17, 172]. The prevalence of overweight and obesity, and the subsequent number of NCDs, gives a picture of the population's health. This severe public health problem, indicated by its growing rates [1], gives reason to believe a resistance to prevention and treatment efforts [31]. The complexity of its underlying causes, which include individual, biological and environmental (psychosocial) factors, make it difficult to implement effective interventions for overweight and obesity [31, 173]. Addressing these challenges might also include policy changes [17, 28].

Considering the poor long-term outcomes of overweight and obesity interventions, focusing on diet, exercise and individual willpower, which is referred to as the personal responsibility attribution, may not be a sufficient solution to the obesity epidemic [31]. Dietary and activity habits are processes and practices embedded in social life, ingrained in people's everyday lives and their habits and routines. There is a need to rethink the idea that it is enough to give people information and steer them towards empowering and motivating themselves to generate their own solutions to their problems [29]. A more potentially promising approach is to prevent the development of obesity by tackling the toxic environment [174]. The control of overweight and obesity ultimately require population based strategies, not just individual behaviour modification [1, 175]. The necessity to include individual, psychological, biological, political, environmental and social factors is well documented [1, 4, 29, 31, 173, 176-179]. Applying a system-oriented multilevel framework to address obesity [176] or a social-ecological theory or model to guide health promotion in the community towards environmental and policy change are suggested [173, 177-180]. Addressing weight stigma in obesity prevention and treatment is also warranted [42].

3 Methodology

This chapter describes the methodological approach, including the research design, the ontological and epistemological approach of hermeneutics and social constructivism in this study, and research strategies. The importance of the researcher's preunderstanding in hermeneutic philosophy and method will also be described. A description of participants and recruitment will follow, together with data collection methods, including individual interviews (Papers I and II) and focus group interviews (Paper III). The two analytical methods, the qualitative content analysis (Papers I and II) and the thematic analysis (Paper III) used in the papers will be outlined and, finally, ethical assessments will be presented.

3.1 Research design

Qualitative methods are useful when studying human characteristics or when searching for deeper understanding of a phenomenon. The goal of qualitative research is the development of concepts that help us to understand social phenomena in natural settings [181, 182]. Malterud explains that qualitative methods are built on theories about human experiences (phenomenology) and interpretation (hermeneutic) [182]. According to Polit and Beck, hermeneutics is a research tradition drawing on interpretive phenomenology, which focuses on the lived experiences of humans within their lifeworld and how they interpret those experiences [181]. A qualitative design may provide insight into complex phenomena (e.g. overweight and obesity) and an explorative and interpretative design, founded in hermeneutic methodology and tradition, was chosen in this study. The aims and the research questions decided the design and methods [183] and, to answer the research questions, qualitative interviews with the service users and HPs in HLCs were conducted. The study consists of three sub-studies. The service users in sub-studies 1 and 2 are the same participants. The textual data

material was analysed using qualitative content analysis (Paper I and II), and thematic analysis (Paper III). An overview of the research design and sub-studies is shown in table 1.

Table 1. Overview of research design and sub-studies

Sub-Study	Research question	Participants	Method	Analysis	Paper
1	1. How do service users participating in lifestyle interventions in HLC experience living with overweight or obesity? 2. What are the service users' perceptions of seeking help to change dietary and activity habits?	13 service users afflicted by overweight or obesity that have participated in a lifestyle course in primary care HLCs	Individual interviews	Qualitative content analyses	Paper I
2	3. What do beneficial SMS and user involvement imply for persons afflicted by overweight or obesity attending lifestyle interventions in HLCs?	13 service users afflicted by overweight or obesity that have participated in lifestyle course in primary care HLCs	Individual interviews	Qualitative content analyses	Paper II
3	4. How do HPs in HLCs provide SMS in lifestyle interventions for persons afflicted by overweight or obesity? 5. What does user involvement imply for HPs in HLCs?	10 healthcare professionals that have experience of lifestyle courses as educators/providers in HLCs.	Focus group interview	Thematic analysis	Paper III

3.1.1 Scientific approach and paradigm

According to Lincoln and Guba [184], qualitative research is often grounded in constructivism, which sees knowledge as relative and socially constructed [184]. In constructionism, everyday knowledge is the outcome of people having to make sense of their encounters with the

physical world and other people, while social scientific knowledge is the outcome of social scientists reinterpreting this everyday knowledge into technical language [185]. As such, qualitative research is concerned with understanding a phenomenon from the perspective of those who live it, with the researcher as a human instrument [184]. This study has an epistemological perspective of social constructivism, which, according to Blaikie, is likely to be used with an abductive research strategy [185] and is associated with the philosophy of hermeneutics [186]. Qualitative research interviews (applied to collect data in this study), according to Kvale and Brinkmann [187], are an active form of knowledge production, a process of recognition that provides us with valid knowledge about our conversational reality and a meaning-making practice [187]. A social constructionist approach views data as dialogic and co-created in and through conversation and language [185, 187].

3.1.2 Interpretivism and hermeneutic philosophy and methodology

In this study, an interpretative exploratory design grounded in hermeneutic tradition was chosen to gain a deeper understanding of service users' needs, beneficial SMS and user involvement. Hermeneutics has its basis in humanistic and holistic research and focuses on understanding, meaning and interpretation of meaning. Understanding is the science of meaning [188] and it is through hermeneutics that the essence of people's perceptions, beliefs, values and commitments can become known and clarified [98, 189, 190]. Hermeneutic reading and interpretation represent a textual method of analysis for finding meaning in human experiences of the world. Two embedded assumptions of hermeneutics are that humans experience the world through language and that this language provides both understanding and knowledge [191]. The purpose of hermeneutic interpretation is to achieve valid and general understanding of a text's

meaning [187]. However, there is no such thing as a correct interpretation [192].

Gadamer described the interpretive process as a circular relationship, known as the hermeneutic circle, where one understands the whole of a text in terms of its parts and the parts in terms of the whole. In this view, a researcher enters into a dialogue with the text, in which the researcher continually questions its meaning [189]. Gadamer's idea of hermeneutics emphasises the embeddedness of language in our understanding of the world. His work helped extend philosophical hermeneutics to critical hermeneutics by stressing the importance of traditions, background and history in our ways of understanding. Understanding involves the 'fusion of horizons' [189, 193] and has some similarities to Giddens's notion of double hermeneutics [185, 194]. Giddens describe double hermeneutics as a hermeneutical spiral, where social scientists study people and society. They study what people do, how people understand their world and how this understanding may form their practice. By using new knowledge, insight and understanding, practices can be changed [185, 194, 195].

3.1.3 Research strategies

Blaikie [185] refers to four research strategies or logics (inductive, deductive, abductive and retroductive) to use when answering research questions and purposes. I have chosen to use inductive (coding and categorisation of empirical data), deductive (use of theory in the interpretations) and abductive (in the form of a hermeneutical spiral interpretation process) research strategies in my inquiry. My understanding rests upon a view of abduction as a hermeneutical spiral, which will guide this thesis approach. Abduction can be seen as a useful approach to answer the research questions, to answer what and how questions and as method of interpreting data [185]. Accordingly, a more comprehensive understanding of human behaviour and, in this study, a

deeper understanding of service users' needs, beneficial SMS and user involvement, can be achieved.

Abductive research strategies incorporate the motives and intentions that people use in their everyday lives and that direct their behaviour [185]. Abduction is an analytical methodological level of how to understand reasoning, logic or how to make inferences that are not inductively generalised or deductively theorised [185]. There is no clear consensus of abductive reasoning or logic and quite a few philosophical, health and social researchers have tried to understand and explain this concept [185, 186, 196-202]. An American philosopher, Charles C. Peirce, worked out the concept of abduction; which also had some similarities with the practical and methodological priorities in grounded theory [198, 199, 203].

Råholm [202, 204] describes abduction as a way to discover meaningful underlying patterns. The first stage of inquiry gives a creative insight into the link between raw data and suggests a new understanding of the phenomenon. The result of abduction is a possibility that we presently find more suitable compared to other possibilities [202]. Abduction is based on existing interpreted knowledge and its strength lies in generating new elements in the research process [204]. According to Danermark, abduction offers a plausible interpretation rather than producing a logical conclusion [198]. Feil and Olteanu (2018) suggest that abduction, and that Peirce theory of abductive inquiry at its core, treats objects of investigation (phenomena) within a hermeneutical framework, calling it 'Peirce hermeneutics' [201]. They also use the term 'interpretation of interpretation', which may also be understood as Gadamer's hermeneutical circle [189], a back and forth movement between preunderstanding and understanding, or Giddens's concept of double hermeneutics [195] as a form of hermeneutic spiral. Alvesson and Sköldberg suggest that a hermeneuticist would claim that abduction implies a kind of hermeneutical spiral; an interpretation of facts in which

we already have a preunderstanding [205]. Figure 2 demonstrates this hermeneutical spiral and the interpretative abductive process.

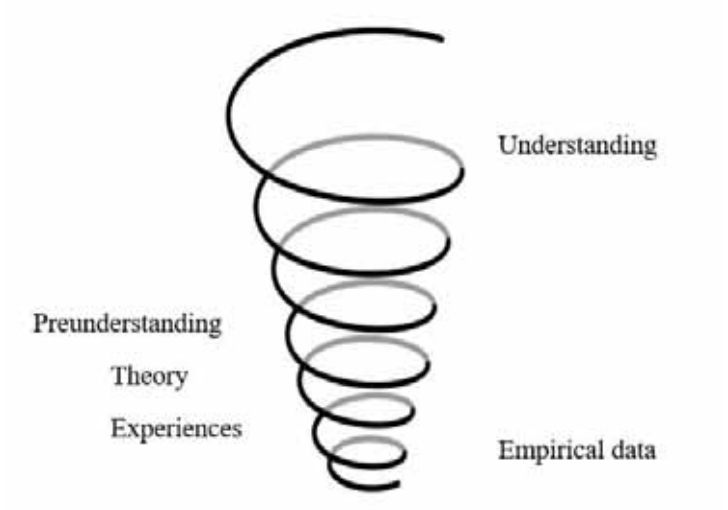

Figure 2. The hermeneutic spiral demonstrating the interpretative abductive process

3.1.4 The researcher's preunderstanding

A researcher's preunderstanding originates from their background; we always carry our experiences, attitudes and expectations in our encounters with others and the world we live in. Gadamer advocated for continually striving to identify our prejudices or pre-understanding and to be aware of how this may affect the inquiry [189]. From a hermeneutic perspective, personal experiences are not considered an impediment to the researcher's ability to understand, but a prerequisite [193]. Therefore, reflexivity in research is a process of critical reflection both on the kind of knowledge produced from research and how that knowledge is generated. A reflexive researcher is one who is aware of all potential influences and is able to step back and take a critical look at their own role in the research process [206].

I have worked for eleven years as a public health nurse in primary healthcare. My clinical experience as a public health nurse includes participating in an interdisciplinary team helping children, adolescents and their families to change their dietary and activity habits. My background and knowledge advocate for a health promotion perspective [70, 71, 88], that it is most important to prevent illness and diseases and that the main focus of healthcare must be on health promotion and prevention rather than treatment. This may be a valuable insight concerning lifestyle change and social stigma or weight bias. Preunderstanding may influence both understanding and misunderstanding and lead to a bias related to people's attempts to change lifestyles. It was important to reflect on my preunderstanding through the whole research process, but especially in the interviews and throughout the analysis, to not force the interviews and the participants' answers in one direction. It was also important to be open in the interpretation of the text, as the purpose was to explore the phenomenon, determine what information the text contained and not to hinder the disclosure of data. The research group (first author and co-authors in the three papers) have various disciplinary and clinical backgrounds and the text was discussed throughout the whole analytical process, which helped increasing the trustworthiness.

3.2 Participants and recruitment

3.2.1 Recruitments of the service users (Papers I and II)

An invitation with a description of the study was sent to 20 local communities on the west coast of Norway, requesting permission to conduct a study in local HLCs. Administrators responsible for each HLC were asked to send requests to participants who had participated in diet and/or activity interventions. Inclusion criteria were persons aged 18 to 80, who had contacted the HLC to obtain help to change their dietary

and/or activity habits, were afflicted by overweight or obesity and who were able to speak and understand the Norwegian language. A purposive sampling technique [207, 208] was used to identify participants for interview, to ensure that the sample included individuals of both sexes and various ages, from small and medium-sized municipalities, with experience of living with overweight or obesity. The individual interviews in this study included 13 participants, eight women and five men, aged 30 to 69, (table 2 and 3), recruited from five different Healthy Life Centres in Norway.

Table 2. Participant characteristics (sub-study 1 and 2)

Characteristics	Number of participants
Gender:	
Female	8
Male	5
Age:	
30-69	13
Civil status:	
Single/divorced	1
Widow/widower	1
Partner/married	11
Education:	
High school	11
Bachelor's degree or higher	2
Occupational status:	
Employee 50-80%	4
Unemployed	2
Disability pension	5
Retiree	2
Participation in HLC:	
Healthy diet courses	11
Activity groups	12
Individual conversations with HP	13
Participation time in HLC	6 months – 3½ years

Table 3. Self-reported challenges, strains and additional diagnoses (number of participants in brackets)

One or several somatic diagnoses:
Type 2 diabetes (3), cardiovascular disease (CVD) (4), Chronic Obstructive Pulmonary Disease (COPD) (2), celiac disease (1), multiple sclerosis (MS) (1), sleep apnoea (1), various chronic pain conditions (8), fibromyalgia (3), cancer (2)
One or several psychosocial strains and challenges:
Anxiety (3), depression (4), loss and grief (1), identity reactions (12), eating disorders (2), suicidal thoughts (2), alcohol abuse (1), isolation (6), financial difficulties (2)

3.2.2 Recruitment of healthcare professionals (Paper III)

An invitation describing this study was sent to 20 administrators responsible for HLCs in the municipalities on the west coast of Norway, asking for requests to be sent to HPs working in the respective HLCs to participate in focus group interviews. The inclusion criteria were HPs with a minimum of six months' experience of lifestyle interventions in HLCs. Purposive sampling [207, 208] was used to establish focus groups with variation in terms of occupational background, well-established and new HLCs, as well as urban and rural municipalities. Ten HPs (nine women and one man), aged 26 to 49 years, from eight different HLCs participated in two focus group interviews. The HPs in focus group 1 (FG 1) were two physiotherapists, one public health nurse and one psychiatric nurse, while four physiotherapists, one bachelor's in public health and one nutritionist took part in FG 2. Their clinical experience in HLCs ranged from one to seven years. Due to the fact that there was only one male participant, with physiotherapists in majority, a table of each HPs' backgrounds will not be attached to safeguard confidentiality. Characteristics of HLCs and HPs in the two focus groups are listed in table 4:

Table 4. Characteristics of HLCs and HPs in the two focus groups

	Occupational background	Gender	Years of clinical experience (HLCs)	Rural / Urban	Population	Years at HLC establish-ment	Number of employees
Focus group 1 (FG-1)	Physio-therapists (2), psychiatric nurse (1) and public health nurse (1)	Female (3) Male (1)	1-7	Urban (2) Rural (2)	8.500 - 38.000	2-5	1-2
Focus group 2 (FG-2)	Physio-therapists (4), bachelor's in public health (1) and nutritionist (1)	Female (6)	2-7	Urban (3) Rural (1)	12.000 - 19.500	2-7	1-4

3.3 Data collection

3.3.1 Qualitative research interview – individual interviews and focus-group interviews

Interview inquiry is a well-known and well-used method in qualitative research. Qualitative methods, such as individual in-depth interviews and focus group interviews, are legitimate techniques used in health and social sciences to gather information and experience from participants, or when searching for deeper understanding of phenomena [187, 209]. The aims and the research questions decide the methods used [181-183].

The purpose of qualitative research interviews is to produce knowledge and to explore the content of meaning in social and cultural phenomena. Individual qualitative research interviews are based on a professional conversation regarding daily life, where the interviewer determines the topic and defines and controls the conversation [187]. Due to the lack of knowledge of service users' experiences and perceptions of their participation in Norwegian HLCs, individual interviews were an

appropriate and relevant method to gain this knowledge and understanding. What emerges in the interview represents the specific understanding people have when they articulate their own experience, reflecting the subjective experience individuals have prior to scientific explanations [187].

Focus group interviews are suitable for exploring new areas with sparse knowledge, as in the case of HPs working in HLCs [209]. According to Morgan [210], the characteristics of focus groups are their explicit use of group interaction to produce data and insights that would be less accessible without the interaction found in a group. The researcher, who often takes the role of moderator, decides the topic and group discussions provide direct evidence about similarities and differences in the participants' opinions and experiences [210].

3.3.2 Data collection (Papers I and II)

This study had three sub-studies (see table 1). To answer the research questions and collect empirical data, individual in-depth interviews were used to gather data from the service users' experiences of living with overweight or obesity and seeking help to change their lifestyle (Paper I) and to gather data on their perceptions and experiences of beneficial SMS and user involvement (Paper II). I conducted all the individual interviews and, in accordance with the participants' wishes, 11 interviews took place in their local HLC and two at a university campus, over a period of five months in 2017. The form of the interview was open and the participants were invited to speak freely about their experiences. In an interview, ethical dilemmas can occur and how to respond to these is a question of ethical practice [206]. Before the individual interviews, precautions had been taken by reflecting on how to take care of the participants if the interview situation became unpleasant or challenging.

The interview setting was well prepared and the service users were offered something to drink and some fruit. Papers and pens to make notes

were placed on the table and the chairs was placed diagonally opposite each other. A respectful and non-judgmental atmosphere was emphasised. I tried to be open and give something back by telling the service users something about my background and interests and why this study was of my interest and tried to answer their questions in a helpful and friendly way. The service users spoke freely about their experiences, needs and values. They gave feedback to me and said that this was an interesting conversation and added that they were feeling safe and had a pleasant feeling of being taken care of. They thanked me for being asked to participate and that it was a pleasure to contribute to science.

A semi-structured interview guide with follow-up questions was used (appendix 7). Personal goals, challenges and need for help were explored. The main questions asked were: *How would you describe living with overweight and seeking help to change your lifestyle? What is your perception of changing dietary and activity habits? Why did you contact the HLC and ask for help?* (Paper I). *What is your perception of user involvement in the HLC? What type of help and support did you experience as beneficial in the HLC? What is important for you and what strengthens you?* (Paper II). At the end of each interview, I asked if there was anything the service users wanted to add. The interviews lasted between 60 and 130 minutes and were audiotaped and transcribed verbatim shortly after the interviews. The sample size for the individual interviews was guided by information power, as discussed by Malterud et al. [207].

3.3.3 Data collection (Paper III)

In sub-study 3, focus group interviews were used to gather information from HPs. The interviews took place at one university campus and one local HLC in 2017 based on practical considerations, such as the shortest possible travel distance for the participants. Most of the participants had met before and several of them collaborated in an inter-municipal

cooperation network. I invited the HPs to speak freely about their work in HLCs, to discuss their praxis and how they provided self-management support and what user involvement meant in lifestyle interventions in HLCs for persons afflicted by overweight or obesity.

The form of the interview was open and I tried to be respectful and friendly, to make the HPs feel safe enough to express their perceptions. At the beginning of the interview, the participants were served sandwiches, water, tea and coffee, which facilitated small talk. The moderator and co-moderator presented their backgrounds and clinical and academic interests, after which, the participating HPs presented their backgrounds and clinical experiences. The study was presented and the HPs were invited to participate in a discussion about beneficial SMS and user involvement. The HPs played an active part in the discussion in a highly reflective manner. Their familiarity from previous networks and working together appeared to make them feel comfortable. The HPs expressed gratitude for being able to participate in providing more knowledge about the HLCs and they felt cared for in the focus group interviews.

A topic guide was used (appendix 6) and the main questions were: *What is your experience/perception of beneficial help and support for the service users attending lifestyle interventions in HLCs? How do you promote self-management and user involvement? What does user involvement imply for you?* Each focus group interview lasted 120 minutes and was audiotaped and transcribed verbatim. Information power, as discussed by Malterud et al. [207], guided the sample size and the number of focus groups.

3.4 Data analysis

Qualitative data can take the form of narrative materials, including verbatim dialogue between an interviewer and a respondent. Analysing such qualitative data, according to Polit and Beck [181], is a challenging

enterprise, because there are no universal rules. The purpose of data analysis is to organise, provide structure to and elicit meaning from data. In qualitative studies, data collection and data analysis often occur simultaneously and the search for important themes, categories and concepts starts early in the process [181]. It is necessary to match the specific research purpose or aim with the appropriate analysis method [181]. Adhering to an analytic procedure (e.g. qualitative content analysis [211] and thematic analysis [212]) may increase the trustworthiness of the study [213]. Careful description of the approach to content and thematic analysis used may strengthen the method's scientific base [212, 214] (e.g. inductive approach described by Krippendorff [215] or conventional, direct or summative content analysis described by Hsieh and Shannon [216]). Content analysis offers researchers a flexible and pragmatic method for developing and extending knowledge of the human experiences of health and illness [216]. In the next paragraphs, the two analytical methods used in this study will be presented.

3.4.1 Analysis method – qualitative content analysis (Papers I and II)

There are various approaches to qualitative data analysis and I chose qualitative content analysis for papers I and II. The theoretical framework for qualitative content analysis in this study is grounded in inductive, deductive and abductive approaches. A data-driven inductive approach is described by Hsieh and Shannon [216] and a text-driven search for patterns is described by Krippendorff [215]. The abductive approach is described as a combined approach and as a movement back and forth between inductive and deductive approaches [217] or, as described earlier and demonstrated in figure 2 (p.38), as a hermeneutical spiral.

Qualitative content analysis involves breaking data down into smaller units, coding and naming the units according to the content they present

and grouping these coded materials based on shared concepts [181]. Graneheim and Lundman [211] describe the analytical steps in qualitative content analysis in nursing research. Their framework has later been described to be in accordance with inductive, deductive or abductive strategies [214]. Creating *categories* is the core feature of qualitative content analysis. A category deals with the question 'what?' and can be identified as a thread throughout the codes. As Graneheim and Lundman see it, a category refers to the descriptive level of the content and is an expression of the manifest content of the text – what the text says [211, 214]. The concept of *theme* can be considered as the thread of underlying meaning found through condensed meaning units, codes or categories, on an interpretative level. A theme is an expression of the latent content of the text – what the text talks about. This underlying meaning, the latent content, can be interpreted on various levels of abstraction and interpretation [214]. Both manifest and latent content deal with interpretation, but the interpretations vary in depth and level of abstraction [211, 214]. Both a phenomenological description of the manifest content (categories close to the text) and a hermeneutical interpretation of the latent content (themes distant from the text) [211] were used in this study, to obtain a deeper understanding of the service users' needs, beneficial SMS and user involvement. The theme development required interpretative efforts, which resonates with the interpretivism and hermeneutical philosophy and methodology adopted in this study.

In papers I and II, the data material consisted of about 200 pages of verbatim transcribed text and was analysed using qualitative content analysis [211, 214]. In line with the analytical steps in this method, the transcripts were read repeatedly to obtain an overall impression and to find preliminary themes and categories. The first author and co-authors of the papers read all the transcribed interviews and the transcripts were discussed at group meetings. The text was divided into meaning units, condensed and further abstracted and labelled with a code by the first

author. A matrix was used to keep an overview of the codes, condensed text and meaning units. The various codes were sorted into sub-categories and categories, by looking for the manifest content, the 'what'. In this early stages of an inductive approach, engaging with literature was avoided. The categories were further revised, renamed and sorted into sub-themes and themes by asking 'What is this about?' – what is the underlying meaning. Reflection on the sub-themes and themes and a review of the literature related to the sub-themes (e.g. theory of self-conscious feelings and theory of stigma) was deductive and helped the naming and labelling of themes and main-themes. The interpretation of the categories into themes (interpretation of the underlying meaning) [193, 214] took the form of a hermeneutic spiral in an abductive approach and method [201, 217], using previous literature, theory and pre-understanding (theoretical and practical) in the interpretation process (figure 2, p.38). The discussion of the data material, categories and themes between the first author and co-authors took place in several meetings over a period of time and the researchers' various disciplinary backgrounds and clinical experiences enriched the analysis and interpretation. This method appeared to be appropriate to analyse the text from the individual in-depth interviews in this study, allowing for both descriptions and wider interpretations.

3.4.2 Analysis method – thematic analysis (Paper III)

Braun and Clarke [212] argue that thematic analysis should be considered as a fundamental method for qualitative analysis and a method in its own right. One of the benefits of thematic analysis is its flexibility and theoretical freedom. Thematic analysis is not tied to a particular theoretical or epistemological position; however, it is compatible with both essentialist and constructionist paradigms. This correspond to the social constructivist paradigm adopted in this study. The most important issue for researchers is to be clear about what they are doing, why they are doing it and how they did it [212]. The aim is to

provide description of both the manifest (semantic, explicit) and latent (underlying interpretative level) content, pattern responses or meaning in the text to develop a new understanding of the phenomenon under study and to answer the research questions [212]. In the theoretical position of constructionism and the importance of the researcher's pre-understanding, I am aware that the themes are developed as a co-productive process, as described by Kvale and Brinkmann [187]. It is important that the theoretical framework and methods match the research question and that the theoretical framework is clear and transparent [212]. The approach in the coding process was mainly inductive and the theoretical framework was grounded in a text-driven search for patterns, as described by Krippendorff [215]. The approach in the interpretation and theme development was mainly abductive, in the form of a hermeneutical spiral (figure 2, p.38) [185, 186, 189].

In Paper III, the data materials consisted of about 70 pages of transcribed text. A thematic analysis, as discussed by Vaismoradi et al. [218] and described by Braun and Clarke [212], was used to analyse the data from the focus groups with the HPs. The aim was to achieve a deeper understanding of how HPs provide SMS and what user involvement implies in lifestyle interventions in HLCs. Thematic analysis is a six-phase flexible method to identify, analyse and report patterns and themes in qualitative data. It is a recursive process and involves constantly moving back and forth between the coded extracts and the entire data set [212]. In the first phase, all the transcripts from the focus group interviews were read repeatedly by all authors, searching for patterns and themes, and discussed in a group meeting. In the second phase, the patterns, meaning units and themes were identified and I generated initial codes. The coding process, entailing data-reduction relevant for the research question and categorisation of the meaning units, was conducted using a matrix. In this early stage, the analysis process was more of an inductive approach, where there was no engagement with literature and previous research. In the third phase, related text elements

from the coding-schemas were reassembled in a new matrix, then abstracted and grouped into sub-themes and themes using mind maps. Data were analysed within each of the focus groups and across the groups to identify both common and specific themes. In the fourth phase, the themes were reviewed to check the coherence between the categories in the themes and the distinctions between the themes. In the fifth phase, the themes were defined and named, then refined and revised, to identify the essence of what each theme was about and ensure there was not too much overlap between the themes. This was a challenging process because of the interrelationship between the themes. This process of revising, defining and naming the themes was a time-consuming process involving reading and rereading the themes in relation to the entire data material. The sixth phase involved writing up the results for publication in a convincing and valid way. This was completed with several quotations, which captured the essence of the themes to answer the research question. The reflection on the sub-themes and themes, entailing a review of the literature related to the sub-themes, also helped with the naming and labelling of themes and main-themes (e.g. theory of self-esteem and dignity, theory of ethical responsibility).

The interpretation of the categories into themes (interpretation of the underlying meaning) [193, 214], took the form of a hermeneutic spiral in an abductive perspective [201, 217], using previous literature, theory and pre-understanding (theoretical and practical) in the interpretation process. In paper III, the discussion of the data material, the interpretation and the defining and redefining the themes was a process and dialogue between the first author and co-authors. According to Braun and Clarke, themes need to be concise or something important in relation to the overall research questions [212]. However, Sandelowski and Leeman prefer labelling the themes and overall theme with a phrase or sentence to capture complete ideas [219]. This was also a preferred choice in this study, especially in papers II and III. The consolidated criteria for reporting qualitative research (COREQ) checklist [220] was used in the presentation of the analysis and results in all three papers.

3.5 Ethical considerations

Ethical guidelines underlie all scientific research [221] and ethical considerations are present throughout the whole research process. Research in human and social sciences is regulated by scientific, ethical and juridical norms [222], and medical science is based on four main ethical principles; respect for autonomy, nonmaleficence, beneficence and justice [78]. Respect for human dignity includes personal integrity, respect for privacy, autonomy and safeguarding against harm. Researchers have a duty to inform, obtain consent to participate and secure the confidentiality of the participants [222].

This study was registered and approved at the Norwegian Centre for Research Data (NSD) in 2016, with project number 48025. The ethical guidelines of the Helsinki Declaration were followed [223]. Participants received oral and written information about the study and signed an informed consent form before the interview started. The HPs gave their oral consent to participate before the focus group interviews started. Participation in the study was voluntary and the participants were informed before the interview started about their right to withdraw at any stage, without this compromising their future health care (relevant in sub-study 1 and 2).

Confidentiality in research implies that private data identifying the participants will not be disclosed. The participants were informed about confidentiality, how the data will be handled and who will have access to the interviews or other material [187]. For reasons of confidentiality, the participants in Papers I and II are coded by gender and age-cohort. In Paper III, the participants are coded by number and focus group number, due to the fact that there was only one male participant and a majority of physiotherapists.

4 Results

The lack of knowledge and research on how HLCs, as a healthcare service, may help people change their lifestyle and how HPs provide SMS was the reason for conducting these studies. The three sub-studies contribute to a deeper understanding of service users' need for help, beneficial SMS and user involvement, from both the service users' and HPs' perspective in Norwegian primary care HLCs. The tables of the analysis (sub-themes, themes and main-themes) are shown in appendix 1 and in the three papers. The findings from each of the three papers will be presented before the subsequent discussion.

4.1 Paper I

The aim of this study was to explore HLC service users' experiences of living with overweight or obesity and perceptions of seeking help to change dietary and activity habits.

This explorative study of 13 service users, using individual in-depth interviews, found that *searching for dignity* reflected the participants' overall experience of living with overweight or obesity and their perceptions of seeking help to change their dietary and activity habits. This main theme was based on the themes 1) *Needing to justify avoidance of personal responsibility* and *2) A desire to change.* For all the service users, living with overweight or obesity impaired their body image and self-esteem, causing a negative self-representation of living a perceived wrong lifestyle. The service users were seeking help with lifestyle changes at the same time as they felt shame about their body and not managing on their own and guilt at not adhering to a healthy diet or doing enough exercise. They had earlier experiences of losing weight and relapses and experienced a constant struggle between a healthy lifestyle and pleasure. They felt a need to explain their weight gain and barriers to change. On the other hand, they desired change and were

motivated and felt pride about taking the initiative and asking for help, exhibiting willpower and discipline. The service users tried to balance protection and disclosure of self with pride for taking the initiative and responsibility for change to feel normal, accepted and worthy.

4.2 Paper II

The aim of this study was to explore beneficial SMS and user involvement for persons afflicted by overweight or obesity attending lifestyle interventions in Norwegian Healthy Life Centres.

Semi-structured individual in-depth interviews were conducted with 13 service users, and the analysis identified that *Regaining self-esteem and dignity through active involvement and long-term self-worth support in partnership with others* reflected the service users' perceptions of beneficial SMS and user involvement. This main theme comprised four themes: 1) *Self-efficacy through active involvement and better perceived health,* 2) *Valued through HPs' acknowledgement, equality and individualised support,* 3) *Increased motivation and self-belief through fellowship and peer support* and 4) *Maintenance of lifestyle change through accessibility and long-term support.*

Overall, the participants were very satisfied with the HLC and the help they had received. They described help as supporting self-worth and increasing their belief in self-management, but they also needed their significant others. They perceived being strengthened by being invited to become involved in an equal partnership, built on a trusting relationship with competent HPs. Participation in supervised groups increased motivation and several of the service users expressed a need for long-term support. User involvement was described as acknowledgement and the HPs' ability to personalise and tailor SMS and lifestyle interventions to the service users' needs and everyday life. Emotional support, increased motivation and self-efficacy as well as a feeling of dignity and a more positive self-esteem, seem to be some of

the successful ingredients in the process of weight self-management and individual empowerment.

4.3 Paper III

The aim of this study was to explore how HPs provide SMS and what user involvement implies for HPs in HLCs.

This third study explored how ten healthcare professionals provide SMS and what user involvement implies for them. Using focus group interviews and thematic analysis, one overall theme was identified: *A partnership based on ethical awareness, non-judgemental attitude, dialogue and shared responsibility*. This main theme comprised four interrelated themes: 1) *Supporting self-efficacy, self-worth and dignity through an attitude of respect, acknowledgement and generosity*, 2) *Promoting self-belief and self-perceived health*, 3) *Collaborating and sharing responsibility* and 4) *Being flexible, adjusting and sharing time*.

HPs provide SMS and user involvement in lifestyle interventions in HLCs through ethical awareness and a non-judgemental and open attitude and dialogue. Self-efficacy, self-worth and dignity are supported by a respectful way of being and acknowledging the service users for who they are. User involvement and SMS takes place through shared responsibility in a partnership with the service users. HPs take responsibility for creating a mutual and trusting relationship, emphasising equality, acknowledgement and generosity in this collaborative partnership. Flexibility and adjustment of the support to match the service users' needs and situation are essential and the temporal nature of the collaborative partnership and follow-up is important. The HPs seems to have learned the art of meeting the other in their most vulnerable situations and may help persons who are struggling with overweight or obesity so change their lifestyle and to regain dignity.

5 Discussion of results and methodology

The purpose of this chapter is to synthesise and interpret the findings (explore what the findings mean) and to discuss the methodological considerations.

5.1 Discussion of results

The results from each sub-study have already been discussed and interpreted by the use of previous research, literature and theories in the papers (I to III). The overall aim of this PhD thesis was to contribute to a deeper understanding of service users' need for help, beneficial SMS and user involvement in lifestyle interventions in Norwegian primary care HLCs, by exploring and interpreting service users' and HPs' experiences and perceptions of these phenomena. To answer this aim, this thesis had one research question: *How can service users' needs, beneficial SMS and user involvement be understood?*

The results from the three papers have been synthesised through an abductive strategy [185, 205] and applying some new theories and perspectives [224-230]. This process of interpretation was demonstrated in figure 2 (p.38) as a back and forth movement and interaction between the empirical data and literature (theory), preunderstanding and new understanding, as supported in the methodological literature of abduction and hermeneutics [185, 189, 201, 204, 205]. The interpretation process and this new synthesis of the findings are demonstrated in figure 3 (p.58).

I found that responsibility is a term that recurred in all three sub-studies. Lifestyle change seems to be a question of personal responsibility, as assuming and/or avoiding responsibility for healthy living (Papers I and II). In Paper III, I found that HPs reported a professional ethical responsibility for providing support and care. This further synthesis led to three new themes. The service users' needs, beneficial SMS and user involvement can be interpreted and understood as *The dual face of*

personal responsibility in health – the burden and the value, *The art of acting ethically* and *The challenges and possibilities in sharing responsibility.*

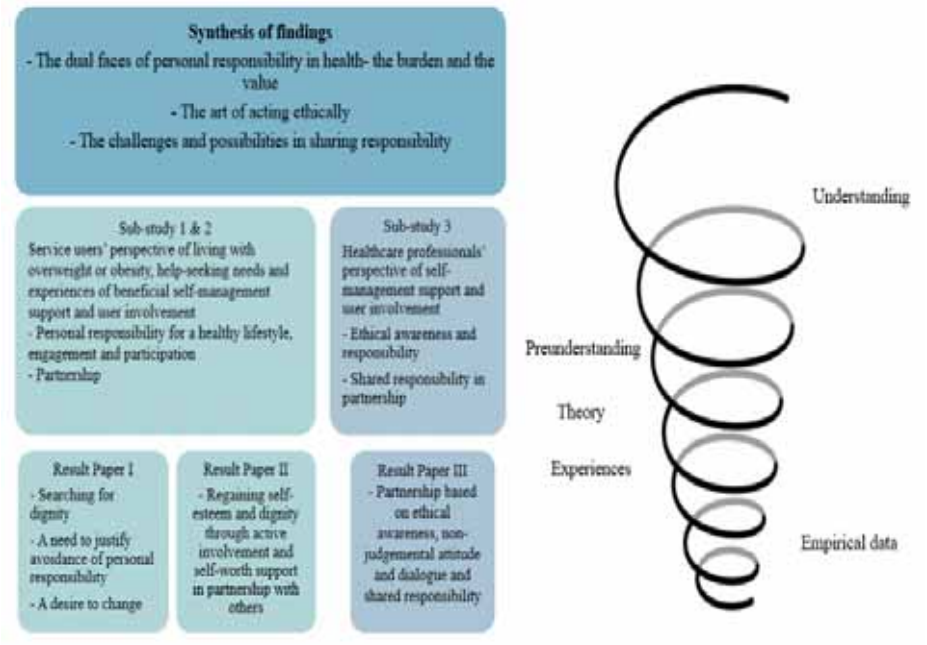

Figure 3. Overview of results (Papers I-III) and synthesis of findings

5.1.1 The dual face of personal responsibility in health – the burden and the value

In the following discussion of personal responsibility, I will highlight the concepts of shame, guilt and weight stigma (the burden), together with dignity and pride (the value).

The results from Papers I and II, and partly from Paper III, show that the service users' personal responsibility for health has at least two conflicting sides that need to be balanced. In papers I and II, the dual face of personal responsibility, burden and value, become evident. The service users explicitly describe their personal responsibility for living a

healthy lifestyle and that this responsibility can belong to no-one else (Paper I). This personal responsibility in health is also reported in previous studies [33, 231]. Self-management is highlighted in modern society and healthcare [66, 118, 232] and is defined as 'an individual's ability to detect and manage symptoms, treatment, physical and psychosocial consequences, as well as the lifestyle changes inherent in living with a chronic condition' [114] (p.178), such as exercise and diet change. This ideal may be seen as a vast burden of responsibility for most people and for people living with a chronic condition, especially. When living in an obesity-promoting society, finding a balance in personal responsibility for health is necessary. Self-management in overweight and obesity, therefore, needs an expanded understanding.

The results in Paper I show that the service users are trying to explain their weight gain and to justify avoidance of personal responsibility. As suggested in Paper I, too much personal responsibility may lead to avoidance of responsibility. Personal responsibility for health is the dominant discourse in the discussions about obesity and symbolises self-control, hard work, ambition and success in life, including the control of behaviour and health [27, 28, 233, 234]. Failing to perform the ideal behaviour and follow health authorities' recommendations for healthy living places many people in a situation whereby they feel guilty [27, 34, 48, 233, 235]. Lifestyle change has been described as an eternal struggle and a hopeless enterprise [60, 110], leading to feelings of unworthiness [27, 34, 236]. Paper I suggested that a one-sided focus on individual responsibility for health and health behaviour change adds more blame or shame to people afflicted by overweight or obesity, because it reflects the major attitude in the society towards individual responsibility.

The burden of personal responsibility, as shown in this study (Paper I), is related to the guilt, shame and weight stigma that follows being afflicted by overweight or obesity. Living with overweight and obesity, and seeking help for a perceived wrong lifestyle, led most of the service users to feeling shame for not managing on their own and guilt for not

maintaining diets and exercise. Guilt involves negative feelings about a specific behaviour or action taken by the self [237, 238], whereas shame involves negative feelings about the stable, global self [237, 238]. According to Mead, the development of self is a social process between the individual and the society, developing in our observation of others' reactions to oneself [239]. Giddens's view of modernity and development of self-identity illuminates an important aspect in how we view personal responsibility for health. Giddens [225] describes how self-identity is created as a reflexive project for which individuals are responsible. We are not what we are, we make ourselves. This reflexivity becomes continuous, asking 'Who am I? What am I doing?' and extends from the self to the body [225]. This self-understanding may be especially important for persons afflicted by overweight or obesity, understanding that they live a wrong lifestyle according to government-recommended guidelines and receiving feedback from society that they are less worthy because of their body size, which becomes their image or narrative of self.

The analyses of the empirical data in Paper I showed that service users are basically searching for dignity to develop a better self-image and maintain their integrity. The service users try to assume responsibility, describing pride in taking responsibility at the same time as they are trying to justify avoidance of personal responsibility (Paper I). It will be difficult to perceive dignity if deprived of responsibility and escaping from responsibility can result in a feeling of unworthiness, according to Eriksson [224]. As the results in Paper I show, feeling less worthy leads to a search for dignity and most of the service users regained their dignity through self-worth support from competent HPs when participating in the lifestyle interventions in HLCs (Papers II and III). Being in a position to help may be dependent on a HP's capability to decrease feelings of shame, guilt and embarrassment. When participating in lifestyle interventions, service users need HPs to be compassionate, understanding, genuinely interested and non-judgemental in their

support. Likewise, when it comes to the service users previous and present lifestyle, they do not need to hear that they have to be more responsible, eat less and do more exercise. The service users want to assume responsibility (Papers I and II), but are restrained from this due to emotional distress.

Reducing feelings of shame or increasing self-efficacy is a two-sided process and shame and self-efficacy are correlated [226]. The construction of agency and control is closely tied to self-efficacy beliefs [123]. Both self-efficacy and shame are constructs closely tied to the foundational construct of the self [240]. The study by Baldwin et al. [226] suggests a new direction of treating shame 'through the backdoor'; that is, the improvement of self-efficacy (or the treatment of either aspect) could positively impact the other aspect. By helping patients heal from shame, self-efficacy could be raised, and by helping to raise self-efficacy, shame could be reduced [226]. Another study shows that social support in obesity treatment was related to higher self-efficacy, and suggest that HPs should emphasise strategies to increase self-efficacy in these interventions [241]. HPs' efforts to increase self-efficacy by facilitating emotional and social support in group sessions (Paper I to III) can be seen as an important therapeutic contribution in HLCs to reduce shame in people afflicted by overweight or obesity. Service users' active involvement and initiative also contributes to increased self-efficacy (Paper I -III) and seem to be essential elements in self-management and the feeling of being a responsible person (Papers I and II).

Several of the service users wanted to have a better appearance and feel normal. Most of the service users experienced low self-esteem, a sense of failure and negative feelings about their own appearance. Several were afraid of other people's judgement and some of them experienced weight stigma (Paper I). This is also described in previous research [34, 39, 48, 231, 235]. The burden of guilt, shame and weight stigma, and the negative physiological and psychological effects on health, are supported

in previous research [38, 41-43, 48, 234, 235]. Tomiyama describe how this internalised weight stigma leads to stress-reactions and interferes with psychological and physical health, describing a vicious cycle of stress to obesity to stigma to stress [41, 43]. Stress and having a stigmatised body can impact physical health, increase overeating and decrease physical activity [43]. Williams and Annendale [36] explain how the broader understanding of the internalisation of weight stigma as a biopsychosocial process gets under the skin as an embodied process and that the lived experience of obesity stigma is mediated through the body. A Norwegian study exploring weight stigmatisation and what this does to people with obesity found embodiment through a stigmatising process of self-identity and social identity [242]. These perspectives may also be supported in Merleau-Ponty's phenomenology of embodiment – the relationship between the mind and the body, the objective world and the experienced world [243].

The search for dignity is a response to the shame and stigma linked to being afflicted by overweight or obesity. Goffman [244] describes stigma as a deviation from our expectations of normality and the body plays an important role in mediating the relationship between self-identity and social identity. Every social act is influenced by the chance of loss of face or public shame, and people worry about losing acceptance or social status in the eyes of others. According to Goffman, individuals see themselves through a mirror that reflects society's prejudices [244, 245]. The issue of self-representation and personal responsibility found in Paper I are in line with previous studies, where patients tried to defend themselves against shame [33] and presented themselves as responsible and pro-health in dialogues about lifestyle [33, 246]. The service users' need to present themselves as responsible, and having a personal responsibility for lifestyle change (Paper I) can also be supported by Goffman's argument that people wish to present themselves in a positive light [245].

The service users take responsibility by taking initiative to contact the HLCs because they want change, due to health risks and because they want better management of their daily life. The value of personal responsibility may be explained by the service users' descriptions of pride in taking responsibility for initiating lifestyle changes and pride in managing these changes (Papers I and II). Pride, such as in assuming personal responsibility, may be closely tied to the development of self-esteem [237, 247] and motivates human behaviour [247]. It seems like pride may be the most important human emotion when it comes to motivating social behaviour [237, 248], and have probably evolved to provide information about an individual's social status and acceptance [237]. This study highlights the meaning of pride in the service users' self-presentation and in the process of regaining integrity and dignity, which may be a positive mechanism in managing lifestyle change and individual empowerment (Papers I and II).

Dignity is the opinion of others about our worth [249]. Eriksson [224] explains how dignity has several dimensions, where dignity involves having worth. All human beings have, in the deepest sense, the same dignity and worth and everyone has their own understanding of their dignity. The inner dimension of dignity is associated with trustworthiness, sense of honour and morality. The outer dimension is associated with status, appearance and reputation [224]. The service users appreciated the friendly and non-judgemental way of being met and seemed to regain their dignity through self-worth support from HPs and from the social fellowship of peers in group sessions (Papers II and III).

The findings in this study, and the possible interpretation and understanding of this duality of personal responsibility, gives a deeper understanding of the service users' needs. The findings also give direction for the future development of HLCs and lifestyle interventions and highlight the necessity of addressing self-conscious feelings (guilt, shame and pride) as the underlying causes and nature of the problem, as

suggested in previous literature [42, 234, 236, 250]. It will be important to address both the burden and value of personal responsibility, to help service users manage lifestyle change and develop feelings of wellbeing and quality of life. The vast emphasis on personal responsibility for health may affect their capability to assume responsibility. Instead, a more relational, structural, social, political and cultural responsibility may decrease the burden of being afflicted by overweight or obesity and help people assume responsibility. The responsibility of HPs and a structural responsibility will be elaborated on in the next sections, starting with HPs' ethical and relational responsibilities.

5.1.2 The art of acting ethically

In the discussion in this section, I will focus on ethical and relational responsibility and awareness, a non-judgemental attitude and dialogue, a person-centred approach including the ethical principles of autonomy and beneficence and, finally, the empowering process as a result of HPs' ethical responsibility.

The results in Paper III from the HPs' perspectives and the results in Paper II where the service users describe beneficial SMS as self-worth support from competent HPs show that ethical awareness, action and responsibility are important parts of HLC's provision of SMS and user involvement. Ethical awareness, a non-judgemental attitude and dialogue (Paper III) may reflect an essential mechanism in user involvement and beneficial SMS for persons afflicted by overweight or obesity. This seem to involve the HPs' reflectiveness of the service users' needs, which include seeking help for a perceived wrong lifestyle and feeling stigmatised and ashamed (Paper I). HPs emphasise being flexible and adjust to the service users' needs, as described by Roger's [79] person-centred approach, where the focus is on creating a climate for change through acceptance and caring, emphatic understanding and listening, genuineness and an unconditional positive regard [79]. The findings in Papers II and III show that HPs participating in this study are

firmly rooted in humanistic values that support people's existential needs, as described by Kierkegaard [251], and emphasise an 'I and Thou' dialogue, as described by Buber [252] (Paper III). They are especially aware of the existential needs in persons struggling with overweight, obesity, low self-esteem and weight stigma, and that this awareness and ethical acting is essential if they are to support the service users to regain their integrity and dignity. Their practice involves acknowledgement and a non-judgemental attitude and dialogue, which is a prerequisite for working with sensitive problem areas and people in vulnerable situations. Overweight and obesity is for many people a sensitive topic. The HPs in this study seem to have developed the art of meeting the other human being's seeking help with lifestyle change. This way of being and doing seems to be an integrated practice in their work and the culture in HLCs (Papers II and III).

The findings in both Papers I and II show that service users perceive HPs as compassionate, sensitive, genuinely interested and as having a positive attitude toward those who are seeking help. A listening caregiver, who shows compassion and who has the courage to remain in the struggle of suffering from shame and guilt, can help others find a new direction in life in accordance with their own fundamental desires [253]. The results in paper II show that service users regain their self-respect and dignity through self-worth support from HPs and peers in group-sessions. The other participants contributed to fellowship, identity and sharing of experiences in a safe environment created by the HPs. HPs are described as 'building the service users up' by their way of being, their genuine interest, their competence and through their non-judgemental attitude and dialogue, making the service users feel appreciated and worthy. As discussed in Paper III, confirming a person's worthiness and sense of self involves showing genuine respect for each individual as a unique human being and such confirmation is an essential prerequisite for autonomy and integrity [254].

The ethical principles of autonomy and beneficence can be used to further illuminate and discuss the ethical responsibilities of HPs working in primary care HLCs. The relationship between the person-centred approach and the ethical principles of autonomy and beneficence are reflected throughout HPs' practice, their provision of SMS and how they involve service users in the interventions. Autonomy is an important principle in the ethics of caring and in user involvement [78, 92]. HPs in HLCs safeguard this principle by asking the service users what their goals and needs are and let those needs be the object of their support (Papers II and III).

Levinas's [255] theory of existential responsibility towards others was discussed in Paper III, providing a fundamental basis for discussing HPs' ethical responsibilities, including the principles of autonomy and beneficence. The autonomy principle is to safeguard service users' values, needs and decision-making in issues regarding their healthcare and treatment [78]. Beneficence is an ethical principle of wanting to do well and act in the benefit of others. As HPs, we are morally prohibited by rules of nonmaleficence from causing harm to anyone at all times [78]. It is a HP's responsibility to prevent all forms of violation and to give service users and patients the possibility to experience their full worth [224]. Levinas [255] believes that the access to another human being's face is immediately ethical and cannot be reduced to a perception. The face is significant in itself and in the meeting of another's face, there is a commandment to answer their appeal [255]. Ethical responsibility is about our commitment to take care of others and arises in face-to-face interactions with other people. According to Levinas, we are not free to choose our moral or ethical responsibilities [255, 256]. The results from Papers II and III show that HPs seem to understand their ethical responsibility. They have an ingrained understanding of the importance of autonomy (focusing on and tailoring SMS to service users' needs and situations) and beneficence (wanting service users to feel well and experience the effects of training and

lifestyle change). They also see the importance of getting to know the service users and of building a trusting partnership, taking their time, focusing on service users' needs and adjusting the offered support to meet their needs (Papers II and III).

The results in Papers II and III show an empowering process through HPs' ethical awareness and responsibility. The responsibility of the HPs to create a trusting relationship and a collaborative partnership based on acknowledgement and equality was described by both the service users (Paper II) and HPs (Paper III) as important for beneficial SMS and user involvement. The HPs' responsibility was described as letting the service users' voices be heard and emphasising equality, in addition to the necessity of the service users' experiential knowledge and complementary competence in the clinical partnership (Paper III). This shows that the HPs are aware of their responsibility as professionals and assign responsibility to the service users. This is in line with the intention of health promotion, user involvement and individual empowerment approaches described in the Ottawa Charter [70]. Empowerment is a process through which people gain greater control over decisions and actions affecting their life [71], but also a process of reducing guilt and assuming personal responsibility [89, 257]. Letting service users' voices be heard and having a person-centred approach enables people to increase control over and improve their health and life-situation and is integral to the achievement of social equity [70, 88, 89, 257]. This is also in accordance with Freire, who emphasises the importance of people taking responsibility for their problems, suggesting that people who do not feel personal responsibility for their problems will also not endeavour to find solutions to them [89]. Therefore, strengthening and empowering service users in the lifestyle change process is essential.

The HPs (Paper III) and the service users (Paper II) described the necessity of relationships and collaborative partnerships in accordance with the 'co-production' term of user involvement, where the patient

must co-produce the health service individually and/or collectively with healthcare professionals [94-96]. Interpersonal relationships between HPs, service users and peers in group sessions (Papers II and III) and informal social networks established outside HLCs (maybe on the HP's initiative) may foster collective actions [177]. Patient health behaviours and health literacy may become an effect of their HP's behaviour and their mutual interactions [122]. HPs have an important role in highlighting the importance of social, political and environmental factors in determining health and to collect and disseminate information about a host of opportunities in communities to policy makers [177], creating possibilities to manage, for example, physical activity on their own after the intervention period in HLCs. Empowerment holds both an individual and a structural dimension [90]; this structural dimension will be discussed further in the next section.

5.1.3 The challenges and possibilities in sharing responsibility

Under this third and last theme, I will highlight and discuss the concepts of sharing responsibility. This will include a whole-system approach, demonstrated through a socio-ecological model of how responsibility in health may be shared (figure 4, p.71). In this discussion, I will include the challenges related to political and structural responsibility in a post-modern and neoliberalist ideology. Finally, the concept of self in self-management will be debated, as well as the possibility of a more collective understanding of self-management as a potential development of the healthcare services in HLCs.

The consequences of a one-sided emphasis on personal responsibility for health in contemporary society is discussed above (5.1.1). The literature often highlights health behaviour change at an individual level, focusing on biomedical models of behaviour change and rarely at a professional or societal level [28, 173, 176]. According to the biomedical perspective, overweight and obesity is essentially the result of an energy imbalance

driven by individual behaviour. Self-management outcomes tend to focus on biomedical indicators selected and monitored by professionals, rather than on outcomes important to the patient [258]. The common approaches to obesity treatment have been attempts to change individual behaviour by changing energy imbalances, primarily through health education [15]. This approach has had significant implications for obesity treatment and prevention, influencing clinical practice and government policy in spite of the evidence against its effectiveness at the population level [173].

The recommendation to establish HLCs in all municipalities is one effort to help people to change their lifestyles [13]. In theory, HLCs and the government guidelines view overweight and obesity as a complex problem with multiple interconnected variables [5]. However, in practice, the lifestyle interventions offered focus on a biomedical view, where the service users are offered healthy diet courses and exercise sessions aimed at helping the individual change their behaviour [13]. A pragmatic RCT study of HLCs does not support a strong emphasis on behaviour change at an individual level as a way of targeting general health and risk reduction at a population level [259]. Adherence to programmes is poor (high drop-out rates) [58, 62] and patients in lifestyle interventions experience a lack of long-term success [17, 29, 172, 173]. Because of the complex systems that affect obesity [15, 17, 29], several studies suggest a whole-system approach to address the multiple factors and levels [17, 173, 176].

A unilateral focus on personal responsibility was suggested to inflict more guilt and self-blame (Paper I). The HPs in this study are aware of their professional responsibility and assign responsibility to the service users for the purpose of sharing responsibility (Paper III). Sharing responsibility and focusing on wellbeing, better perceived health and management of everyday tasks, instead of weight and BMI, are suggested in Paper III to reduce the pressure on weight loss and the burden of guilt, shame and stigma (Papers I and III). An important

therapeutic mechanism in beneficial SMS and user involvement may lie in the possibility of sharing responsibility between service users and HPs (Paper III).

It may also be possible to go beyond personal and intrapersonal sharing of responsibility and examine the structural and political responsibility in society. Socio-ecological models, founded in Bronfenbrenner's socio-ecological theory [81], are suggested to guide health promotion efforts towards structural, environmental and political changes [173, 177-180]. The socio-ecological model considers economic, cultural, social and political determinants and presents individual obesity as, at least partially, influenced by forces external to the individual [5, 177, 179]. Biomedical, socio-ecological and complex models all contribute to our understanding of obesity and are needed to inform our efforts to intervene [5, 173, 176]. Applying a socio-ecological model (inspired by Bronfenbrenner [81, 260] and Stokols [180]) to better understand the concept of responsibility and sharing responsibility (including a deeper understanding of the service users' needs, beneficial SMS and user involvement) are illustrated in figure 4:

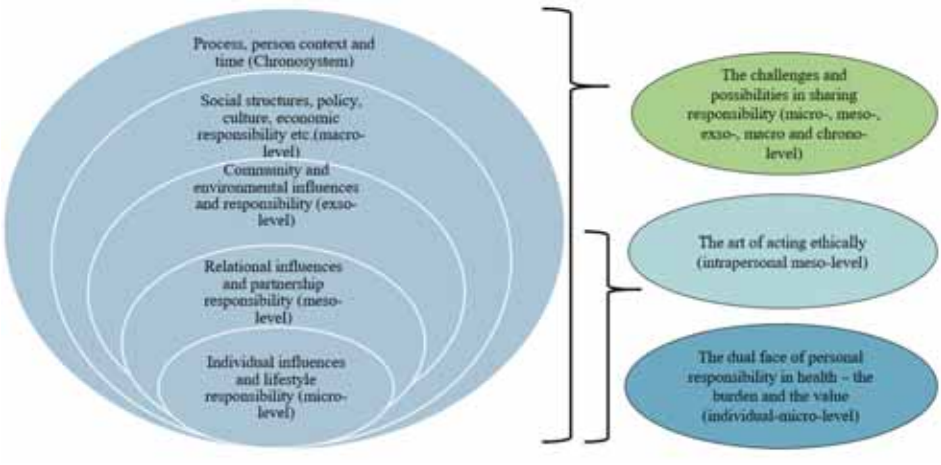

Figure 4. A socio-ecological model of responsibility in health

Responsibility for health promotion and preventing and managing illness lies in many levels; from individual responsibility (personal responsibility for a healthy lifestyle), relational and partnership responsibility (professional responsibility and HPs providing support and care), to society's responsibility (a healthy environment and structural responsibility for policy).

Both the service users and the HPs (Papers II and III) perceive the need for long-term follow-up (table 2, p.40). On both the micro- and meso-level, there will be possibilities of sharing responsibility and developing relationships and interventions to safeguard long-term follow-up, with easily accessible contact with HPs in HLCs if necessary (Papers II and III). However, there must be a greater focus on follow-up programmes, where service users know they will be met in a friendly and welcoming way and that no one will judge or tell them to take more responsibility in the long-term. Therefore, the chronosystem [260], considering the process of lifestyle change, time and context, is essential in a holistic understanding.

Upstream prevention is a concept from McKinlay [261] that focuses on actions aimed at reducing the magnitude of inequality by recalibrating systems to move further up etiologic pathways, finding the 'causes of the causes' [261]. It is important to strengthen prevention services, deliver care in novel ways, honour grassroots wisdom and broaden care to include health determinants [262]. The NCD strategies [9, 10], the European Policy for Health and Wellbeing [88], WHO's European Healthy Cities Network [263] and the Norwegian White Paper [5] emphasise a whole system approach. This includes creating a society that promotes health and decreases health inequalities for the whole population, in accordance with the Ottawa Charter's strategies for public health and health promotion [70]. The Norwegian government is given the responsibility for public health work nationally, to identify challenges and factors affecting health, to plan and design national measures, to assist the municipal sector and to facilitate a systematic and knowledge-based public health work [5, 7]. The White Paper [5] states that there must be a balance between the community's responsibility for the population's health and the individual's responsibility for their own health. As long as the systematic differences in health are related to inequalities in society's distribution of resources, it will be the community's responsibility to influence this distribution in a more justifiable direction. This can include making healthy choices easier and more attractive and unhealthy choices more difficult [5]. Considering the challenges related to the government's efforts and decisions to increase taxes on sugary food and beverages, and being forced to go back on the agreements [264], may explain some of the difficulties in making unhealthy choices more difficult. In the end, service users are made responsible for their choices. Policy makers believe that changing environmental and social policy is of the utmost importance; however, they consider it unlikely that such politics would be implemented without political will and popular support [231].

Postmodern and contemporary societies with a neoliberalist ideology and new public management as a management ideology, emphasise an individual's free choice. The core of liberalism implies that individuals take precedence over society and collective ideas [265]. In Scandinavian welfare states, the welfare ideology of communal values, solidarity and equality have become increasingly powerless and fragmented at the cost of capitalism and individualism. In this ideology, where people are self-interested, competitive and independent individuals, the balance between individual and community duties and responsibilities is subtle [227]. Neoliberal values are evident in the health discourse of consumer choice and empowerment and are shaping the policy of self-management in chronic diseases [266, 267]. This agenda is underpinned by respect for patients and their self-determination, a construction of the patients as empowered, able to participate, autonomous and capable of making choices that some have argued resonates with the neoliberal philosophy [95]. Patients are held responsible for enforced choice and 'responsibilisation' may be the hidden component of patient involvement [95].

By encouraging patients to self-manage, person-centred care has shifted the responsibility for health onto the individual and away from the government [95, 268]. This may result in politics, social structures and organisations that evade or disclaim responsibility [95]. This can also influence the responsibility for health and may inflict a greater burden on people not managing the health authorities' guidelines for a healthy lifestyle (Paper I). It may also affect the common view of laypersons and health professionals, that the individual is responsible for their own life and health, and maintain weight stigma, blame and self-blame. This will make it difficult to address weight stigmatisation of people with overweight and obesity on a societal and cultural level. However, it will be important that HPs continue to reflect upon human values, ethical responsibility and shared responsibility, as this shows the importance of increasing people's ability to assume personal responsibility (Paper I-

III). In Gidden's modernity, more and more actions occur in faceless relationships (internet, banking, commerce, apps for self-help) [269]. Face-to-face relationships in HLCs are important (Paper I-III) and maybe it is the human, close relationships with 'fellow strangers' that are satisfied within HLCs. Therefore, it can be problematic to transform HLCs to a more individualistic 'arena of independence', when there is no need for everyone to be independent (as people need people).

This neoliberal ideology may have some similarity to the concept of governmentality and liberal governmentality [95]. Governmentality is an organised practice through which individuals are governed and is a calculated means of directing people's behaviours and actions [228]. In a neoliberal government, power is delegated to the individuals; with this, responsibility is also transferred to the individual and self-governing capabilities and autonomy is highlighted [95, 228]. Steering towards increased user involvement (individual choice) and empowerment, this may also increase the risk of the government's disclaimer [95]. Are people reasonable and capable of making healthy choices all the time? The prevalence of overweight and obesity, its growing rates and the subsequent number of NCDs [1] gives reason to believe a resistance to established prevention and treatment efforts [31] and that people find it difficult to assume personal responsibility for a healthy lifestyle (Paper I and II). Self-governing capabilities [228] are similar to the understanding of self-management, independence and the individual's ability manage treatments, as well as lifestyle change [114, 118].

One can question the ideal view of self-management and independent individuals. Modern society and policy, especially neoliberalism disseminating in more countries, highlight the free and independent individual and, therefore, personal responsibility. It has never been more important that patients willingly and skilfully take on daily self-management responsibility [270]. Too much focus on self-management in a neoliberalist society may result in a greater burden for service users and patients because they are not 'good' self-managers [229]. The

concept of a good self-manager highlights the moral dimension of self-management. A good self-manager is an individual who is re-moralised, takes responsibility for their health, is knowledgeable and uses this to manage risks, and is active in using information to make informed decisions regarding health and social wellbeing. Ellis et al. suggest moving away from the neoliberal discourse and towards truly valuing patient choice without moral judgement and critique [229]. It appears HPs in HLCs in this study believed a non-judgemental attitude and dialogue was essential to get in position to help, and reduce the burden of moral personal responsibility (Papers II and III).

Greenhalg [66] suggests that self-management programmes based on the expert patient model (e.g. individual responsibility) are still the preferred policy in many countries and that the evidence base for their efficacy is weak. A more holistic model, considering a person's family, friends, social and political contexts, is needed [66]. This challenges the concept of self-management in weight management and lifestyle changes and the understanding of responsibility. Therefore, self-management, responsibility and SMS for lifestyle change is suggested to have a great potential if and when responsibility is shared between HPs, social networks, community and policy (Papers II and III). The results in all three papers (I to III) show that service users need support from significant others; however, not all people have available support. People need people – they need to be seen, listened to and have confirmation – people need to be needed and to mean something to others.

This is also one of the mechanisms in SMS in HLCs, the emphasis of social support and fellowship in group sessions and the joy and meaningfulness of participating in these groups (Papers II and III). This is not, of course, the whole answer to overweight and obesity prevention and treatment; however, it is an essential part of self-management. This makes the 'self' in self-management contradictory, due to people being more or less dependent on others for their wellbeing, meaningfulness and support. The term 'self', with regard to chronic diseases, should be used

more cautiously and critically [270]. In chronic disease management, self-management is problematic and contradictory [270] because family, community and societal conditions influence the choices people make or can make [5, 70, 270]. Family-based interventions in chronic illness have shown positive results for patients with chronic conditions [271]. In diabetes 2 prevention, having a family and being part of a social network could improve outcome of lifestyle intervention programmes [272]. Family-based interventions targeting childhood obesity are successful in producing weight loss in the short and long term [273]. However, there are no studies found on interventions including family and friends in adults' lifestyle changes in overweight and obesity; this may be a promising intervention given the importance of relational and social support in managing lifestyle change, as suggested in Paper II.

The results in all three Papers (I to III) indicate and describe the importance of social support and networks for lifestyle change. This is in line with the health promotion literature, which emphasises contextual determinants (where people 'learn, work, play and love' [70]) and a socio-ecological approach and understanding of health behaviour change [176-180]. Healthy living is not always an individualised process of correct choices that result in improved health and independence. The results show that service users need emotional and self-worth support from significant others (Paper II), where responsibility is shared (e.g. at the individual and meso-level) (Paper III). Vassilev et al. [230] emphasise the important role social networks play in self-management and suggest a more collective understanding of self-management and collective-efficacy, rather than self-efficacy. This view may affect the ability of key players to work in partnership. Interventions could be more productively designed to maximise the possibilities for social engagement [230]. The findings in Papers I to III indicate a need for prolonged support and follow-up and a more collective approach, engaging families and friends in the interventions was suggested (Paper II). Another study found a restricted capacity of primary care to provide

SMS, and building a system capable of engaging social network capacity to mobilise resources for SMS from the broader community was suggested [274]. The call for a more collective form of responsibility was also identified in this study (Papers I to III). This is also one of the intentions described in the HLC guidelines [13]. Some of the physical activity groups established in HLCs, as described by some of this study's service users and HPs (Papers II and III), continue to meet once or twice a week and network groups are established on social media, such as Facebook and Messenger (Paper II).

In line with Askheim [90], the key to individual empowerment and better self-management is to see the relationship between the service users' challenges and life situations and the social and structural conditions. A one-sided emphasis on individual aspects may indicate that the political, structural and collective aspects are not considered in the empowerment process [90]. Less focus on biomedical models (at the level of individuals) and a greater focus on socio-ecological models (including political, environmental, cultural and economic determinants) may be a way to share responsibility for health promotion, prevention and treatment in community healthcare and HLCs. The purpose of sharing responsibility should not deprive the individual need to take responsibility or the experience of pride in taking responsibility. Sharing responsibility may be an opportunity to better succeed in health promotion and to improve the effects of interventions on public health. Thus, building social relationships and networks seems to be essential for lifestyle change. Measures must, therefore, be more widely applied at various levels in the socio-ecological system.

5.2 Methodological considerations

Due to the lack of research in Norwegian HLCs at the start of this project in 2015, I chose a qualitative, explorative study grounded in hermeneutic methodology and tradition. This is because qualitative methods can be useful when studying human characteristics, when exploring

participants' experiences, perceptions, values and needs, or when searching for deeper understanding of phenomena [181-183, 187]. Studies from Sagsveen et al., published in 2018 [64, 65], explored user involvement in HLCs. If these studies had been available earlier in my research process, the research questions may have been asked differently or more precisely. However, finding newly published studies of user involvement is also a confirmation of other researchers' views of the need for more knowledge and a deeper understanding of this phenomenon in Norwegian primary care HLCs.

Individual in-depth interviews and focus group interviews were chosen as they are appropriate data-collecting methods in qualitative research [187, 209, 210]. This is in line with the social constructivism paradigm adopted in this study and in the co-creation of reality through language and dialogue [185, 187].

Individual interviews with the service users were used in sub-studies 1 and 2, due to the private and sensitive aspects of the topics of overweight and obesity and the users' efforts to seek help. Individual in-depth interviews on sensitive topics are preferable to focus group interviews, to protect and safeguard the participants and I assumed that it would be easier for the service users to speak openly. My role was to create a dialogue and help users elaborate on the topics and phenomena under study. The service users spoke openly about their challenges, desires and experiences. This may not have occurred in a group environment where the service users did not know each other.

Focus group interviews were chosen to collect data from the HPs. For the HPs in HLCs, the topic and phenomenon under exploration (beneficial SMS and user involvement for persons afflicted by overweight and obesity) is not a private or personal issue in the same way as for the service users. Focus group interviews were chosen to reveal different views, create discussion and use the group interactions to produce data. My role was to moderate the discussion, ask questions,

follow up answers and reflections, and ensure that all HPs were involved. The HPs appreciated the opportunity to discuss their practice with other HPs in HLCs, which for them became an arena of learning. A multi-stage focus group interview was planned. With respect for the HPs' time and due to difficulties in finding a time that suited all participants, this was changed to a one-time focus group interview. The level of discussion, reflection and amount of data in each focus group was considered sufficient to respond to the aim and answer the research questions.

5.2.1 Strengths and limitations

I was involved in all parts of the study, created the design, conducted the recruitment and data collection and undertook the initial coding and categorisation in the analysis process. This means that I have a significant knowledge of the data and understand the study as a whole.

The analysis was conducted and described as thoroughly as possible through the analytical steps of qualitative content analysis [211] and thematic analysis [212] in the method section (3.4.1 and 3.4.2). The coherent and systematic use of qualitative content analysis (Papers I and II) and thematic analysis (Paper III) strengthen this study.

All three papers and the synthesis of the findings in section 5.1 are strengthened by the use of inductive coding and categorisation of empirical data [215, 216] and by using theory (deductive) [215-217] in further processes of the analysis. The demonstration of the analysis processes as a hermeneutical spiral (in figure 2, p.38 and figure 3, p.58), including the hermeneutical interpretation, the researcher's preunderstanding [189, 193] and the abductive strategy [185, 201, 204, 205] used to develop themes and main-themes in the latter part of the interpretation process, may increase the understanding of the analysis and the subsequent results.

After searching the comprehensive literature on SMS in chronic conditions, I found that very few studies have focused on SMS related to persons afflicted by overweight or obesity. Therefore, this study revealed new and relevant knowledge, especially for use in Norwegian HLCs, as well as for international interventions and research. This study provides a deeper understanding of both SMS and user involvement in lifestyle changes, particularly for persons with overweight or obesity, due to the emphasis on a more interpretative analysis method (a hermeneutic spiral and abductive approach) rather than a more descriptive phenomenological approach.

The strength of sub-studies 1 and 2 lies in the semi-structured in-depth interviews. The intention behind using a semi-structured interview guide with open questions (Paper I and II) was to reveal experiences and perceptions from the service users' perspective. Open questions allowed for elaboration of the service users' understanding. The intention was to interpret what the service users were searching for and what beneficial SMS and user involvement meant to them. Each interview lasted between 60 to 130 minutes, providing the users with opportunities to elaborate on the questions and the researcher to follow up the responses. The variety in age, gender and socio-economic status strengthened the utility and transferability of the findings, which are enhanced by the rich descriptions of the context, the inclusion of service users from five different HLCs in Western Norway (both rural and urban municipalities), the data collection and analysis, and the inclusion of quotations from a number of participants. Information power [207] guided the data collection to ensure a variety of perceptions.

The strength in sub-study 3 lies in the use of focus group interviews. This was a plausible method for exploring HPs' values and reflections. A topic guide was used to initiate the discussion. The HPs played an active part in the discussions, in a highly reflective manner. The familiarity between HPs from previous networking and working together made most of them feel comfortable, with everyone taking the opportunity to speak.

This reflects the benefits of choosing a focus group to collect data from the HPs' perspective. It was also a strength that the HPs represented both rural and urban municipalities and reflected multiple realities and different occupational backgrounds and practices.

However, after seeing the three sub-studies together and synthesising the findings of the three papers, it appears the analysis process and results of Paper I, especially regarding the capability of personal responsibility, have influenced the analysis process and results in Papers II and III. The results in Paper II then affected the analysis process and results in Paper III. This is natural and logical, as I asked the same questions of the service users and HPs in relation to their perceptions of SMS and user involvement. However, in addition to similarities in the importance of acknowledgement and prolonged and individualised self-worth support, the study concentrating on HPs (Paper III) identified the importance of professional ethical responsibility.

Some methodological limitations should be addressed. In Papers I and II, the recruitment of service users could have been influenced by the HPs' knowledge of those who were especially satisfied with the lifestyle intervention. The service users may have also been influenced by the ongoing process of change and participation in both dietary and activity interventions over an extended period of time prior to the interviews. The self-selection of volunteers to participate and the service users' opportunity to participate in HLC interventions in the daytime (due to their life and employment situation) may have influenced their descriptions of user involvement and satisfaction, such as everyday structure and social and emotional support. We have no data on those who declined to take part in the study or those who were prevented from participating for various reasons. However, in Paper II, the research question concerned perceptions of beneficial SMS (and not useless support and barriers to participation). The recruited service users participating in this study were, therefore, suitable [182, 207].

In Paper III, one possible limitation might be the gender balance, as there was only one male participant. However, this reflects the general gender balance in HLCs, as most HLCs have a majority of female employees. Another limitation that should also be considered concerns the composition of the focus groups [209]. The participants in one of the groups had experience of inter-municipal collaboration over a period of several years, while the participants in the other group had only met a few times and had less experience working in a HLC. A potential limitation lies in the high degree of consensus, although none of the participants appeared to be reticent about expressing their opinions and perceptions.

5.2.2 Trustworthiness for papers I to III

Trustworthiness concerns the need to present arguments that support the most probable interpretation [213]. Lincoln and Guba [184] have made a clear criteria for trustworthiness in qualitative inquiry, which is applicable to a Gadamerian research process [193]. This criteria is to clearly document various decisions made during the research process and different stages of analysis. Increasing trustworthiness in qualitative research involves addressing aspects of credibility, dependability, transferability and confirmability [184].

Credibility can be established by ensuring that the perspectives of participants are represented; quotations from the participants can help the reader to make a judgement on this matter [184]. To facilitate the interpretation and analysis of data, direct quotations to strengthen credibility and represent the participants' perspectives were included in the papers (I to III). All three papers used quotations in the results sections, to bring out the voices of the participants in this study and to illustrate the themes.

Dependability holds judgement about the stability of the study findings, based on the potential for replication [184]. The categories and themes found in the analysis process showed a high degree of similarity between the participants' perceptions and understandings. The methods used in recruitment, data collection and the context and analysis processes were described in detail in all papers.

Confirmability can be managed by returning to the participants at all stages of the research process. Objectivity in hermeneutic research occurs by faithfully representing the text, although this is an ideal that cannot be achieved entirely, as readers will interpret research findings from their own horizons [184]. Consensus about the meaning of the statements will be in line with the concept of confirmability. Gadamer explains there is no statement that is universally true, because no statement can escape the complexities of interpretation. Understanding can only be achieved by consensus on the whole and the parts of the text, this is only through one's preunderstanding that understanding is possible [189, 193]. The significance of the preunderstanding and theoretical framework has been clarified and implies awareness in the whole process of research and in the interpretation of data, as discussed in paragraph 3.1.4. Discussion of the sub-themes and themes between the authors on several occasions over a period of time aimed to find the most appropriate interpretation and increase the confirmability of the findings. Confirmability is predicted by common characteristics, such as language, culture and time [193]; in this study, the participants live in the same culture with the same language and the data collection was limited to a five month period in 2017.

Transferability, whether the findings from the study can be transferred to other settings or groups, is another aspect of trustworthiness in qualitative research [184]. One mechanism for promoting transferability is the amount of information qualitative researchers provide about the study context. The researcher can provide descriptions necessary to make a transfer of the research conclusion about whether transfer can be

contemplated as a possibility, and relevant to other situations [184]. In this study, HLCs as the study context have been described comprehensibly, including content and duration of the interventions. This study was based on a relatively small group of service users and HPs in one part of Norway. The familiarity between the HPs, their inter-municipal collaboration and network meetings may have influenced their attitudes and understanding of SMS and user involvement. Participants from other parts of Norway and from larger municipalities may have revealed other results.

5.2.3 Ethical considerations and reflexivity

In this study, there are several ethical aspects. Undertaking research on stigmatised individuals (e.g. the experiences of obese persons) in vulnerable situations requires particular care [275], presenting the researcher with unique opportunities and dilemmas. An interview is a moral enterprise, according to Kvale and Brinkmann [187]. Ethical issues typically arise in interview research because of the asymmetrical power relationship between interviewer and respondent, where researchers are usually positioned as the relatively more powerful side. Ethical problems arise particularly because of the complexities of researching private lives and placing accounts in the public arena [187]. The knowledge produced by such research depends on the social relationship of the interviewer and interviewee, which rests on the interviewer's ability to create a stage where the subject is free and safe to talk of private events recorded for later public use. This, again, requires a delicate balance between the interviewer's concern for pursuing interesting knowledge and ethical respect for the integrity of the interview subject. It is important not to offend subjects, while at the same time the researcher has to give something of themselves to merit an open response [187]. This was emphasised and described in sections 3.3.2 and 3.3.3.

In this study, the interview could have been an unpleasant reminder that the service user is not living a healthy life in line with health authority guidelines and some may feel that they impose an additional burden to the society and healthcare services [27, 28, 42, 235], which can cause distress. If any of the participants showed any discomfort when asked a question or did not respond, this was not followed up with the same questions. I respected the participants' privacy and restraint in some areas, by noting the answers they gave and their body language. This was not a problem and most of the participants were more open and outspoken than expected.

Guillemin and Gillam [206] emphasise the respect of people and that respect for the dignity and wellbeing of people takes precedence over the expected benefits to knowledge. They identify the interview as an unnatural social situation, a polite interrogation of the participant that is not aimed solely at benefiting them, and that this practice is ethically questionable [206]. Avoiding causing harm to participants is an absolute and basic consideration [222]. Guillemin and Gillam suggest we need a process and a way of thinking that will actually lead to ethical research practice, which is where they see an important role for reflexivity. Reflexivity in research is a process of critical reflection, both on the kind of knowledge produced from research and how that knowledge is generated [186, 187, 206]. The knowledge produced in this study concerns experiential knowledge, which may contribute to a deeper understanding of service users' needs, beneficial SMS and user involvement. Implementing this knowledge in practice may benefit service users and HPs

The researcher's reflexivity is important in qualitative research and concerns the capacity to reflect on one's role and position, subject of interest, methods and analyses throughout the entire research process [182, 183, 206]. In this study, my role as researcher has been critically reflected upon throughout the entire process. Throughout the data collection, interviews and analysis, I had to be aware of my role as a

researcher, rather than as a public health nurse, and my responsibility to act in respect of the participants (HPs and service users), create a safe environment and ensure confidentiality. In line with the hermeneutic approach employed in this study, there is always a possibility of ambiguity and different interpretations of the meaning of the text [182, 187]. The analysis and interpretation were influenced by my own and my co-authors preunderstanding, which must be considered when interpreting the participants' reality. My theoretical background and clinical experience (as a public health nurse) have been described in all the papers. This background provided a preunderstanding and experienced-based knowledge of the research phenomenon, in addition to valuable insights concerning lifestyle change and social stigma and the understanding of overweight and obesity leading to problems with self-esteem, weight stigma and psychosocial health. This knowledge and preunderstanding can also be seen as a methodological strength in this research process. However, to minimise potential bias, the supervisors and co-authors of the three papers read all the transcribed interviews. The researchers' various disciplinary backgrounds and clinical experiences, as a psychiatric nurse, a public health nurse, from patient education and intensive care, enriched the analysis and interpretation, increasing the trustworthiness.

6 Conclusion

This study has explored service users' needs, beneficial SMS and the significance of user involvement for persons afflicted by overweight or obesity attending lifestyle interventions in HLCs, from both service users' and HPs' perspective. A synthesis of the findings in the three papers can provide a deeper understanding of service users' needs, beneficial SMS and user involvement by means of three new themes: *The dual faces of personal responsibility in health – the burden and the value*, *The art of acting ethically* and *The challenges and possibilities in sharing responsibility*.

The first theme, *The dual faces of responsibility in health – the burden and the value*, is based on the service users' search for dignity and the emotional alternation between shame, guilt and pride. This duality can be understood as living with overweight and obesity as a burden of shame and weight stigma that influence the users' capability to assume personal responsibility. The value can be understood as a perception of dignity, pride, active involvement and assuming responsibility.

The second theme, *The art of acting ethically*, seems to be an integrated attitude of beneficence in HPs' practice and is demonstrated by their capability to engage in a person-centred approach and to see the service users' existential needs in a vulnerable situation. HPs meet the service users with generosity and acknowledgement and SMS tailored to the service users' needs. The SMS (including self-worth support) that HPs provide is based on ethical awareness, a non-judgemental attitude, dialogue and shared responsibility. This may help the service users to increase their self-efficacy, improve their self-management and regain their integrity, self-respect and dignity. Through the HPs' way of meeting and involving service users in interventions and lifestyle change processes, through their 'ethical acting', we get an understanding of how

HPs involve service users and what user involvement implies for the HPs in HLCs.

The last theme, *The challenges and possibilities in sharing responsibility*, is built on the findings that HPs treat service users as equal partners in a collaborative partnership based on shared responsibility. One challenge is that, for several of the service users in this study, lifestyle changes required long-term follow-up. Another challenge is that lifestyle changes and self-management are linked with relational, emotional and social support and that significant others are important for individual empowerment. Not all service users have such support from others. The burden of too much personal responsibility in an obesity-promoting environment and society may also challenge the service users' self-management. In addition, there are serious challenges related to sharing responsibility at a structural and political level, which requires political will. An important therapeutic mechanism in beneficial SMS and user involvement may lie in the possibility of sharing responsibility, rather than a unilateral focus on personal responsibility (as supported in a neoliberal society). The HPs' way of being and sharing relational responsibility (as long as the service users need this), may reduce the burden of personal responsibility, shame, guilt and weight stigma. This may also increase self-efficacy and help service users live a healthier life and experience a better quality of life and wellbeing. Accordingly, there is a possibility of sharing responsibility at a relational level and to highlight collective approaches from a socio-ecological perspective.

7 Implications for clinical practice

Effective SMS interventions are critical for qualitative healthcare services. Through this explorative, hermeneutical and abductive study, the findings contribute to a deeper understanding of service users' needs, user involvement and SMS in lifestyle change and may have significance for HPs' provision of SMS in clinical practice.

The findings show that, to be in a position to help, HPs need to be interested, sensitive and take the time to listen. It will be important for the service users' self-respect that they actively engage in any intervention and in the lifestyle change process. HPs focusing on the service users' resources and management, and continuing to create a safe environment in HLCs with the emphasis on dialogue, equal partnership and a non-judgemental attitude and atmosphere, may provide opportunities for individual empowerment and lifestyle change. HPs in HLCs have something to teach us about ethical acting and helping persons who are struggling with overweight or obesity and in a vulnerable situation to change their lifestyle and regain dignity.

HPs need to address self-conscious feelings like guilt, shame and internalised stigma, as well as responsibilities related to dilemmas about a right or wrong lifestyle, as this is often the cause of the problem and leads to avoidance of responsibility. The findings in this study, suggesting that service users regain dignity and self-respect through their participation in lifestyle interventions in HLCs, is interesting. The main object of HLCs is to help, facilitate and empower service users towards better self-management. HPs in this study highlighted their commitments to ethical and relational responsibility, beneficence and raising service users' self-efficacy, which seems to reduce feelings of shame and weight stigma. This study shows that Norwegian HLCs seem to have a great potential to support self-management in lifestyle change for persons afflicted by overweight or obesity. However, the SMS and user

involvement in lifestyle interventions need to focus on shared responsibility in a collaborative and equal partnership, rather than personal responsibility.

The study shows that most service users need emotional and social support and long-term follow-up. Initiating and motivating participants to participate in HLC interventions together with a friend, family or a partner may lead to more lasting lifestyle changes. A collectivist perspective can integrate the importance of significant others' involvement and shared responsibility. Providing long-term support will strengthen the ability of HLCs to provide beneficial SMS to persons afflicted by overweight or obesity. This indicates that it will be of importance to engage in a holistic approach, such as a socio-ecological model of lifestyle intervention, rather than biomedical approaches, which often emphasise weight and BMI outcomes, what to eat and the amount of physical activity.

8 Implications for further research

The findings in this study suggest that it may be time to highlight the need for SMS and user involvement to focus on shared responsibility in partnership rather than on personal responsibility. More research is required to explore the conditions for such practice, including intervention strategies to reduce weight stigma. It would be interesting to explore the effects of self-management interventions on experiences of shame, guilt and weight stigma, as well as experiences of pride.

How HPs in HLCs manage to prioritise time and their challenges and needs related to the organisation of lifestyle interventions requires further investigation. Cooperation between HLCs and the important role of GPs in overweight and obesity treatment need to be investigated. Further research should also focus on the high drop-out rates and explore reasons for drop-outs.

If self-management were the desired outcome, some of the solutions that HLC can provide would be to focus on long-term self-care strategies, including supportive design and practice for interventions to promote self-esteem, self-respect and dignity. In addition, cost-effective follow-up programmes, maybe over years, should be developed. Further studies should also focus on methods to improve these programmes with regard to social support, such as the recruitment of service users with friends or families to safeguard the necessary long-term social support.

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Paper I

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Healthy Life Centre participants' perceptions of living with overweight or obesity and seeking help for a perceived "wrong" lifestyle - a qualitative interview study

Elin Salemonsen[1,2*], Britt Sætre Hansen[2], Georg Førland[1] and Anne Lise Holm[1]

Abstract

Background: Overweight and obesity are complex conditions, associated with a wide range of serious health issues. In contemporary society, body size is an important part of a person's self-representation. Lifestyle changes are difficult and long-term weight management is associated with a high risk of failure. In primary health care in Norway, lifestyle interventions are offered by Healthy Life Centres (HLCs) to those seeking help with weight management. The aim of this study was to explore HLC participants' experiences of living with overweight or obesity and perceptions of seeking help to change dietary and activity habits.

Method: This exploratory study employed a qualitative design. Semi-structured in-depth interviews were conducted with 13 participants. Data were transcribed verbatim and analysed using qualitative content analysis.

Results: The analysis resulted in one main theme: *Searching for dignity*, based on two themes: 1) *Needing to justify avoidance of personal responsibility* and 2) *A desire to change.*

Conclusion: Changing dietary and activity habits is difficult as the emotional alternation between shame, guilt and pride influences the ability to assume personal responsibility. A deeper understanding of each participant's perceptions and experiences is important for the ability to tailor and provide a high quality health service. Addressing participants' emotional distress and search for dignity is necessary for enabling dietary and activity change. This should be considered in the future development of HLCs and health promotion interventions in order to educate service users about emotions and the role they play in food consumption and inactivity. Weight stigma at individual and system level as well as responsibility related to dilemmas about "right" or "wrong" lifestyle should be addressed.

Keywords: Overweight, Obesity, Help-seeking, Personal responsibility, Healthy life Centres, Shame and pride, Qualitative research

Background

Overweight and obesity present an increased risk to health and are major risk factors for a number of non-communicable diseases (NCDs) including type-2 diabetes (T2DM), cardiovascular disease (CVD), chronic obstructive pulmonary disease (COPD), some types of cancer, musculoskeletal disorders and mental health problems [1–3]. The risk of NCDs is primarily driven by tobacco use, physical inactivity, unhealthy diet and alcohol abuse [2]. The Norwegian Directorate of Health recommends the establishment of Healthy Life Centres (HLCs) in all municipalities in order to assist persons at risk of NCDs, or in need for support for health behaviour change or weight management [4]. Empirical evidence highlights the importance of lifestyle change as a key component of risk reduction and the promotion of healthy development [5]. A healthy lifestyle is associated

* Correspondence: elin.salemonsen@hvl.no
[1]Faculty of Health and Social Sciences, Department of Health and Caring Science, Western Norway University of Applied Sciences, Bjørnsons gate 45, 5528 Haugesund, Norway
[2]University of Stavanger, Faculty of Health Sciences, Kjell Arholmsgate 39, 4021 Stavanger, Norway

with protective risk factor levels and lower levels of symptoms and illness, including psychological illness [6]. The outcome of educational interventions aimed at increasing the level of physical activity (PA) with follow up in primary care is uncertain [7]. In addition, a quantitative study of HCL lifestyle interventions reveals that participation in a prescribed group-based exercise programme for 3 months may improve physical fitness and Health Related Quality of Life (HRQoL) [8]. In a literature review, the main barriers to the success of educational programmes were found to be psychological and environmental, but also socio-economic [9].

The individualization of health has been discussed in recent decades and this ideological shift in health promotion makes every individual responsible for her/his own health and for learning to adopt rational lifestyle behaviours [10, 11]. Studies of attitudes towards obesity show that as many as 72% mentioned individual reasons for obesity. Media and public health campaigns may solidify beliefs that obesity is due to individual causes, thus increasing the stigma [12]. A Norwegian study of normative newspaper messages on obesity and health, revealed a focus on bodily conformity, linking leanness with attractiveness, obesity with ugliness and lack of control with lack of responsibility [13]. Numerous studies have documented harmful weight-based stereotypes such as persons with overweight and obesity are lazy, unintelligent, have poor willpower and are noncompliant with weight-loss treatment [14, 15]. These stereotypes give rise to stigma, prejudice and discrimination against obese persons in multiple domains of life [15, 16], thus contributing to their lower psychological functioning and well-being [17]. Stigma can be a barrier to seeking help for weight management [18, 19].

In a qualitative study of primary care physicians and nurses responsible for lifestyle change, a majority reported that a major barrier was patients' unwillingness to change their habits [20]. In earlier studies of participants' perceptions of self-responsibility in an intervention to prevent T2DM, the informants had an ambivalent attitude towards self-responsibility and their own role in lifestyle change and its maintenance [21]. A majority of lifestyle intervention participants characterize lifestyle change as a constant struggle [21, 22] and weight management as an endless battle against temptations [21]. In a study about lifestyle issues in clinical dialogues, patients took a proactive role in defending themselves against shame and made great efforts to present themselves as responsible agents in matters of health [23]. The participants in a previous qualitative study of Norwegian HLCs described how earlier life experiences and emotional baggage can influence lifestyle change and questioned whether or not HLCs can actually help participants with substantial emotional baggage to change their lifestyle [22]. In addition, HLC stakeholders have a wide range of expectations and they describe HLCs as a concept in development [24]. In a newly published cross-sectional study of the characteristics of participants who started attending a HLC, the most frequent reasons were being overweight, wanting to increase physical activity, improve dietary habits and cope with musculoskeletal health challenges [25].

The scientific evidence of the long term effects of health promotion interventions in primary care is still not convincing [9, 26, 27]. There are few studies of lifestyle interventions in HLCs in Norway and sparse knowledge of the participants' background, and help-seeking needs. There is a need for a better understanding of the participants' experiences and perceptions in order to understand how HLCs can provide a qualitatively good health service and support them to change their lifestyle. More research is needed to understand their perspective, as well as the more complex, less articulated influences such as knowledge, skills, motivation and emotional status that can lead to weight gain and inactivity, but also to change. The aim of this study was therefore to explore HLC participants' experiences of living with obesity and perceptions of seeking help to change dietary and activity habits.

Method

Design

We chose a qualitative, descriptive and interpretative design grounded in hermeneutic methodology and tradition [28, 29]. The purpose of a qualitative approach is to explore complex phenomena and discover themes or patterns based on experiences and perceptions to understand behaviour in order to inform clinical practice [30].

Study context

The Norwegian healthcare system provides health promotion in primary healthcare. HLCs constitute an interdisciplinary primary healthcare service providing effective, knowledge-based measures for people with, or at high risk of disease, who need support for health behaviour change and to cope with health problems and chronic disease [31]. This low threshold service is easily accessible through direct contact or by referrals from general practitioners (GPs) and participation is not based on Body Mass Index (BMI). At the HLCs, health education is provided by healthcare professionals (including physiotherapists, public health nurses, psychiatric nurses and bachelors in public health) to help participants change their lifestyle habits. The health conversation is based on each participant's perception and understanding of the challenges for which she/he is seeking help. Physical activity in the form of individual or group-based in- and outdoor activities, often with a physical therapist, is offered two to three times a week.

HLCs also have a healthy diet course consisting of 4 to 5 two-hour sessions with practical tasks and theory, often with a public health nurse or nutritionist. An intervention lasts for 3 months with the possibility to extend it on two occasions, although this is practiced differently in the various municipalities. The organisation of the HLC differs between the various municipalities and small communities have inter-municipal cooperation that enables participants to attend courses across municipal boundaries.

Participants

Purposive sampling [32] was used to identify participants for interview to ensure that the sample included individuals of both sexes and various ages, from small and medium-sized municipalities, with experience of living with overweight or obesity. The inclusion criteria were; women and men aged 18 to 80 years with overweight or obesity, who had contacted the HLC to obtain help with weight management, and who were able to speak and understand the Norwegian language. HLC administrators were asked to send requests to service users who had participated in lifestyle courses. The participants in this study were recruited from five different HLCs in Norway. The first author contacted all the service users after they had consented to participate. A total of 13 participants were included in this study (Table 1). The majority had contacted the HLC on their own initiative because they wanted to change their lifestyle habits and lose weight. Some were recommended lifestyle changes such as regular moderately intensive physical activity, healthy diet and weight reduction by their GP. The participants were either overweight or obese and had additional challenges and diagnoses which put them at risk (Table 2).

Table 1 Participant characteristics

Characteristics	Number of participants
Gender	
Female	8
Male	5
Age	
30–69	13
Mean age women	47,5
Mean age men	55,4
Civil status	
Single/divorced	1
Widow/widower	1
Partner/married	11
Education	
Secondary school	11
Bachelor degree or higher	2
Occupational status	
Employee 50–80%	4
Unemployed	2
Disability pension	5
Retired	2
Participation in HLC	
Healthy diet courses	11
Activity groups	12
Individual conversations with HP	13

Data collection

Individual semi-structured in-depth interviews were conducted to gather data on the service users' perceptions of living with overweight or obesity and seeking help to change dietary and activity habits. ES and ALH developed the thematic interview guide with follow up questions in accordance with Kvale and Brinkman [33] and the first author (ES) performed the individual interviews over a five-month period in 2017. In accordance with the participants' wishes, 11 interviews took place in the local HLCs and two at a university campus. After a presentation about the purpose of the study each interview was tape-recorded. The form of the interview was open and the interviewer invited the participants to speak freely about their experiences. The main questions asked were; *What is your perception of changing dietary and activity habits* and *why did you contact the HLC and ask for help?* Other questions explored personal goals, their need for help and their challenges. The interviews, which lasted between 66 and 131 min, were transcribed verbatim by the first author (ES). ES, ALH and BSH discussed the data in relation to the participants' descriptions and if, and to what degree, the data material could answer the research question. Information power as discussed by Malterud et al. [32] guided the sample size.

Analysis

The theoretical framework of qualitative content analysis in this study is grounded in a data-driven inductive approach, conventional qualitative content analysis,

Table 2 Self-reported challenges, strain and additional diagnoses (number of participants in brackets)

One or several of somatic diagnosis: type 2 diabetes (3), cardiovascular disease (CVD) (4), Chronic Obstructive Pulmonary Disease (COPD) (2), celiac disease (1), multi sclerosis (MS) (1), sleep apnoea (1), various chronic pain conditions (8), fibromyalgia (3), cancer (2)
One or several of psychosocial strains and challenges: anxiety (3), depression (4), loss and grief (1), identity reactions (12), eating disorders (2), suicidal thoughts (2), alcohol abuse (1), isolation (6), financial difficulties (2)

described by Hsieh and Shannon [34] and a text-driven search for patterns as described by Krippendorf [35]. The analysis process in our study was systematic and the codes, categories and themes are strongly linked to the raw data [34, 36]. Data were analysed by the analytical steps in Qualitative Content Analysis (QCA) described by Graneheim & Lundman [37] and in the light of the methodological discussion by Graneheim, Lindgren & Lundman [36]. According to Graneheim and Lundman, categories present the manifest content of the text. A theme is a tread of an underlying meaning on an interpretative level and an expression of the latent content of the text [37]. Both the phenomenological description of the manifest content (categories close to the text) and the hermeneutical interpretation of the latent content (themes distant from the text) [36] was used in our study. In line with the QCA method, all authors read the anonymized transcripts independently to obtain an overall impression, after which they met to discuss the material. The text was analysed by searching for content that described the participants' perceptions of living with overweight or obesity and seeking help to change their dietary and activity habits. Based on the discussion all authors agreed on preliminary themes and categories. The first author (ES) then coded the interviews according to these themes. The text was divided into meaning units, abstracted and labelled with a code. The whole context was considered when labelling meaning units and codes. The various codes were compared based on differences and similarities and sorted into categories, sub-themes and themes. Categories were identified through an iterative process of identifying, grouping and regrouping. The development of the main theme and themes based on sub-themes and categories took the form of a hermeneutic spiral [36, 38] in a back and forth discussion process between all the authors over a period of several months.

Results

The analysis resulted in one main theme: *Searching for dignity*, which was based on two themes: *Needing to justify avoidance of personal responsibility* and *A desire to change.*

Searching for dignity

The main theme reflected the participants' experience of living with overweight or obesity and their perceptions of seeking help to change their dietary and activity habits. For all the participants, living with overweight or obesity impaired their body image and self-esteem, causing a negative self-representation of living a perceived wrong lifestyle. The participants was seeking help with lifestyle change at the same time as they felt shame about their body and not managing on their own, and guilt of not adhering to a healthy diet or doing enough exercise. They had earlier experience of losing weight and relapses, and experienced a constant struggle between a healthy lifestyle and pleasure. They felt a need to explain their weight gain and barriers to change. On the other side, they desired change and motivation and felt pride about taking initiative and ask for help, exhibiting willpower and discipline. The participants tried to balance protection and disclosure of self with pride for taking the initiative and responsibility for change in order to feel normal, accepted and worthy. Searching for dignity seemed to be a red tread throughout the data, themes and sub-themes. The main theme is based on two themes with associated sub-themes and categories presented in Table 3. We will elaborate further on the findings below.

Needing to justify avoidance of personal responsibility

The participants' need to justify avoidance of personal responsibility was based on the sub-themes *Strain and challenges as barriers to change* as well as *A constant struggle and negotiation between healthy living and pleasure*, and *Feelings of shame, guilt and discouragement affect weight management.*

Strain and challenges as barriers to change

It was important for the participants to explain their weight-gain and give reasons for why they ended up seeking help to change their lifestyle. Although the participants wanted to change their dietary and activity habits, they mentioned numerous barriers to change. These included grief, loss and identity issues, strain and life challenges such as depression, eating disorders, inactivity, alcohol abuse, suicidal thoughts, isolation, financial difficulties, being stuck in old habits and postponing things. Some of the participants were affected by their personal employment situation, changes in life, identity issues and the struggle to maintain their dignity and sense of worthiness. Only four were employed on a 50–80% basis, while the others were in receipt of a disability pension, retired or unemployed. One participant explained her loss of identity due to unemployment as follows:

> *I identified myself with the job ... that was what made me. I worked in a kindergarten then and received a salary for what I did, but suddenly there was nothing. I felt like I was nothing. I could not go to work and could not manage what was normal for people to do ... self-image and everything...*(Female 50-59)

Table 3 Overview of the main theme, themes, sub-themes and categories

Main theme: *Searching for dignity*		
Theme	Sub-Theme	Category
Needing to justify avoidance of personal responsibility	Strain and challenges as barriers to change	Grief, loss and identity reactions
		Strain and life challenges
		Stuck in old habits and deferral
	A constant struggle and negotiation between healthy living and pleasure	Knowledge of healthy living
		Recognition of health risk and consequences
		Lack of willpower and relapses
		Expression of personal responsibility
	Feelings of shame, guilt or discouragement affect weight management	Negative feelings related to body image, self-esteem and confidence
		Feeling bad about not adhering to the diet or activity plan
		Lack of management in daily life
A desire to change	Health challenges and the need for improved self-respect trigger change	Personal goals to improve health, fitness, weight loss and better management of everyday life
		Health challenges, illness and risks
	Pride in self-management	Taking the initiative to change and asking for help
		Maintaining new habits and exhibiting willpower
	Hope, self-efficacy and meaningfulness increase motivation	Hope and self-belief
		Meaningfulness in life

Another participant explained that he started to gain weight when he lost his job and developed serious depression:

> *I was a CEO and then I was fired… and after that… I have had no work... because after that my world shattered.* (Male 60-69)

One participant described different kinds of grief reaction in response to the loss of his spouse and later his dog, stating that he isolated himself, started drinking, ate unhealthy food, just sat on the sofa and became inactive:

> *I have to admit that after my wife died, I sat down… and then died … we had a dog and the dog died too, and I couldn't bear anything…and I didn't go out…it was a voluntary isolation…*(Male 60-69)

The participants described being stuck in old habits, making multiple excuses, procrastination, deferrals and denial. Some of the participants expressed fear of losing control and stated that they put up walls to escape responsibility. One described how she intended to address the issue:

> *I have really neglected the diabetes a little bit … I have parked it on the stairs for a long time. It's very hard to accept it! I have to learn to live with... that's what it's all about, right?* (Female 30-39)

A constant struggle and negotiation between healthy living and pleasure

This struggle can be described as negotiation between knowledge of healthy living and recognition of the health risks and consequences of being unable to resist the temptation of unhealthy food. It is a clear expression of personal responsibility to act upon this knowledge on the one hand and lack of willpower and discipline on the other. All the participants described their knowledge and understanding of healthy diets, the importance of being physically active and the relationship between lifestyle habits and illness. Their problem was not lack of knowledge and information but adhering to the new habits and changing routines. One of them expressed:

> *We know what we should eat and what to do, but don't act accordingly. That's why we are gaining weight.* (Female 50-59)

Several participants found it difficult to be active and to resist unhealthy foods and some also described that lack of willpower to resist temptation is often reinforced by repeated efforts and relapses. The eternal struggle against temptation and pleasure was illustrated as follows:

> *I have a problem with sugar. When I taste it, it's hard*

*…weaning is difficult. I think it's the same mechanism as with alcoholics that you get hooked and you have to empty the bottle. That's the way it is for me too, even if I'm stewed … if there is more chocolate left in the bowl I cannot leave before its empty, even if I know I'll get a headache and feel sick … But anyway, sugar … it's not good, but for some reason I eat it… it is completely sick! (*Male 50-59*)*

Sometimes you want to live your life too. To always be in focus and think about lifestyle change and think of exercise … it's quite tiring and a mental strain to be in focus in the long term. (Female 30-39)

I have to be aware of what I eat, right? It's the first commandment to know what I'm eating, but I'm vacuuming the fridge in the evening, open the doors … "is there anything good here" … you know … then you'll figure out, right in the mine-field… (Male 70-79)

The participants recognised the health risks, seriousness and future consequences of their situation. Two of the participants with T2DM explained:

It's almost five years since I got type 2 diabetes and if I don't do anything about it… I know the consequences. Diabetes is actually quite serious and maybe I underestimate it a little because I … the later harm and consequences are quite brutal. You can actually become blind, your legs can become numb, amputation … these are the major aspects of having diabetes. (Female 30-39)

I knew if I didn't turn over a new leaf I would never live to be an old man … and I would like to … at least live a little longer … because the lifestyle I had, sitting still, diabetes, the imminent risk of a heart attack… (Male 60-69)

The participants blamed themselves for gaining too much weight and believed that they all have a personal responsibility to do something about their situation. Some of the participants suggested that people should take more responsibility for own health and that the health authorities should make more demands on the personal responsibility of people at risk and oblige them to participate in lifestyle interventions. One of them said:

I thought when I was diagnosed with COPD… now I just have to start training… one can't go around being so overweight with a COPD diagnosis … it's hopeless … but I did not start here only because of my COPD … it's the weight …it was clear…I can't have it anymore … I have to do something… (Female 40-49)

Feelings of shame, guilt or discouragement affect weight management

Most of the participants had negative thoughts and ambivalent feelings about their body image, self-esteem and confidence, describing shame, discomfort and uncertainty related to their body. Many of them mentioned insufficiency in the areas of self, work, family, partner and children. It was evident that several of the participants had strong feelings about their body image and some of them expressed:

I was afraid to go to the gym… pictures of slim and young people…I didn't fit in with my big body… (Male 60-69)

At first it was incredibly difficult… it was scary … I was pretty scared because there is prejudice against people with obesity … being at the gym, exercising, sweating and feeling uncomfortable, all of these … and all these walls I've built up around myself … (Female 30-39)

Some experienced challenges related to sexuality:

Overweight and sexuality are a combination that does not work well. Sexuality is a core of life that is quite important for many people, but there are many problems. I have a lot of complexes in relation to my sexuality … and the desire for sex has become low because of the way I look and feel … but that's how I feel … less nice, less appealing … and it's about putting yourself down … self-image and self-esteem, because it's part of yourself… (Female 30-39)

A clear sense of shame was described, both in relation to their own body, but also to not managing to lose weight and change to a healthier lifestyle by themselves. Some found asking for help difficult:

Firstly, because you have to admit that you need help … it becomes such a mental process to admit that you cannot quite manage it yourself … and to train with others … it was one of those barriers …. you pant and gasp … I will never forget the first time … knowing that others will see what bad shape you are in … (Female 40-49)

The participants had a great deal of experience trying to change their dietary and activity habits to lose weight. They described their negative weight loss experience and efforts as difficult due to constant relapses. Before starting at the HLC they had attended several "slimming programmes" and followed various diets, experiencing an initial weight loss but after a time gaining weight again.

Several of the participants described feeling guilty for not sticking to their diet and activity plan. The challenge is to maintain the changes and make the new routines and habits permanent. After repeatedly slimming, dieting, gaining weight again and lack of a mastery experience, many participants experienced defeat, resignation and discouragement:

> *I cannot say I did not wish there was an easier way to see progress. I saw it when I was training ... in the first two months I lost weight, but after that it stopped and I think stayed the same for three months... without losing anything...* (Male 30-39)

A desire to change

The participants' desire to change is based on the sub-themes *Health challenges and the need for improved self-respect trigger changes*, *Pride in self-management* and *Hope, self-efficacy and meaningfulness increase motivation.*

Health challenges and the need for improved self-respect trigger changes

All the participants had additional diagnoses (Table 2), which constitute a risk to their health. Their understanding of the severity and consequences triggered the turning point at which they made the decision to change their dietary and activity habits. They also had different personal goals and wishes for change. The desire to change to a healthier lifestyle was triggered by feedback from their body about health challenges, illness and risks, but also for preventive purposes. Several of the participants stated that they were limited in terms of the activities they could perform. Limitations in daily life, such as being unable to climb the stairs, play with grandchildren or participate in activities with one's partner and children, make life more challenging and affect self-image. This desire to lose weight and be able to keep up with one's children was expressed as:

> *I have two youngsters at home…and I knew… when we were doing things together, I had to sit down because I was so tired. So my goal was to become more physically active… but it was that weight ... I knew I had to lose weight ... yes ...that was the starting point ...* (Female 40-49)

For several participants, better health, feeling strong, improved fitness and managing everyday tasks was most important. Others had additional needs and a desire for change, such as to control their blood glucose and reduce their medication. Some of the participants wanted to keep their job or be able to work again, while for others it was just about surviving. One participant stated:

> *My goal is to survive ... quite simply. Get rid of those negative thoughts as well by being active ...* (Male 60-69).

One young participant described his need for normality and independence:

> *That's my reason..., basically, I may never get rid of it ... but the point is that I wish to get into such good shape that I no longer need the c-pap machine ... that's my goal...* (Male 30-39)

The desire to lose weight was described by all participants as a means of achieving a feeling of normality, acceptance and worth. One of them stated:

> *There is a big body-focus in society. You actually feel less worthy when you are overweight and it's very tiring. I've probably just felt it myself yes... but I feel it ... yes ...* (Female 40-49)

Pride in self-management

Recognition of the health risks, seriousness and consequences of their situation led them to take the initiative to ask for help and do something about their situation. Taking responsibility for one's own health and changing dietary and activity habits leads to pride. Participants taking the initiative to change and asking for help, adhering to new habits and exhibiting willpower and discipline, expressed this pride directly and indirectly. Most of the participants presented themselves as responsible and explained how they took the initiative to change. They had read about HLCs and searched the internet for information and help, several of them had asked their GP for a referral to the HLC. Some of the participants emphasized their ability to maintain new habits and what they had experienced and managed to change in their diet and daily activity level. Even if some of them did not succeed in changing their dietary habits, they had a need to describe how they changed their activity habits or other things.

> *My goal was to quit insulin injections before Christmas last year and I managed it in November... in the hospital they said that I was one of the few who had followed their advice.* (Male 60-69)

Several of the participants found it necessary to highlight what they actually managed and were proud of, how they took care to do their best. Willpower and discipline are two of the significant

aspects that the participants described as necessary to successfully change habits. One participant described his willpower as follows:

> *When I started cycling I had to turn back after 500 m because I was so out of breath. The following day, it was only sheer willpower that made me get on my bike. However, within a week, I went from cycling 500 meters and having to turn back, to cycling halfway to the city, which is 6 km! Now that's pretty good progress ... (laughter)* (Male 30-39)

One of the participants showed pride and willpower by describing how he performed despite the fact that he did not enjoy it:

> *I've been spinning before and did not like it then, so I saw no reason that I'll like it now. However, I joined in and never missed a lesson. Nevertheless, I hate it as much now as I did before…but it works.* (Male 60-69)

Hope, self-efficacy and meaningfulness increase motivation

The participants believed they would manage to change their activity and dietary habits, while some even believed they could lose weight using their own resources. They were of the opinion that such change would increase their quality of life. All of them found motivation in self-management and mastering small changes, as well as management of daily life and everyday tasks. For several participants, voluntary work became a meaningful part of their life. Some of the participants had already experienced a change in strength and fitness, which they described as making them more socially active, leading to a feeling of hope, self-efficacy and well-being, which in turn strengthened their motivation to continue implementing lifestyle changes.

> *It's about those little things, the small milestones and steps and they are just as important as the chocolate I could enjoy after three months or ... Being able to go and work out with my daughter ... they are the important things ... to be able to do. I feel now ... now there's a lot more inner drive ...* (Female 40-49)

Several of the participants described their hope and belief that someday, in one way or another, they will manage to change their dietary and activity habits to achieve a healthier lifestyle. No one perceived this as simple or easy, but hope is important for remaining motivated.

Discussion

This study explored how HLC participants experienced living with overweight or obesity and their perceptions of seeking help to change their dietary and activity habits. Below, we discuss the findings in the context of existing literature within this field.

The results suggest that the participants are basically seeking dignity to gain a better self-image and maintain their integrity. Several of the participants described low self-esteem and mental health issues, while some were painfully aware that they weigh too much and their weight issues reflect a deep sense of unworthiness. The desire to change may be seen as a wish to be normal and thereby feel worthy. Dignity can be related to self-esteem, as it refers to the worth of human beings, the right to be valued and respected. According to Schopenhauer, dignity is the opinion of others about our worth, while a subjective definition of dignity is our fear of others' opinion [39]. This can illuminate the basic search for dignity in all human beings and in particular for persons with overweight and obesity.

There are a number of possible explanations for this search for dignity. It can be seen as a response to the stigma linked to being afflicted by overweigh or obesity. Goffman describes stigma as a deviation from our expectations of normality [40]. When reporting how they experienced living with overweight or obesity, the participants in our study described negative feelings related to body image, self-esteem and confidence (feelings of shame), feeling bad about not adhering to the dietary and activity plan (guilt) and lack of self-management in daily life (discouragement). This is consistent with previous studies showing that persons afflicted by overweight or obesity perceive that they are less worthy and experience a great deal of guilt, discouragement and shame [14, 23, 41, 42]. Several previous studies have described lifestyle change as an eternal struggle [22, 43], leading to feelings of unworthiness [14, 42, 44].

The participants in our study tried to explain the reasons behind their weight challenges and why they find change so difficult. In some cases it was a reaction to grief, the loss of a spouse, while others perceived challenges to their identity related to losing a job or being diagnosed with a chronic disease. These findings are in line with earlier studies and support the view that changing lifestyle habits is difficult as psychological and emotional distress can influence the ability to change [22, 45–47]. Participants with complex challenges and insufficient coping strategies, many of whom suffered from mental health problems, often struggled with follow up [8, 24]. Our participants also reported previous experiences of attending slimming programmes and losing weight, but subsequently gaining weight again after the intervention period. Some of them experienced these efforts as a hopeless enterprise and the relapses as shameful. This struggle is supported in earlier studies that the risk of weight regain includes a history of weight

cycling and relapses [48]. Grant and Boersma [44] suggest that it is better to understand the nature of the problem rather than change the person. As the dominant counselling approach in weight management programmes is based on behavioural or cognitive behavioural paradigms, the benefits of a psychodynamic approach would be worth further exploration.

Several of the participants in our study reported lack of discipline and willpower as a challenge, and blamed themselves for not having more control. Jallinoja et al. [43] suggest that no matter how self-disciplined individuals are, if the dilemma between pleasure and health are not disentangled, lifestyle change will only be short term. In general, the participants in our study stated that their personal responsibility for a healthy lifestyle and changing their own situation was important to them. These findings are supported by an earlier study, which revealed that participants in an intervention to prevent type 2 diabetes had an ambivalent stance towards self-responsibility, yet constructed themselves as responsible and knowledgeable pro-health persons [21]. This can be supported by Goffman's argument that people are likely to present themselves in a light that seems favourable [49].

Self-conscious emotions like shame, guilt, embarrassment and pride play a central role in motivating and regulating almost all of people's thoughts, feelings and behaviour, and differ from basic emotions because they require self-awareness and self-representation [50]. This issue of self-representation was very clear in our study and is in line with the study by Guassora, Reventlow & Malterud [23] where patients presented themselves as responsible in dialogues about lifestyle and tried to defend themselves against shame [23].

The participants in our study expressed and believed that their overweight or obesity was self-inflicted and considered themselves guilty of not eating healthy food and adhering to their dietary and activity plan. This is in line with previous studies where positive attributes are accorded to people who are healthy, while those who become ill or have a less perfect body are blamed and considered self-indulgent, lazy, unmotivated, lacking self-discipline, less competent or even irresponsible and immoral [13, 14, 41, 42]. The personal attributes assigned to persons with overweight or obesity highlight the victim-blaming that occurs [12, 42]. Brownell et al. [51] hold that the two most important words in the national discourse about obesity are personal responsibility and that the concept of personal responsibility for health is deeply ingrained in our culture and political system. They state that good health has become more than a means to achieving personal goals such as greater attractiveness and increased longevity, but symbolizes self-control, hard work, ambition and success in life. Inherent in this symbolism is the concept that the individual controls behaviour, which in turn controls health. [51]. This paradox of control places many people in an untenable situation whereby they feel guilty about failing to perform the ideal behaviours [42] and are ashamed when they become ill, as is the case with the participants in our study (T2DM, CVD, COPD). According to the review by Puhl & Heuer, obese persons are blamed for their weight and a common perception is that weight stigmatization is justifiable and may motivate individuals to adopt healthier behaviours [14]. However, stigmatization of persons with overweight or obesity threatens psychological and physical health [14–16, 41] and generate health disparities [16]. Findings in a study by Täuber et al. [17] suggest that weight bias internalization in the form of moral condemnation contributes to the lower psychological functioning and well-being of people with overweight and obesity. The participants' perceptions of responsibility in our study are clear, but we suggest that this emphasis on personal responsibility may lead to even greater shame when people experience lack of management or condemnation from society.

The theory of these self-conscious emotions is described by Tangney [50], Tangney & Fisher [50] and Tracy, Robins & Tangney [52]. In relation to shame and guilt, they argue that shame involves negative feelings about the stable, global self («I am a fat person»), whereas guilt involves negative feelings about a specific behaviour or action taken by the self ("I didn't try hard enough to lose weight"). When the attentional focus is directed towards the public self, such as being publicly exposed as incompetent, it becomes an embarrassment. The public self is always present because it reflects the way we see ourselves through the real or imagined eyes of others [52, 53]. Goffman [40] noted that every social act is influenced by even the slightest chance of public shame or loss of face and people worry about losing social status in the eyes of others.

Some of the participants described isolating themselves from the outside world. This isolation was partly due to depression, but also because of negative feelings attached to self-esteem and body image. According to previous literature, the immediate response to shame is often to retreat or make oneself as small as possible [54, 55], which may explain why some of the participants in our study isolated themselves. There is a tremendous pressure in post-modern Western society to be thin and have a specific body shape, which for many symbolizes self-control, discipline, hard work, success and ability to manage indulgence [42, 54]. In the self-esteem theory, Maslow [56] described self-esteem as a basic human need or motivation that reflects a person's overall subjective emotional evaluation of her/his own worth. He claimed that all people have a need or desire for

a stable and high evaluation of themselves and self-respect in the form of self-confidence, skills and capability. Ignoring these needs produces feelings of inferiority and helplessness, which in turn give rise to basic discouragement.

In general, the participants described their desire for change as feedback from their body. Some seemed to be motivated to change their diet and level of activity by their appearance or health challenges, while for others the desire for change was for preventive reasons. Several participants reported that the seriousness of the health challenges serve as an ultimatum if they want to live longer and achieve better health. Several of our participants were either at risk of or had already developed NCDs as reported in Table 2. This finding is consistent with a previous study by Følling et al. [22], which reported that 91% of the participants in a HLC lifestyle intervention had multi-comorbidities, such as overweight, obesity, T2DB, muscle- and skeletal diseases and psychological issues. It is also in line with previous findings from Samdal et al. [25] describing the reasons for attending a HLC as the wish to increase physical activity and achieve a healthier diet in order to manage overweight, obesity and multiple health challenges. Our study adds to the literature about the challenges involved in health promotion interventions for overweight and obesity. In addition, we add to the literature on help-seeking needs, the underlying importance of self-representation, integrity, acceptance and dignity.

The participants in our study described pride in self-management. They were eager to talk about their initiative to change and the fact that they themselves asked for help. Theories of pride explain that when it comes to motivating social behaviour, pride may be the most important human emotion [52, 57]. Our most meaningful achievements, both on an everyday and life changing level, are accompanied by a feeling of pride. It is likely that pride evolved to provide information about an individual's current level of social status and acceptance. Self-esteem may be an important part of this process and the development of pride may be closely linked to the development of self-esteem [52]. In a study by Guassora et al. [23], patients described their achievements as matters of honour, shifting from problematic issues to achievements of which they were proud. Our study supports these findings and highlights the meaning of pride in people's presentations of self. In addition, our study contributes to descriptions of how participants alternate between shame, guilt and pride and how these self-conscious emotions influence the ability to assume or avoid responsibility.

The turning point can appear when the individuals in question understand the severity of the situation and realise that after several attempts and mistakes doing things by themselves, they need help and support from others, as the participants in our study recognized. Asking for help may involve swallowing hubristic pride as described by Tracy & Robins [52]. Studies have shown that individual motivation to lose weight and perceived self-efficacy are associated with better weight loss and beneficial effects on physical health and life satisfaction [58, 59]. Bandura's theory of self-efficacy, the belief in one's own ability to manage different tasks and reach specific goals, is important for behavioural change [60]. Previous studies have shown that participants who contacted a HLC themselves more often expressed a will for lifestyle change and less often dropped out than those referred by GPs [8, 24, 25]. Although the participants in the study by Samdal et al. [25] had autonomous motivation, they suggest that interventions have to address impaired self-efficacy. Our findings suggest that the participants experienced hope and self-efficacy related to using their own resources, but most of all as a result of the support they experienced at the HLC, which in turn strengthened their motivation to continue implementing lifestyle changes.

Trustworthiness, strengths and limitations

A qualitative design may provide insight into complex phenomena. In line with the hermeneutic approach employed in this study, there is always a possibility of ambiguity and different interpretations of the meaning of the text. Addressing aspects of credibility, dependability, transferability and confirmability to increase trustworthiness is important [29]. We argue that the credibility, confirmability and dependability of the findings were strengthened by coherently and systematically analysing data using inductive coding [34, 35] and categorization in the interpretation process (hermeneutical circle) [28, 38]. The discussion of the findings on several occasions, as well as the variation in the disciplinary backgrounds of the author and co-authors, who are public health nurses (ES and BSH), a nurse specializing in health education (GF) and a psychiatric nurse (ALH), enriched the analysis and increased trustworthiness and confirmability. The analysis and data interpretation were influenced by the authors' preunderstanding, therefore the findings are a constructionist coproduction of the participants' perception of reality [30, 33, 61]. The first author (ES) conducted the data collection and the co-authors read all the transcribed interviews in order to minimize potential bias. The first author (ES) has several years of clinical experience as a public health nurse and also worked in an interdisciplinary team helping children, adolescents and their families to change their dietary and activity habits. Her background provided a preunderstanding and experienced based knowledge of

the research phenomenon, in addition to valuable insights concerning lifestyle change and social stigma. The second author (BSH) and third author (GF) also have experience of health promotion and health education, which provides a valuable and useful overview of health promotion perspectives. The fourth author (ALH) contributed understanding of and valuable insights into the psychological and emotional findings. Another strength of this study is the semi-structured in-depth interviews, which allowed the participants to focus on their needs and perceptions. Each interview lasted from 66 to 131 min, providing opportunities to elaborate on the questions and follow up the responses. The variety in age, gender and socioeconomic status strengthens the utility and transferability of the findings, which are enhanced by the rich descriptions of the context, the informants from five different HLCs in Western Norway, the data collection and analysis, as well as the inclusion of quotations from a number of participants. Information power [32] guided the data collection in order to ensure a variety of perceptions. This paper meets the requirements of the COREQ [62] checklist.

The strength of our study is the contribution to knowledge of HLC participants' experiences of living with overweight or obesity and seeking help to change their dietary and activity habits. As a relatively new health service, there is a need for a better understanding of this phenomenon in order to provide a high quality health service. The findings of the Finnish study, in which nurses and GPs reported that the participants' unwillingness to change lifestyle behaviour was a major barrier to lifestyle change [20], are in contrast to our findings, where the participants themselves stated that it is not unwillingness but rather shame, guilt and ambivalence towards assuming responsibility that hinder them. The unwillingness reported by the nurses and GPs may be a result of stigmatization and prejudice. However, the fact that it differs from the perceptions of the participants in the present study is also an interesting issue, which highlights the importance of the service user perspective.

Some methodological limitations should be taken into account when interpreting the results. Providers recruited participants from ongoing lifestyle interventions, thus it is possible that the participants were selected because it was known that they were satisfied with the HLC programme. The participants may have also been influenced by the ongoing process of change, and participation in both dietary and activity interventions over a period of time prior to the interviews.

Conclusion

This study explored HLC participants' experiences of living with overweight or obesity and perceptions of seeking help to change dietary and activity habits. Being stigmatized and feeling shame and guilt for not managing to live a healthy lifestyle and have a normal body, have consequences for people's psychological and emotional health and affect their quality of life. This study contributes to the descriptions of emotional distress experienced by persons afflicted by overweight or obesity. In addition, the findings add to previous knowledge by illustrating the impact of shame, guilt and pride, as well as demonstrating the complexities involved in assuming responsibility for changing dietary and activity habits. Self-conscious emotions such as shame, guilt and pride play a central role in motivating and regulating almost all of people's thoughts, feelings and behaviour. It is therefore necessary to address these emotions in lifestyle interventions and offer treatment that takes account of such feelings. It is easy to forget the person living with overweight or obesity when both the person her/himself and the provider are mainly focused on weight loss treatment. Future HLC and health promotion interventions need to educate service users about emotions such as shame, guilt and pride, and their role in food consumption and inactivity so that people with overweight or obesity are able to regulate their intake of food and physical activity. We suggest that regaining positive self-esteem and dignity will lead to the ability to assume personal responsibility for achieving a better quality of life. Weight stigma at individual and system level and as well as responsibility related to dilemmas about the "right" or "wrong" lifestyle should be addressed.

Abbreviations

BMI: Body Mass Index; COPD: Chronic obstructive pulmonary diseases; CVD: Cardio vascular diseases; GP: General Practitioners; HLC: Healthy Life Centres; PA: Physical activity; T2DM: Type 2 diabetes

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Ethical approval and consent to participate

This study was registered and approved at the Norwegian Centre for Research Data (NSD) project number 48025. The ethical guidelines in the Helsinki Declaration were followed. Participants received oral and written information about the study and signed an informed consent form before the interview started. Participation in the study was voluntary and the participants were informed about their right to withdraw at any stage without compromising their future health care. For reasons of confidentiality, the participants are coded with gender and age-cohort. In this study an interview could be an unpleasant reminder that the participant is not living a healthy life in line with health authority guidelines, which can cause distress to her/him. The interview setting was well prepared and a respectful, non-judgmental atmosphere was emphasised.

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Availability of data and materials
Due to considerations of confidentiality and to ensure the participants' anonymity, there are restrictions on the availability of the raw data material.

Authors' contributions
ES planned and designed the study in cooperation with ALH. ES collected the data and performed the interviews with guidance from ALH and BSH. ES transcribed and conducted the initial analysis and coding of the data material with guidance from ALH, BSH and GF. The manuscript was drafted in close collaboration with all the co-authors. All authors contributed to the writing process before the final version was approved. All authors read and approved the final manuscript.

Consent for publication
Not applicable.

Competing interests
The authors declare that they have no competing interests.

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Paper II

Title Page

Title: **Service users` experience of beneficial self-management support and user involvement in Healthy Life Centres – a qualitative interview study**

Elin Salemonsen[1,2], Georg Førland[1], Britt Sætre Hansen [2], Anne Lise Holm[1]

[1]Western Norway University of Applied Sciences, Faculty of Health and Social Sciences, [2] University of Stavanger, Faculty of Health Sciences

Corresponding author: Elin Salemonsen, elin.salemonsen@hvl.no

Elin Salemonsen, RPHN, MSc, Research Fellow at Western Norway University of Applied Sciences, Faculty of Health and Social Sciences, Department of Health and Caring Science, Bjørnsons gate 45, 5528 Haugesund, PhD student at University of Stavanger, Faculty of Health Sciences, corresponding author: elin.salemonsen@hvl.no , https://orcid.org/0000-0002-3289-4884

Georg Førland, RN, MSc, PhD, Associate Professor at Western Norway University of Applied Sciences, Faculty of Health and Social Sciences, Department of Health and Caring Science, Bjørnsons gate 45, 5528 Haugesund, georg.forland@hvl.no

Britt Sætre Hansen, RPHN, CCN, MSc, PhD, Professor in Nursing Science and Leadership at University of Stavanger, Faculty of Health Sciences, Kjell Arholmsgate 39, 4021 Stavanger, Norway, britt.s.hansen@uis.no

Anne Lise Holm, RPN, MSc, PhD, Professor at Western Norway University of Applied Sciences, Faculty of Health and Social Sciences, Department of Health and Caring Science, Bjørnsons gate 45, 5528 Haugesund, anne.holm@hvl.no, https://orcid.org/0000-0003-2043-8547

Paper III

Title Page

Title: Understanding beneficial self-management support and the meaning of user involvement in lifestyle interventions: a qualitative study from the perspective of healthcare professionals

Elin Salemonsen[1,2], Georg Førland[1], Britt Sætre Hansen [2], Anne Lise Holm[1]

[1]Western Norway University of Applied Sciences, Faculty of Health and Social Sciences, [2] University of Stavanger, Faculty of Health Sciences

Corresponding author: Elin Salemonsen, elin.salemonsen@hvl.no

Elin Salemonsen, RPHN, MSc, Research Fellow at Western Norway University of Applied Sciences, Faculty of Health and Social Sciences, Department of Health and Caring Science, Bjørnsons gate 45, 5528 Haugesund, PhD student at University of Stavanger, Faculty of Health Sciences, corresponding author: elin.salemonsen@hvl.no , https://orcid.org/0000-0002-3289-4884

Georg Førland, RN, MSc, PhD, Associate Professor at Western Norway University of Applied Sciences, Faculty of Health and Social Sciences, Department of Health and Caring Science, Bjørnsons gate 45, 5528 Haugesund, georg.forland@hvl.no

Britt Sætre Hansen, RPHN, CCN, MSc, PhD, Professor in Nursing Science and Leadership at University of Stavanger, Faculty of Health Sciences, Kjell Arholmsgate 39, 4021 Stavanger, Norway, britt.s.hansen@uis.no

Anne Lise Holm, RPN, MSc, PhD, Professor at Western Norway University of Applied Sciences, Faculty of Health and Social Sciences, Department of Health and Caring Science, Bjørnsons gate 45, 5528 Haugesund, anne.holm@hvl.no, https://orcid.org/0000-0003-2043-8547

Title: Understanding beneficial self-management support and the meaning of user involvement in lifestyle interventions: a qualitative study from the perspective of healthcare professionals

Elin Salemonsen[1,2], Georg Førland[1], Britt Sætre Hansen [2], Anne Lise Holm[1]

[1]Western Norway University of Applied Sciences, Faculty of Health and Social Sciences, [2] University of Stavanger, Faculty of Health Sciences

Corresponding author: Elin Salemonsen, elin.salemonsen@hvl.no

Abstract

Background: In light of the high prevalence of overweight and obesity among adults and the subsequent stigmatization and health consequences, there is a need to develop effective interventions to support lifestyle change. The literature supports the key role of healthcare professionals (HPs) in facilitating self-management through lifestyle interventions for those with chronic conditions. However, there is a lack of knowledge about how HPs practice self-management support (SMS) and user involvement for persons afflicted by overweight or obesity in lifestyle interventions in primary care Healthy Life Centres (HLC). The aim of this study was to explore how HPs provide SMS and what user involvement implies for HPs in HLCs.

Methods: An interpretative exploratory design, employing a qualitative thematic analysis of data from two focus group interviews with ten HPs from eight different HLCs, was performed.

Results: The analysis resulted in one overall theme; A partnership based on ethical awareness, non-judgemental attitude, dialogue and shared responsibility, comprising four interrelated themes: 1) Supporting self-efficacy, self-worth and dignity through an attitude of respect, acknowledgement and generosity, 2) Promoting self-belief and self-perceived health, 3) Collaborating and sharing responsibility, and 4) Being flexible, adjusting and sharing time.

Conclusion: HPs in HLCs see service users as equal partners in a collaboration based on shared responsibility, acknowledgement and generosity. In order to help, their practice involves a heightened level of ethical awareness, including a non-judgemental attitude and dialogue. HPs in HLCs have something to teach us about ethical acting and helping persons who are struggling with overweight or obesity to change their lifestyle and regain dignity. They seem to see the service users' existential needs and have learned the art of meeting the other in her/his most vulnerable situation i.e., seeking help for a "wrong lifestyle". It may be time to highlight the need for SMS and user involvement to focus on shared responsibility in partnership rather than personal responsibility. More research is required to explore the conditions for such practice.

Keywords: dialogue, dignity, healthcare professionals, overweight and obesity, primary care, partnership, self-management support, shared responsibility, user involvement

Background

Overweight and obesity are complex conditions with serious social and psychological dimensions and one of the contributing factors of non-communicable diseases (NCDs), including type 2 diabetes, cardiovascular diseases, chronic respiratory conditions and cancer [1, 2]. Lifestyle changes are difficult and long-term weight management is associated with emotional distress and a high risk of failure [3, 4]. Shame and stigma can be a barrier to seeking help for weight management [5-7] and people with internalized stigma tend to have a lower self-worth [8].

The increasing number of patients with chronic diseases represents a challenge for the healthcare system and has led to an increase in the development of educational self-management interventions [9-12]. There is a growing interest in the impact and outcomes of self-management interventions [13], and the literature supports the key role of healthcare professionals (HPs) in facilitating self-management in chronic conditions and lifestyle interventions [14, 15]. These self-management support (SMS) interventions aim to equip service users and patients with the necessary information and skills to manage their own healthcare (independency), maintain optimal health and minimize the consequences of their conditions [9, 10, 12, 16]. Self-management is defined as an individual's ability to detect and manage symptoms, treatment, physical and psychosocial consequences, as well as the lifestyle changes (such as exercise and diet) inherent in living with a chronic condition [11, 17]. One of the key goal of SMS is to raise self-efficacy [10, 12], the belief of individuals in their own ability to manage different tasks [18]. SMS approaches emphasize a clinical partnership, collaborative care, promote service users' identification and achievement of realistic goals and teach problem-solving skills [10, 19]. Potential benefits of SMS include quality care tailored to the service users' preferences and situation [17], which in some cases improve outcomes and reduce costs [10, 13].

There has been an increased commitment in health policies to empower and more actively involve patients in their healthcare through a bottom-up approach [20-23]. The intended consequences of user involvement include heightening people's level of independence, with the objectives of enabling greater equality and more democratic decision-making [24]. Additionally, user involvement is seen as a means of ensuring accountability and balancing professional power, as well as improved health services and quality of care [22, 25]. According to Beresford [24], user

involvement is a term which is poorly defined and carelessly used. User involvement is often treated in isolation as a technical rather than an ideological matter and needs to be understood in the historical, political, ideological and cultural context [24]. In this study, user involvement is understood as a clinical partnership between the service user and HPs [22], and characterised in terms of co-production of healthcare service [20, 21].

As a part of Norway's national strategy to prevent NCDs, improve health and reduce morbidity, HLCs have been established as part of the municipalities' primary healthcare system [16, 26]. The purpose of HLCs is to support lifestyle change and promote self-management. The interventions offered are based on a salutogenic foundation, using motivational interview (MI) as one of the conversational approaches [16]. MI is a directed, person-centred counselling style that involves users and elicits behaviour change. It is defined by its spirit as a facilitative style for interpersonal relationship [27, 28]. The underlying spirit of MI, its mind-set or perspective on how to practise it is important, emphasizing four interrelated elements; partnership (collaboration), acceptance, compassion and evocation [28]. MI is also described being based on the principles of experimental social psychology and the concept of self-efficacy [29].

Previous studies from the service user perspective reveal that user involvement is significant for the quality of the healthcare service in HLCs and highlight acknowledgement and individualized SMS [30, 31]. One qualitative study from a HLC found that having a trustful relationship with the providers, being respected and experiencing continuity in the care were essential for service user involvement [30]. The support from significant others, peers, family, friends and health professionals is important for self-management and individual empowerment [3, 30-32]. Long-term self-worth support is essential for starting, continuing and participating in lifestyle change processes and a means to self-management [31].

From HPs' perspective, one qualitative study by Abildsnes et al. [33] found that HPs emphasized person-centred advice based on the participants' willingness to change and their impression of the participants' condition and life circumstances. Another qualitative study by Sagsveen et al. [34] explored how HPs described involving service users in individual- and group-based counselling and

activities at HLCs. It demonstrates the importance of HPs building a trustful relationship, adjusting to the users' needs, strengthening the users' ownership of and participation in the lifestyle change process and that HPs are involving users through MI. Sagsveen et al. [34] call for greater reflection on what user involvement implies in the HLC and in each user's situation.

There is a need for more knowledge of HPs' experience and perceptions in order to understand how they can provide a qualitatively good healthcare service for persons afflicted by overweight or obesity. There is also a need to better understand how HPs create a mutual relationship (partnership) with service users, practise SMS, promote self-management and what user involvement implies for HPs in HLCs. Due to the paucity of studies pertaining to the perspective of HPs in HLCs, the aim of this study was to explore how HPs provide SMS and what user involvement implies for HPs in HLCs.

Method

Design

Qualitative methodologies aim to explore complex phenomena of human experiences, meaning and attitudes [35, 36]. An interpretative exploratory design was chosen in order to gain a deeper understanding of beneficial SMS and user involvement as described by HPs working in HLCs. Focus groups are a suitable method for data collection [37, 38]. In this study data were collected by means of two focus group interviews, collecting data through group interaction and discussion on a topic determined by the researcher [38].

Study context

The HLC is an interdisciplinary primary healthcare service, which offers individual and group-based lifestyle interventions for people at risk of NCDs or in need of support to change their lifestyle or manage chronic conditions [16]. The initial health conversation is based on each service user's needs and desire for help, after which a group-based healthy diet course and/or physical activity sessions was offered. If desired, individual counselling is also available. Group-based healthy diet courses consist of four to five two-hour sessions with theory and practical tasks. Physical activity sessions, two to three times a week, are based on both indoor-and outdoor activities. The purpose of HLCs is to promote health and empower service users to engage in better

self-management. HLCs are easily accessible for service users through direct contact or by referrals from general practioners (GPs). The lifestyle interventions that are provided by HPs (including public health nurses, psychiatric nurses, physiotherapists, dietitians and bachelor's in public health) employ a person-centred approach and use e.g. MI as a conversational method. An intervention lasts for three months with the possibility to extend it on two occasions. The practice of extending participation and the organisation of the HLCs differs between the various municipalities. Small communities often have inter-municipal collaboration [16].

Participants and recruitment

The participants for this focus group study were recruited from different HLCs in Western Norway, and 15 HLCs was invited to participate. The aim was to recruit HPs with experience from lifestyle interventions in HLCs working with people afflicted by overweight and obesity. Purposive sampling [39, 40] was used to establish focus groups with variation in terms of occupational background, from well-established and new HLCs as well as urban and rural, small and medium-sized municipalities. Ten HPs (nine women and one man, aged 26 to 49 years) from eight different HLCs participated in two focus groups (table 1). Information power guided the sample size [39].

Table 1 Characteristics of HLCs and HPs in the two focus groups

	Occupational background	**Gender**	**Years of clinical experience (HLCs)**	**Rural /Urban**	**Population**	**Years of HLC establishment**	**Number of employees**
Focus group 1 (FG-1)	Physiotherapists (2), psychiatric nurse (1) and public health nurse (1)	Female (3) Male (1)	1 -7	Urban (2) Rural (2)	8.500 - 38.000	2-5	1-2
Focus group 2 (FG-2)	Physiotherapists (4), bachelor's in public health (1) and nutritionist (1)	Female (6)	2-7	Urban (3) Rural (1)	12.000 - 19.500	2-7	1-4

Data collection

Focus group interviews are suitable for exploring new areas with sparse knowledge [37], and to explore experiences, attitude and views [38, 41]. Focus groups were employed to collect the

qualitative data in this study [37-39]. The characteristic of focus groups (FG) and group interviews as research method and data collection method is their explicit use of group interaction and discussions to produce data and insights that would be less accessible without the interaction found in a group [38].

Participation was voluntary and everyone received both an oral and a written invitation and information about the study prior to the interviews. The focus group interviews took place at one university campus and one local HLC in 2017, based on practical considerations such as the shortest possible travel distance for the participants. Most of the participants had met before and several of them collaborated in an inter-municipal cooperation network. In accordance with an explorative design [42], a flexible format topic guide (table 2) with loosely phrased questions was developed to guide the group discussions [37, 38]. The form of the focus group interview was open and the participants were invited to speak freely about their experiences of work in the HLC. The participants played an active part in the discussions in a highly reflective manner and the familiarity from previous networks and working together seems to make them feel comfortable. The first author (ES) moderated the discussions, and added supplementary open- ended question when necessary. A co-moderator made notes and observed the interaction and dynamics in the group [38]. Each focus group interview lasted 120 minutes, was recorded on audio-files and subsequently transcribed.

Table 2 Topic guide in focus group interviews

Self-management support (SMS):
• What do you experience as beneficial help and support for the service users afflicted by overweight or obesity attending lifestyle interventions in the HLCs?
• What do you perceive as beneficial support for lifestyle change?
• How do the service users describe beneficial support?
• How do you promote self-management in the interventions?
• Can you describe how you work?
• What is important in the promotion of self-management and supporting lifestyle change?
User involvement:
• What do you understand by user involvement at the HLCs?
• What is important in the involvement of the service users?
• How do you involve the users in the intervention and in the process of change?
• What is the significance of user involvement?
• What do user involvement imply?

Data analysis

Thematic analysis as described by Braun and Clarke [43] and Vaismoradi et al. [36] was used to analyse the data from the focus groups. Thematic analysis is a method to identify, analyse and report patterns and themes in qualitative data [36, 43]. The aim is to provide description of both the manifest (semantic, explicit) and latent content (underlying interpretative level), pattern response or meaning in the text to develop a new understanding of the phenomenon under study and to answer the research question [43]. The theoretical framework was grounded in an inductive text-driven search for patterns described by Krippendorf [44]. The approach in the interpretation and theme development was abductive in the form of a hermeneutical spiral [42, 45, 46].

The transcripts from the two focus group interviews with HPs were read independently by all the authors (ES, GF, BSH & ALH). Patterns and themes identified in the data were coded, discussed in group meetings, refined further and organized into themes. A matrix was developed by the first author (ES) and all data were systematically apportioned using Excel and tables. Related text elements were reassembled in a new matrix, abstracted and grouped into themes, which were discussed by all the authors in the context of our aim and research question. Data were analysed within each of the focus groups and across the groups to identify both common and specific themes. The primary analysis, coding (data-reduction relevant for the research question) and categorization of the meaning units and preliminary themes were performed by ES. In addition, the themes were discussed, revised and interpreted into one overall theme by all the authors. Theme development was conducted in an analytic cyclical process (hermeneutic spiral [46], both inductive and abductive [44, 45]). Labelling the themes and overall theme with a phrase or sentence is preferable to a single word label for capturing complete ideas [47] or something important in relation to the overall research question [43]. The selection of quotations to illustrate the data was performed by ES.

Results

Table 3 Overall theme and themes describing how HPs provide SMS and what user involvement implies for HPs in HLCs.

Overall Theme	**A partnership based on ethical awareness, non-judgemental attitude, dialogue and shared responsibility**			
Theme	Supporting self-efficacy, self-worth and dignity through an attitude of respect, acknowledgement and generosity	Promoting self-belief and self-perceived health	Collaborating and sharing responsibility	Being flexible, adjusting and sharing time

The analysis resulted in one overall theme; A partnership based on ethical awareness, non-judgemental attitude, dialogue and shared responsibility, comprising four interrelated themes: 1) Supporting self-efficacy, self-worth and dignity through an attitude of respect, acknowledgement and generosity, 2) Promoting self-belief and self-perceived health, 3) Collaborating and sharing responsibility, and 4) Being flexible, adjusting and sharing time (table 3).

A partnership based on ethical awareness, non-judgemental attitude, dialogue and shared responsibility

HPs provide SMS and user involvement in lifestyle interventions in HLCs through ethical awareness, a non-judgemental and open attitude and dialogue. Self-efficacy, self-worth and dignity are supported by a respectful way of being, acknowledging the service users for who they are. HPs aim to prevent new disappointments and promote self-belief and better perceived health to support self-management. User involvement and SMS takes place through shared responsibility in a partnership with the service users. HPs take responsibility for creating a mutual and trustful relationship, emphasizing equality, acknowledgement and generosity in this collaborative partnership. Flexibility and adjustment of the support to the service users' needs and situation are essential, and the temporal nature of the collaborative partnership and follow-up is important.

Supporting self-efficacy, self-worth and dignity through an attitude of respect, acknowledgement and generosity

The first theme described how HPs supported self-efficacy, self-worth and dignity through an open, positive and accepting attitude and professionalism, communicating generosity and acknowledgement to promote self-management. HPs described user involvement as a way of being, emphasizing human values and generosity, using humour and sharing personal experiences. They wanted to be a helpful partner who is sensitive, attentive, curious and genuinely interested in the

participants as persons. It was important for them to meet the service users were they were with friendliness and hospitality, to see, listen and acknowledge the service users for who they are:

> *The most important is to be interested in the person in front of you and to explore: "what is important for you in your life and what would you like me to help you with?"* (10-FG2)

The initial health conversation was important and they described using MI or other health pedagogic conversations tools. HPs underlined the necessity of creating a relationship and employing their communication skills. They described their attempts to create an environment that invited confidential conversations, opened up for questions and enabled the service users to dare to tell their story to someone with time to listen:

> *Caring and communication skills are essential.* (4-FG1)

HPs expressed a perception of service users as experts on themselves, possessing complementary expertise in the change process and the necessity of withholding their own opinion of the service users' needs and what she/he should do. All of them described the importance of meeting the service users with respect, seeing them as valuable persons and addressing their guilt, shame, defeats and relapses by means of normalisation and humanisation, in an attempt to enable them to regain self-belief:

> *We never tell them what to do or not to do (6-FG2). We do not moralize or be condescending* (7-FG2) … *and we ask for permission to give them advice.* (8-FG2)

Several of the HPs gave examples for how they asked for permission to give advice, such as kindly asking:

> *"Would you like me to tell you what has helped others?* or *"Would you like me to tell you what we have experienced as helpful?"* (5-FG2).

HPs noticed the importance of giving feedback to and expressing belief in service users, their capability, strength and power, to support self-efficacy. It was also essential to express an understanding of the challenges of lifestyle change that involves more than "to exercise more and

eat less" and to avoid being patronizing so that service users do not have to defend themselves. HPs explained that the concept of HLCs is that HPs respect each service users own reasons for seeking help there. HPs experienced that service users appreciated their kindness and lack of strictness, their acknowledgement despite failures, their non-judgemental attitude, the absence of condescending behaviour and not making service users feel that they have been given up on managing lifestyle change:

> *We experience the service users' comfort and thankfulness for arriving in an arena where they do not need to explain or justify why they need to change their lifestyle, where there is nobody to arrest or judge them.* (9-FG2)

Promoting self-belief and self-perceived health

The second theme described how HPs aim to guide and promote self-management and user involvement by strengthening service users' belief in themselves and avoiding new disappointments. An important purpose of HLCs is to improve service users' self-perceived health. The initial health conversation lays the foundation for a trustful relationship where the HP becomes a helpful partner. HPs recognized that the service users had complex challenges that made it difficult for them to change their dietary and exercise habits. Some of the most important issues described by HPs were the need to emphasize well-being, help the service users to thrive and make them want to come back and continue to participate in the HLC intervention:

> *Our greatest goal is to keep them, make them thrive and give them a feeling of meaningfulness by participating in the HLC.* (1-FG1)

HPs described that some of the service users had expected to be given a fixed plan and that they had to turn this expectation into an understanding of the importance of service users making the plan themselves. They helped the service users to set realistic goals that were possible to reach, avoid new disappointments, failure and setback and helped them get back on track when they had a relapse. They believed that the service users needed to achieve some goals in order to regain belief in themselves. Several of the HPs recognized getting better at assessing and identifying service users who were not yet ready to start a full lifestyle intervention due to their excessive distress in life, with the intention of avoiding new disappointments:

> *I have become better at questioning the service users who have too much psychological distress and life-challenges if this is the right time to start a lifestyle change.* (4-FG1)

HPs recognized the necessity of adopting a holistic approach and addressing psychological challenges and emotional distress. They described working with "life-self-management" as essential rather than only covering what to eat and the amount of exercise and activity:

> *I believe that this group of people have complex conditions and challenges and need help to manage life, not only advice about what to eat or how much to exercise.* (7-FG2)

HPs also described trying to turn the focus on better perceived health away from weight, BMI, special diets and slimming:

> *Our job is to strengthen the service users to take care of their own health, by explaining and emphasizing that this is not a slimming programme.* (2-FG1)

They noticed that the service users were motivated by experiencing the effects of training. According to the HPs, the service users reported having more energy, finding it easier to perform daily activity, greater well-being, more confidence, increased self-efficacy and motivation after participating in lifestyle interventions in HLCs. For several of the service users this could include better fitness, feeling stronger, lower blood pressure, blood glucose and cholesterol, while some of them also mentioned weight reduction. A number of the HPs stated that the purpose of user involvement is for the service users to discover their own resources, the significance of good health and strength and increase their self-efficacy. HPs emphasized the need to focus on the service users' resources, give them feedback and help them to see all the small changes they had achieved. Regular follow-up conversations were often necessary to make them aware of what they managed and to increase positive self-talk. They experienced that positive feedback on achievements led to self-belief, pride and motivation:

> *They need feedback on every little achievement so that they don't give up. They need to be conscious of the small changes they make…* (8-FG). *Much of the purpose of user involvement is to let the service users discover which possibilities and resources they have and raise their belief in self-management.* (3-FG1)

Collaborating and sharing responsibility

The third theme described how HPs emphasized collaboration partnership with the service users as well as the importance of a trustful relationship and shared responsibility to increase user involvement and self-management. HPs outlined how they explored the service users' needs, set goals together and sometimes did the problem solving together with the service users. They experienced that it was more helpful to be a partner who listens than an expert who gives advice. HPs emphasized equality and the value of complementary competence. They described a philosophy based on the importance of the service users' experiential knowledge for all parties:

> *They are the ones who know where the shoe pinches, they are the experts on themselves and I think that we have complementary expertise.* (7-FG2)

They stated that service users and HPs had different responsibilities. The users' responsibility was to follow the plan they were involved in making, participate and attend all appointments and intervention sessions, while the HPs were responsible for letting the service users' voices be heard, being available, addressing expectations, helping, being generous, interested and providing follow-up. Written contracts signed by both parties outlined the expectations, responsibilities and commitments. Relational commitments and expectations to participate were important, but there were no commitments or expectations about outcome or weight loss. The relational commitments, meaning that someone is waiting for you (also in groups), are both desirable and important for both parties:

> *We write and sign a contract that we have to adhere to. We make commitments to provide follow-up, while the service users make commitments to follow their plan …and the service users appreciate the commitments and expectations because of the difficulties getting into the activity groups and "getting started" on their own.* (10-FG2)

Being flexible, adjusting and sharing time

The fourth and last theme described the importance of adjusting self-management support to the service users' needs and the significance of time, flexibility and extended support for lifestyle change. HPs described their role as being an available, supportive partner in the process of change, guiding each service user in the best possible way. They stated that sufficient time to get to know the service users and their values in order to identify their needs creates the basis for user involvement, as well as for the possibility to adjust and tailor the person-centred care and

individualized support. Giving the service users time to tell their story and exploring their concerns (not the experts' concerns) were essential. They acknowledged that they had more time for exploring the service users' needs and values compared to GPs:

> *It is important to have time to listen and to get to know the person in front of you, who feel the challenges in her/his body* (9-FG2)

HPs described the service users as a very heterogeneous group with different resources, needs and wishes. Several of them had complex challenges and different follow-up needs. HPs recognized the importance of supporting the service users' own choices and goals, not those of the "experts" or professionals:

> "*We let them define their own goals and help them to make a plan"* (7-FG2)

The HPs described that being flexible and adjusting within the limits of what was possible was required. It was necessary to be sensitive, give service users an opportunity for expressing freely and listening to them, even if the HPs could not fulfil all their wishes. It was important to emphasize well-being and offer an intervention with a variation in activities that was meaningful and related to service users' needs and wishes. HPs described their contribution to creating new structures, routines and habits, highlighting the transferability to the service users' situation and everyday life. In this process of adjustment, HPs tried to avoid giving advice too quickly. They attempted to "lay back" and let the service users find the solutions on their own and use their problem-solving skills first, describing this as both time-consuming and crucial. Communication skills were perceived as more important than having the right answer to every question:

> *It is important to learn to lean back and let the service users be in control.* (9-FG2)

Supervised group-sessions and individual health conversations were recognized as helpful for both parties. In activity group-sessions, HPs regularly experienced beneficial contact and an opportunity for follow-up. Individuality was perceived as a possibility, even in group-sessions, by creating a safe environment for the acceptance of diversity and that everyone and everything was "good enough". Flexibility related to the service users' preference for individual counselling and support,

which was accepted and possible, although some of the HPs tried to give the service users a friendly push toward group participation. Time was essential in this process of "persuasion" to convince the service users of the advantages of group participation. However, they accepted those who absolutely did not want to "belong" to a group without compromising their healthcare:

> *The great thing is that we have both groups and individual support. Those who do not want to be in a group can have individual follow-up, which is perfectly ok.* (9- FG2)

They described trying to make the service users understand that lifestyle change takes time by communicating a long-term perspective and stressing that change does not occur in two weeks. They tried to confirm the normality of ups and downs, trial and error, and the possibility to get back on track. HPs perceived long-term follow-up as one of the most important conditions for successful lifestyle change. Several service users repeatedly joined a new course. HPs allowed those who needed extended follow-up to continue after the end of an intervention period and "gaming the system" of a maximum of three 3-month interventions. However, this was practised differently in the various HLCs:

> *There is something about recognizing that change takes time and we don't expect the service users to achieve their goals of change by the end of the course.* (4-FG1) *We let them continue with the training sessions after the end of the intervention.* (5-FG2)

Discussion

The aim of this study was to explore how HPs provide SMS and what user involvement implies for the HPs in HLCs. The HPs in this study exhibited a high degree of self-reflection and an in-depth understanding of human needs and behaviour when discussing their role as supervisors responsible for SMS and user involvement for persons afflicted by overweight or obesity. The overall findings suggest that a partnership based on ethical awareness, non-judgemental attitude and dialogue as well as shared responsibility is a description of how HPs provide SMS and involve service users in the lifestyle interventions in the HLC. This discussion will focus on the overall theme*; A partnership based on ethical awareness, non-judgemental attitude and shared responsibility*. We will discussed the elements in this theme in light of previous studies and the literature.

A partnership based on ethical awareness, shows that the SMS in HLCs takes place through a trustful relationship (partnership) with the service users. The HPs described both relational and communicational skills as essential for SMS and user involvement. This is in line with the study by Sagsveen et al. [34], underpinning the importance of participative communication skills among HPs in HLCs to promote involvement. The HPs in our study emphasized human values and generosity as the core relational skills, in addition to the importance of being genuinely interested, curious, sensitive, friendly and helpful. This attitude can be seen as a means to get to know each service user and understand her/his values, needs and interests. This awareness also reflects the ethical principles of autonomy and beneficence [48]. The importance of a trustful relationship has been highlighted in previous studies [30, 34, 49-51]. Our findings add to the literature by underlining the importance of a respectful way of being for building a trustful relationship with service users that places HPs in a position to help with overweight or obesity. There is a need to strengthen the service users' experience of dignity and self-worth due to their social stigma that goes beyond their self-worth [4]. The service users' shame and search for dignity [4] imply an ethical requirement for HPs in HLCs to meet these service users' existential need for integrity and dignity, and it seems as if the HPs in the present study are doing just that. Our study indicates that HPs are meeting the service users' existential needs with self-worth support, acknowledging them for who they are and being genuinely interested in them. Their descriptions illustrate how the HPs managed to be sensitive and meet their perceived "wrong" lifestyle, vulnerability and shame with respect, acknowledgement and generosity, allowing them to fail and not being condescending about their lifestyle. According to Gjengedal et al. [52], being sensitive to the vulnerability of the other may be a key to acting ethically. The HPs in our study saw "service users as experts on themselves", which may imply safeguarding their autonomy and taking advantage of their own contribution so that they can preserve something of themselves and regain their dignity. In the findings from Salemonsen et al. [31], the service users in HLCs highlighted the professionals' competence, attitude and the feeling of increased self-worth and dignity they obtained through participation in the HLCs. Acceptance and self-worth support may lead to a positive body image and less guilt and shame. According to Tranvåg et al. [53], confirming the person's worthiness and sense of self involves genuine respect for each individual as a unique human being and such confirmation is an essential prerequisite for autonomy and integrity.

A non-judgemental attitude and dialogue, is revealed by the findings in our study, describing HPs using elements of MI in their dialogue with the service users. Partnership in MI means an active collaboration between experts, with a view that people are the undisputed experts on themselves. Acceptance in MI includes four aspects of absolute worth, accurate empathy, autonomy support and affirmation [27, 28]. It seems as if the HPs in our study were influenced by MI and made their own dynamic "tool-box" of elements that they experience as beneficial. Their use of elements, adjustment and the adaptive capacity of this communication style shows their competence and that the spirit of MI and humanistic values have become an integrated part of their thinking and way of working. The adaptive capacity and use of elements may characterize a professional who has integrated these into her/his way of doing, being and meeting the "other", described by Benner [54] as a theory from novice to expert in nursing practice. In addition, the findings in our study confirm that the HPs emphasize a person-centred approach found in Rogers' [55] theory of a client centred approach in psychological therapy and Buber's [56] theory of dialogue. Rogers highlights the importance of genuineness, creating a climate for change through acceptance and caring, emphatic understanding and listening, extending unconditional positive regard [55]. The philosophy of Buber and his theory of dialogue emphasizes an "I and Thou" approach in the conversation as opposed to an "I and It" approach. Buber states that the ontological basis of human existence lies in the dialogue between the self and others and that dialogue is about relationality and meetings between people [56]. In HLCs the non-judgemental attitude and dialogue seem to be an integrated part of the practice and personality of authentic and honest HPs. Their way of seeing and being demonstrate that they are firmly rooted in humanistic values that support existential needs. Consequently, the use of a non-judgemental dialogue and attitude, sensitivity and hospitality may lead to a wish to participate in the lifestyle interventions in HLCs and give service users a sense of worth and motivation for continuing lifestyle changes. Healthcare settings have been reported to be one of the sources of weight-stigma [57, 58]. Several HPs hold strong negative attitudes about people with obesity [5, 59], and this attitude and weight-stigma can reduce the quality of care and weight-management [5, 60] . We believe that HPs in general, in healthcare services, have something to learn from HPs in HLCs and their "MI –spirit". Negative attitudes affect whether one has a non-judgemental attitude or not, and changing attitudes among HPs may be an important and necessary step to help persons in vulnerable situations.

Shared responsibility, shows how HPs taking responsibility for creating a mutual relationship through interaction and collaboration. They emphasized equality, in addition to the necessity of the service users' experiential knowledge and complementary competence in this clinical partnership. A collaborative partnership is described in the literature as one of the most important prerequisites in SMS [10]. Additionally, the HPs communicated that the service users have no responsibility for the outcome or for weight loss. They emphasized participation and that the service users perceived better health, well-being and a healthier lifestyle. This shows that HPs are aware of their responsibility as professionals and assign responsibility to the service users for the purpose of sharing responsibility. Sharing responsibility may also reduce the pressure for weight-loss and the feeling of guilt and shame. In other studies, however, HPs held patients accountable for both their body weight and their attributed lack of responsibility for investment in change [60]. A dominance of a traditional model of care, where HPs remained in a position of authority and limited collaboration was found. The psychosocial and temporal nature of interaction was excluded and the context was characterized by the service users' individual responsibility and accountability for self-management and adherence [61]. Those findings may challenge equality, respect and acknowledgement in the clinical SMS partnership, and are inconsistence with our findings.

The HPs in our study practice SMS through tailored support and counselling, emphasizing flexibility, adjustment and sharing time. The importance of flexibility and adjusting support to service users' needs and context is supported by several previous studies that demonstrated how essential such aspects are for lifestyle change and self-management in chronic conditions [50, 51, 62, 63]. HPs saw the need for frequent support and follow-up over time for several of the service users. Previous studies emphasize follow-up as a prerequisite for maintenance of lifestyle change [50, 63, 64], maybe over several years [31, 65-67]. Establishing a trustful relationship takes time. The HPs are aware of this and take responsibility for prioritizing the allocation of time to get to know the service users and build a relationship. In a study exploring HPs' perceptions of user involvement in HLCs, being present in the situation and devoting sufficient time to the health conversations were also described as essential [34]. HPs in our study made a decision to give those service users who needed extended follow-up more time and counselling than the intervention entailed. While this may be interpreted as a form of "gaming the system", it can also be interpreted

as HPs assuming their relational and moral responsibility for the service users' need for extended help and support. So, what do relational and moral responsibility towards the service users imply? The HPs in our study described their responsibility to meet the service users with respect, hospitality and a desire to help the other, often asking them; *"what is important for you in your life"* and *"what would you like me to help you with?"*. They described a practice of moral responsibility and ethical awareness similar to our understanding of Levinas' theory of responsibility. According to Morgan [68], Levinas teaches us to acknowledge what we owe to others, to be kind, caring and generous. Responsibility is about our commitment to take care of or deal with and that moral responsibility arises in the face-to-face interaction with another person. In all relationships, we are faced with a demand to take responsibility for the other and are thus not free to choose our moral responsibility. This ethical and moral responsibility cannot be shared or given away [68-70]. Being a responsible HP entails facing up to the consequences of our behaviour and actions. By prioritizing time and focusing on the service users' needs and situation, it seems as if the Levinanian responsibility comes into play. In relation to time, continuity and having enough time to get to know the service users and their needs is important and in line with other studies [34, 49]. How HPs in HLCs manage to prioritize time and their challenges and needs related to the organisation of lifestyle interventions in HLCs requires further investigation.

The focus on individual responsibility for health in contemporary society described in earlier studies [71-74] shows that responsibility for behaviour change is often discussed at an individual level and rarely at a professional or societal level. Very few studies focus on shared responsibility between the partners in a clinical partnership in either lifestyle interventions or society in general. Consequently, this may reflect the major attitude towards individual responsibility in society, which may add more blame or shame to people afflicted by overweight or obesity. Our findings add to the literature and illustrate how ethical awareness, a non-judgemental attitude, shared responsibility and avoidance of negotiation of responsibility for outcome and weight management may strengthen the service users' self-efficacy, self-worth and dignity.

Trustworthiness

Trustworthiness in this qualitative study is based on Lincoln and Guba [75] and the aspects of credibility, dependability, confirmability and transferability. Confirmability and dependability of the research was confirmed through the systematic, analysis and discussion of the findings between all the researchers over a period of time [35, 37, 43, 75]. Quotations from the interview data have been included in order to illustrate and ensure the credibility and dependability of the HPs' perspectives and descriptions. Data collection and context are carefully described in order for the reader to decide on the transferability of the findings to similar contexts. The interpretation was influenced by the preunderstanding of the researchers, which must be taken into account [46, 76]. The authors have various clinical experiences and disciplinary backgrounds such as public health nurse (ES & BSH), psychiatric nurse (ALH), patient education (GF) and intensive care (BSH), which enriched the analysis and interpretation, thereby increasing trustworthiness and minimizing potential bias. The present paper was cross-checked to comply with the consolidated criteria for reporting qualitative studies using the 32-item COREQ checklist [77].

Strengths and limitations

Our study has contributed to a deeper understanding of HPs' practice of SMS and service user involvement. Focus group interviews were a plausible method for discovering this knowledge of HPs' values and reflexivity. HLCs are a relatively new healthcare service in primary care. Due to the sparse knowledge and understanding of the HPs' perspective, this study contributes to deepening the understanding of how to provide a qualitatively good healthcare service. One possible limitation might be the gender balance with only one male participant. However, this reflects the general gender balance in HLCs, which have a majority of female employees. Another limitation that should also be taken into consideration concerns the composition of the focus groups. The participants in one of the groups had experience of inter-municipal collaboration over a period of several years, while the participants in the other group had only met a few times and had less experience of working in a HLC. However, none of the participants appeared to be reticent about expressing their opinions and perceptions. A potential limitation is related to the small number of focus groups, however information power guided the sample size [39].

Conclusion

This study reveals that HPs in HLCs provide SMS and involve service users through extensive tailored support based on the service users' needs and situation. The findings show that the HPs see the service users as equal partners in a collaborative partnership based on shared responsibility, acknowledgement and generosity. To be in a position to help, their practice involves a heightened level of ethical awareness, including a non-judgemental attitude and dialogue. The HPs seems to be dedicated and to take a personal interest in those seeking help through openness, compassion, sensitivity and a positive attitude. HPs in HLCs have something to teach us when it comes to ethical acting and helping persons who are struggling with overweight or obesity to change their lifestyle and regain dignity. They appear to see the service users' existential needs and have learned the art of meeting the "other" in one of her/his most vulnerable situations i.e., seeking help for a "wrong lifestyle". Our findings contribute to a wider understanding of user involvement and SMS in lifestyle change. It may be time to highlight the need for SMS and user involvement to focus on shared responsibility in partnership rather than personal responsibility. More research is required to explore the conditions for such practice.

Abbreviations

FG (focus group), GPs (general practioners), HLCs (Healthy Life Centres), HPs (health professionals), MI (motivational interview), NCDs (non-communicable diseases), SMS (self-management support)

Declarations

Ethical approval and consent to participate

The participants in this study received written and oral information about the study and gave their written consent to participate before the focus group interviews started. The interview setting was well prepared and a respectful, non-judgmental atmosphere was emphasised. Participation in the study was voluntary and the participants were informed about their right to withdraw at any time. The participants are coded by number and focus group number (for example 1-FG1 (participant 1 in focus group 1) or 7-FG2 (participant 7 in focus group 2) for reasons of confidentiality due to the fact that there was only one male participant and most of the participants were physiotherapists. This study was registered at, and approved by the Norwegian Centre for Research Data (NSD) project number 48025. It adheres to the requirements and ethical guidelines contained in the Helsinki Declaration.

Consent for publication

Not applicable

Availability of data and materials

The dataset used and analysed during the current study are available from the corresponding author on reasonable request.

Competing interests

The authors declare that they have no competing interests.

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Authors' contributions

ES planned and designed the study and was responsible for the ethical approval application in cooperation with ALH. ES collected the data and performed the focus group interviews with guidance from ALH. ES transcribed the interviews, conducted the analysis and interpretation of the data material with guidance and input from ALH, BSH and GF. ES was the main contributor in writing and revising the manuscript with input from ALH, GF and BSH. All authors participated in the critical revision of the manuscript and approved the final manuscript for submission.

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Appendices 1-7

1. Table of analysis
2. Approval from Norwegian Centre for Research Data
3. Assessment from Regional Committees for Medical and Health Research Ethics
4. Study information with consent to participate - healthcare professionals
5. Study information with consent to participate - service users
6. Topic guide - focus group interviews with the healthcare professionals
7. Interview guide - individual interviews with the service users

Appendix 1. Table of analysis

Paper I. Overview of the main theme, themes, sub-themes and categories

Main theme:	**Searching for dignity**					
Theme	Needing to justify avoidance of personal responsibility			A desire to change		
Sub-Theme	Strain and challenges as barriers to change	A constant struggle and negotiation between healthy living and pleasure	Feelings of shame, guilt or discouragement affect weight management	Health challenges and the need for improved self-respect trigger change	Pride in self-management	Hope, self-efficacy and meaningfulness increase motivation

Paper II. Main-theme, themes and sub-themes describing service users' experiences of user involvement and beneficial self-management support in the HLCs

Main-theme	**Regaining self-esteem and dignity through active involvement and long-term self-worth support in partnership with others.**						
Theme	**T1: Self-efficacy through active involvement and better perceived health**			**T2: Valued through HPs acknowledgement, equality and individualized support**			
Sub-theme	Being in control by having ownership of personal goals	Responsibility by showing initiative and participating	The significance of the effects of training	Knowledgeable health professionals increase trust and safety	Feeling stronger by perceiving emotional support from interested and sensitive health professionals	Sense of equality and worth through acknowledgement	The importance of flexibility and individualized support
Theme	**T3: Increased motivation and self-belief through peer support and fellowship**			**T4: Maintenance of lifestyle change through accessibility and long-term support**			
Sub-theme	Encouragement and a sense of worth through peer support in an inclusive environment	A sense of identity and fellowship through the sharing of experience	Meaningfulness by obtaining structure and commitment	A need for continued awareness and focus		A need for long-term support to maintain lifestyle change	The importance of accessibility

Paper III. Over all theme and themes describing how HPs provide SMS and what user involvement implies for HPs in HLCs.

Overall Theme	**A partnership based on ethical awareness, non-judgemental attitude, dialogue and shared responsibility**			
Theme	Supporting self-efficacy, self-worth and dignity through an attitude of respect, acknowledgement and generosity	Promoting self-belief and self-perceived health	Collaborating and sharing responsibility	Being flexible, adjusting and sharing time

Appendix 2. Approval from Norwegian Centre for Research Data

Elin Salemonsen
Avdeling for helsefag Høgskolen Stord/Haugesund
Postboks 1064
5407 STORD

Vår dato: 27.04.2016 Vår ref: 48025 / 3 / BGH Deres dato: Deres ref:

TILBAKEMELDING PÅ MELDING OM BEHANDLING AV PERSONOPPLYSNINGER

Vi viser til melding om behandling av personopplysninger, mottatt 17.03.2016. Meldingen gjelder prosjektet:

48025 *Brukermedvirkning i kommunale frisklivssentraler*
Behandlingsansvarlig *Universitetet i Stavanger, ved institusjonens øverste leder*

Daglig ansvarlig *Elin Salemonsen*

Personvernombudet har vurdert prosjektet, og finner at behandlingen av personopplysninger vil være regulert av § 7-27 i personopplysningsforskriften. Personvernombudet tilrår at prosjektet gjennomføres.

Personvernombudets tilråding forutsetter at prosjektet gjennomføres i tråd med opplysningene gitt i meldeskjemaet, korrespondanse med ombudet, ombudets kommentarer samt personopplysningsloven og helseregisterloven med forskrifter. Behandlingen av personopplysninger kan settes i gang.

Det gjøres oppmerksom på at det skal gis ny melding dersom behandlingen endres i forhold til de opplysninger som ligger til grunn for personvernombudets vurdering. Endringsmeldinger gis via et eget skjema, http://www.nsd.uib.no/personvern/meldeplikt/skjema.html. Det skal også gis melding etter tre år dersom prosjektet fortsatt pågår. Meldinger skal skje skriftlig til ombudet.

Personvernombudet har lagt ut opplysninger om prosjektet i en offentlig database, http://pvo.nsd.no/prosjekt.

Personvernombudet vil ved prosjektets avslutning, 31.07.2019, rette en henvendelse angående status for behandlingen av personopplysninger.

Vennlig hilsen
Kjersti Haugstvedt

Belinda Gloppen Helle

Kontaktperson: Belinda Gloppen Helle tlf: 55 58 28 74
Vedlegg: Prosjektvurdering

Appendix 3. Assessment from Regional Committees for Medical and Health Research Ethics

Vår ref.nr.: 2016/201

Elin Salemonsen

Jeg viser til ditt skjema for fremleggingsvurdering datert 27.1.2016

Etter vår oppfatning er dette prosjektet ikke fremleggingspliktig for REK.

Helseforskningsloven gjelder for medisinsk og helsefaglig forsking på mennesker, humant biologisk materiale eller helseopplysninger der virksomheten utføres med vitenskapelig metodikk for å skaffe til veie ny kunnskap om helse og sykdom jf. hfl. §2.

Slik du beskriver prosjektet synes ikke formålet med prosjektet primært å være å skaffe til veie ny kunnskap om sykdom og helse. Formålet med studien er å se på betydningen av brukermedvirkning og informasjon ved ønske om varig livsstilsendring. Brukere og ansatte skal intervjues om hva som fremme /hemmer livsstilsendringer med hjelp fra tilbudet ved Frisklivsentralene.

Vi gjør oppmerksom på at konklusjonen er å anse som veiledende, jfr. Forvaltningslovens § 11.

Dersom du allikevel ønsker å søke REK vil søknaden blir behandlet i komitémøte og det vil bli fattet enkeltvedtak etter Forvaltningsloven.

Med vennlig hilsen
Anne Berit Kolmannskog
Rådgiver

post@helseforskning.etikkom.no

T: 55978497

Regional komité for medisinsk og helsefaglig forskningsetikk REK vest-Norge (REK vest)
http://helseforskning.etikkom.no

Appendix 4. Study information with consent to participate - healthcare professionals

Til helsepersonell Dato 08.09.16

FORESPØRSEL OM DELTAKELSE I FORSKNINGSPROSJEKTET

Brukermedvirkning i kommunale frisklivssentraler

BAKGRUNN OG FORMÅL

Jeg er utdannet sykepleier og jobber som doktorgradsstipendiat (PhD-kandidat) ved Høgskolen Stord/Haugesund og Universitetet i Stavanger. I denne sammenheng skal jeg utføre en studie / prosjekt som et ledd i en doktorgradsavhandling. Med dette brevet ber vi om ditt samtykke til å delta i en forskningsstudie om brukermedvirkning på livsstilskurs / lærings- og mestringskurs i kommunale frisklivssentraler. Vi søker informasjon fra deg som helsepersonell med erfaring fra livsstilskurs for personer med overvekt eller fedme.

Formålet er å undersøke erfaringer og oppfatninger om nyttig hjelp til livsstilsendring og betydningen av brukermedvirkning for personer med overvekt eller fedme som har deltatt på livsstilskurs i kommunale frisklivssentraler. Studien vil også undersøke om det er noen forskjeller i kvinner og menns erfaringer og behov. Hensikten er å bidra til ny kunnskap relatert til betydningen av brukermedvirkning for varige livsstilsendringer og få større innsikt og forståelse for hva vi som helsepersonell kan gjøre for å gi et kvalitativt godt helsetilbud til personer som sliter med overvekt eller fedme. Prosjektet er et ledd i en doktorgradsavhandling ved Høgskolen Stord/ Haugesund og Universitetet i Stavanger.

HVA INNEBÆRER DELTAKELSE I PROSJEKTET?

Deltakelse innebærer at du deltar i flerstegs fokusgruppe-intervju/ samtale med meg som PhD-kandidat og min hovedveileder, sammen med 5-7 andre som har erfaring fra livsstilskurs i frisklivssentraler. Flerstegs fokusgruppe-intervju innebærer at de samme deltakerne møtes igjen 2-3 ganger med noen måneders mellomrom, for utdyping av tema og erfaringer. Spørsmålene vil omhandle deres forståelse av hjelpsomme strategier for endring av livsstil og erfaringer og meninger om brukermedvirkning. Intervjuene vil foregå i et egnet lokale ved Høgskolen Stord/Haugesund eller annet lokale tilpasset kortest mulig reisetid for deltakerne. Beregnet tid til intervjuet er ca 1 ½ time, og det gjøres lydopptak av samtalen.

HVA SKJER MED INFORMASJONEN OM DEG?

Alle personopplysninger vil bli behandlet konfidensielt. Datamaterialet vil bli behandlet og lagret på en sikker og forskriftsmessig måte. Når alle resultater foreligger og analysen er ferdig, vil lydopptak slettes. Du vil bli sikret full anonymitet og vil ikke kunne gjenkjennes i publikasjonen. Det er kun PhD-kandidat og veileder som har tilgang til dataene. Prosjektet skal etter planen avsluttes 31.juli 2019.

MULIGE FORDELER OG ULEMPER

Deltakelse skal ikke være forbundet med ulemper. Gjennom å delta bidrar du til mer kunnskap om et viktig tema. Samtaler som omhandler helseproblemer som bl.a. overvekt og fedme kan oppleves sensitivt, men er også den viktigste kilden til forståelse.

FRIVILLIG DELTAKELSE OG MULIGHET TIL Å TREKKE SITT SAMTYKKE

Du har mulighet til å trekke deg fra prosjektet når som helst uten å oppgi noen grunn til dette. Dersom du ikke ønsker å delta, vil det ikke få betydning for videre samarbeid.

GODKJENNING

Studien er meldt til Personvernombudet for forskning, Norsk samfunnsvitenskapelig datatjeneste AS, og godkjent med prosjektnummer 48025.

Vedlagt følger svarskjema / samtykkeerklæring, samt adressert og frankert konvolutt. Samtykke kan også sendes på e-post og skjema tas med på første møte. For nærmere informasjon og eventuelle spørsmål, vennligst ta kontakt med Elin Salemonsen. Deltakere vil bli kontaktet på telefon for nærmer avtale om intervju.

På forhånd takk!

Vennlig hilsen

Elin Salemonsen
PhD-kandidat
Universitetet i Stavanger/
Høgskolen Stord / Haugesund
elin.salemonsen@hsh.no
Tlf. 52702819 /988 87 797

Anne Lise Holm
Hovedveileder / Professor
Høgskolen Stord / Haugesund
anne.holm@hsh.no
Tlf. 52702763

HØGSKOLEN STORD/HAUGESUND

Universitetet i Stavanger

SAMTYKKE TIL DELTAKELSE I PROSJEKTET

Brukermedvirkning i kommunale frisklivssentraler

Jeg har mottatt informasjon og er villig til å delta i studien:

……
Navn på deltaker (bruk blokkbokstaver)

Jeg samtykker til deltakelse i studien:

Telefon jeg kan nås på:……..e-post:……..

…… …….
Dato *Underskrift*

Svarskjema kan sendes til

Elin Salemonsen
Høgskolen Stord/Haugesund AFH
Postboks 1064
5407 STORD
elins.salemonsen@hsh.no
tlf. 52702810 / 988 87 797

Appendix 5. Study information with consent to participate - service users

Til deltakere

Dato: 19.10.16

FORESPØRSEL OM DELTAKELSE I FORSKNINGSPROSJEKTET

Brukermedvirkning i kommunale frisklivssentraler

BAKGRUNN OG FORMÅL

Jeg er utdannet sykepleier og jobber som doktorgradsstipendiat (PhD-kandidat) ved Høgskolen Stord/Haugesund og Universitetet i Stavanger. I denne sammenheng skal jeg utføre en studie / prosjekt som et ledd i en doktorgradsavhandling. Med dette brevet ber vi om ditt samtykke til å delta i en forskningsstudie om brukermedvirkning på livsstilskurs / lærings- og mestringskurs i kommunale frisklivssentraler. Vi søker informasjon fra deg som deltaker med erfaring fra livsstilskurs for personer med overvekt eller fedme.

Formålet er å undersøke dine erfaringer og oppfatninger om hva som kan være til hjelp når livsstilen skal endres, og hvilken betydning brukermedvirkning har. Studien vil også undersøke om det er noen forskjeller i kvinner og menns erfaringer og behov. Hensikten er å bidra til ny kunnskap relatert til betydningen av brukermedvirkning for varige livsstilsendringer og for å få større innsikt og forståelse for hva vi som helsepersonell kan gjøre for å gi et kvalitativt godt helsetilbud til personer som sliter med overvekt eller fedme.

HVA INNEBÆRER DELTAKELSE I PROSJEKTET?

Deltakelse innebærer at du deltar i intervju/ samtale med meg som PhD-kandidat. Spørsmålene vil omhandle din forståelse av hjelpsomme strategier for endring av livsstil og erfaringer og meninger om brukermedvirkning. Intervjuene vil foregå i et egnet lokale ved Høgskolen Stord/Haugesund eller annet lokale tilpasset kortest mulig reisetid for deg. Beregnet tid til intervjuet er ca 1 ½ time, og det gjøres lydopptak av samtalen.

HVA SKJER MED INFORMASJONEN OM DEG?

Alle personopplysninger vil bli behandlet konfidensielt. Datamaterialet vil bli behandlet og lagret på en sikker og forskriftsmessig måte. Når alle resultater foreligger og analysen er ferdig, vil lydopptak slettes. Du vil bli sikret full anonymitet og vil ikke kunne gjenkjennes i publikasjonen. Det er kun PhD-kandidat og veileder som har tilgang til dataene. Prosjektet skal etter planen avsluttes 31.juli 2019.

MULIGE FORDELER OG ULEMPER

Deltakelse skal ikke være forbundet med ulemper. Gjennom å delta bidrar du til mer kunnskap om et viktig tema. Samtaler som omhandler helseproblemer som bl.a. overvekt og fedme kan oppleves sensitivt, men er også den viktigste kilden til forståelse.

FRIVILLIG DELTAKELSE OG MULIGHET TIL Å TREKKE SITT SAMTYKKE

Du har mulighet til å trekke deg fra prosjektet når som helst uten å oppgi noen grunn til dette. Dersom du ikke ønsker å delta, vil det ikke få betydning for videre samarbeid eller for videre mottakelse av helsehjelp.

GODKJENNING

Studien er meldt til Personvernombudet for forskning, Norsk samfunnsvitenskapelig datatjeneste AS, og godkjent med prosjektnummer 48025.

Vedlagt følger svarskjema / samtykkeerklæring, samt adressert og frankert konvolutt. Samtykke kan også sendes på e-post eller skjema tas med på første møte. For nærmere informasjon og eventuelle spørsmål, vennligst ta kontakt med Elin Salemonsen. Deltakere vil bli kontaktet på telefon for nærmer avtale om intervju.

På forhånd takk!

Vennlig hilsen

Elin Salemonsen
PhD-kandidat
Universitetet i Stavanger /
Høgskolen Stord Haugesund
elin.salemonsen@hsh.no
tlf. 52702810 / 988 87 797

Anne Lise Holm
Hovedveileder / Professor
Høgskolen Stord Haugesund
anne.holm@hsh.no
tlf. 52 70 27 63

HØGSKOLEN STORD/HAUGESUND

Universitetet i Stavanger

SAMTYKKE TIL DELTAKELSE I PROSJEKTET

Brukermedvirkning i kommunale frisklivssentraler

Jeg har mottatt informasjon og er villig til å delta i studien:

……

Navn på deltaker (bruk blokkbokstaver)

Jeg samtykker til deltakelse i studien:

Telefon jeg kan nås på:……..e-post:……..

…… …….

Dato *Underskrift*

Svarskjema kan sendes til

Elin Salemonsen
Høgskolen Stord/Haugesund AFH
Postboks 1064
5407 STORD eller
elins.salemonsen@hsh.no
tlf. 52702810 / 988 87 797

Appendix 6. Topic guide – focus group interviews with the healthcare professionals

Intervjuguide helsepersonell i Frisklivssentraler

Helsepersonell som har arrangert livsstils kurs for personer med overvekt og/ eller fedme i kommunale frisklivssentraler:

Fokusgruppe intervju

Innledende informasjon:

Dato:

Alder:

Kjønn:

Utdanning:

Når utdannet:

Erfaring med livsstil kurs og veiledning:

Samarbeid med fastleger?

Hva erfarer dere at tjenestebrukerne / deltakerne har behov for når de søker hjelp til livsstilsendring?

- Hvilket behov for støtte og hjelp har de?
- Er det noen forskjell på kvinner og menn?
- Hva har deltakerne behov for å få kunnskap om?

Hva erfarer dere som nyttig hjelp og støtte til personer med overvekt eller fedme som søker hjelp til livsstilsendring?

- Hva opplever dere som nyttig hjelp til livsstilsendring og egenmestring?
- Hvordan beskriver deltakerne nyttig støtte og hjelp?
- Hvordan fremmer dere egenmestring på livsstilskursene?
- Kan dere beskrive hvordan dere arbeider?
- Kan dere beskrive hvordan dere fremmer egenmestring? Hva er viktig?
- Hvordan formidler dere kunnskap om sunn livsstil?
- Hva er viktig når det gjelder fremming av egenmestring når det gjelder livsstilsendring?

Hvordan forstår dere brukermedvirkning / brukerinvolvering i Frisklivssentralen?

- Hva innebærer brukerinvolvering for dere?
- Hvordan involverer dere deltakerne på kurset og i prosessen med livsstilsendring?
- Hva er viktig når det gjelder å involvere deltakerne?
- Hva kan fremme brukermedvirkning / brukerinvolvering?
- Hvilken betydning har brukermedvirkning / brukerinvolvering for livsstilsendring?
- Hvordan kan dere imøtekomme behovet for informasjon og individuelt tilrettelagt tilbud?
- Opplever dere at deltakerne har mulighet for medvirkning?
- Hvordan imøtekommes brukernes meninger?
- Hva kan gi brukerne en opplevelse av medvirkning?

- I hvilken grad blir det lagt til rette for medvirkning og involvering?
- Hva kan styrke deltakerne (empowerment)?
- Hvilken betydning har dialog og samarbeid?
- Hva er viktig for at deltakerne skal bli hørt og møtt på en god måte?
- Hvilke tanker gjør dere dere om fordommer og skam knyttet til overvekt?
- I hvilken grad og på hvilken måte kan fordommer og holdninger ha betydning for tjenestetilbudet, relasjon og mestring?

Er det noe dere vil tilføye til slutt?

Tusen takk for deltakelse!

Appendix 7. Interview guide – individual interviews with service users

Intervjuguide tjenestebrukerne/deltakere

Tjenestebrukerne som har deltatt på livsstils kurs i regi av kommunale frisklivssentraler:

Individuelle intervju

Innledende informasjon:
Dato:

Kjønn:

Alder:

Yrke:

Deltatt på:

Tilvisning: Lege/ anmodet / eget initiativ/andre?

Kan du beskrive hvilke mål du har eller hvilke endringer du ønsker deg?

- Deltok du selv i prosessen med å melde deg på kurs på Frisklivssentralen?
- Hvilke forventninger har / hadde du til kurset?
- Hvilke forventninger hadde du til deg selv?
- Hva betyr dine egne ressurser og styrker?
- Hva betyr støtte fra familie og venner?

Kan du beskrive hva du har erfart som nyttig hjelp på kurset og i samtalene på Frisklivssentralen?

- Hva opplever du som hjelpsomt og nyttig for deg å vite for livsstilsendring?
- Hvordan var informasjonen og støtten tilpasset dine behov?
- Hva mener du ville være den beste hjelpen?
- Hva har gitt deg styrke til å starte og fortsette livsstilsendring?
- Kan du si noe om hva som har styrket og hjulpet deg mest?
- Hva betyr det for deg å klare det?
- Kan du beskrive dine behov for oppfølging i fremtiden?
- Hvordan ser du på ditt behov for informasjon og støtte i fremtiden?

Kan du beskrive hva du forstår med brukermedvirkning / brukerinvolvering på kurs i Frisklivssentralen?

- Hvilken betydning har brukermedvirkning for deg?
- Hva er viktig for deg når det gjelder brukermedvirkning / brukerinvolvering?
- Hvordan ble du involvert?
- Hvordan vil du beskrive samarbeid og dialog?
- Hvordan vil du beskrive din relasjon til de som arrangerte kurset?
- Hva gir deg en følelse av å være involvert / medvirke til endring av livsstil?
- Hvordan ble dine meninger møtt?
- I hvilken grad opplevde du å bli respektert og lyttet til?

- I hvilken grad opplevde du å bli tatt med i avgjørelser som er viktige for at du skal klare å endre livsstil?
- Hvordan vil du beskrive at du blir tatt med i beslutninger?
- I hvilken grad opplevde du at helsepersonell eller andre visste best hva du trengte eller var bra for deg?
- Kan du beskrive din egen rolle i involveringen?
- Hvordan ønsker du å bli involvert?
- I forhold til at du er kvinne/mann; har du opplevd at det har hatt noen betydning i hvordan du har kunnet avgjøre ting eller be om hjelp?
- Hva tenker du om fordommer og skam knyttet til overvekt?
- På hvilken måte tenker du at fordommer og holdninger har betydning for relasjon og mestring?

Er det noe du vil tilføye til slutt?

Tusen takk for deltakelse!