Existential experiences of living with obesity – perspectives from the views of individuals and health professionals.

A qualitative study

by

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Britt Marit Haga

Summary

Background

Obesity is a serious health challenge around the world. It imposes great limitations upon everyday activities, evokes stigmatisation and discrimination and creates a sense of failure. For many of those affected, obesity and fluctuations in weight becomes a lifelong condition and may cause existential challenges. Today's treatment approach to obesity seems to be dominated by biomedical ideas and thoughts. Thus, solutions to the obesity challenge is mainly sought for within the biomedical paradigm. Intertwined with socio-cultural norms and values, the explicit and implicit message that is conveyed to people with obesity, is that they should lose weight. Accordingly, health related research is dominated by research that focus on outcome and experiences related to different types of obesity treatment, aiming at finding a solution to how to treat obesity. However, neither research nor today's treatment approach manage to capture the complexity and depth of life concerns of living with obesity. Health professionals have an important role in the treatment offered to people living with obesity. However, little is known about health professionals' interpretations of existential experiences of people who are living with obesity. It is therefore important to conduct qualitative studies to understand more about the existential experiences in people with obesity, from their perspective and that of health professionals.

Aims

The overall aim of this doctoral thesis was to gain a deeper understanding of existential experiences of living with obesity, by exploring the perspectives of individuals and those of health professionals. The thesis comprised two substudies. The findings of Substudy A are presented in two papers. The aim of paper I was to gain deeper insight into existential experiences of people living with obesity. The aim of paper II was to gain deeper insight into how people living with obesity handle their life

situation. The findings of Substudy B are presented in one paper. The aim of paper III was to gain deeper insight into existential experiences of people who are living with obesity, from the perspective of health professionals.

Methods

Substudy A consists of qualitative in-depth open-ended interviews with people living with obesity. A total of 21 men and women recruited from a residential camp and a Healthy Life Centre participated in the study. The interviews were followed by a three-step analytical process inspired by Ricoeur. Substudy B used focus group interviews with health professionals to complement our knowledge about existential experiences of people who are living with obesity. Three focus groups with 18 health professionals participated. The interviews were followed by analysis using three levels of interpretation of meaning, inspired by Brinkmann and Kvale.

Findings

The findings revealed existential experiences related to living with obesity. People living with obesity seem to face limitations in life because of their bodies, leading to feelings of having their life on hold. At the same time, they seem to struggle towards balance in life to make living bearable, despite their perceived limitations. These existential experiences make living with obesity ambiguous. The potential for well-being in the search for meaning and balance in existence and the life phenomena in constant fluctuation, make living with obesity movable. Health professionals seem to sense existential experiences in people living with obesity, but the meaning of the existential experiences might not be fully comprehended. However, nuances in the health professionals' interpretations was revealed pointing towards ambiguity and movement. As such, the main findings of this thesis are that living with obesity seems to be ambiguous and movable.

Conclusions

Within the context of a system aimed at treating obesity, the dualistic view of the body implicit in the biomedical model seems to be of limited use when meeting with the person with obesity's lifeworld. Informed by the lifeworld approach, this thesis findings allow for a more extended description of an individual with obesity's relationship to the world, self and existence and a better understanding of how living life with obesity unfolds. Lifeworld led reflection in general and reflections on the intertwining of body and mind in particular, may pave the way to well-being for the individual. This is a holistic alternative to the biomedical approach, originating in the lifeworld of people living with obesity. Taking the findings into account, a new way of thinking is required.

Abbreviations and clarification of concepts

Obesity: The concept obesity is rooted in the health-related tradition of this thesis. In health care, the body mass index (BMI) is used to measure obesity. A person whose BMI is 30 or above is considered obese. The subcategories “moderate” obesity is above 30; “severe” obesity is above 35, and “very severe” obesity is above 40. This thesis does not make these differentiations, nor does it enter the debate on the problematic use of BMI.

Overweight and obesity: Overweight and obesity is used some places in this thesis as a conceptual pair. The terms are used interchangeably in daily speech (Westland Barber, 2017). In the interview guide and the information provided to the individual, the term *overweight* is used. People with obesity themselves seem to prefer the term *overweight* to *obesity* (Strömmen et al., 2015).

Individual/person with obesity vs. patient: Substudy A has used the term individual or person about the human being living with obesity. Substudy B has several places used the term patient because of the concept’s relatedness to the term health professionals. This thesis will mostly use the term *individual* or *person* when referring to the human being with obesity, but in some extent to *patient* where this is natural i.e. in combination with other concepts such as “health professionals”.

Illness: The concept illness in this thesis is to be understood as *the subjective experience* of a health challenge. Illness must also be understood as different from disease. Disease refers to professionals’ view of a patient’s condition, expressed in biomedical terms (Delmar, 2006). The Norwegian language do not differ between disease and illness like for instance the English language does and this makes it necessary with a clarification of concepts. In this thesis, illness is understood and

used correspondingly with the theoretical framework. Thus, the references to illness further in this thesis must exclusively be understood as a collective term for individuals own understanding of their condition. Furthermore, this view of illness must not be understood as taking a stand in the debate on whether obesity should be defined as a disease or not (Hofmann, 2016), or whether it is a chronical disease (Svenaeus, 2013; WHO, 2000). Rather this thesis must be seen as a contribution to the discussion that challenges the pathologizing of phenomena in peoples life (Jespersen & Møller, 2015; Svenaeus, 2013) by how this thesis shed light on surrounding elements that inform life with obesity.

List of papers

This thesis comprises the three papers, referred to in the text by Roman numerals.

Paper I

Haga BM, Furnes B, Dysvik E, Ueland V (2019). Putting life on hold: lived experiences of people with obesity. *Scandinavian Journal of Caring Sciences*. 34(2). https://doi.org/10.1111/scs.12756

Paper II

Haga BM, Furnes B, Dysvik E, Ueland V (2019). Aspects of well-being when struggling with obesity. *International Journal of Qualitative Studies on Health and Well-being.* 14(1). https://doi.org/10.1080/17482631.2019.1699637

Paper III

Haga BM, Furnes B, Ueland V (2020). Existential experiences of people with obesity from the perspective of health professionals. Ready for submission.

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1 Introduction

"No… I must wait to buy clothes until I've lost weight."

I heard this from a woman, looking at the same clothes as me outside a clothing shop a summer day a couple of years ago. Then she walked away. She is of the growing number of people falling into the category "obesity". She clearly did not believe that she deserved new clothes. Her comment can be interpreted as an existential expression related to living with obesity, how she experiences her life. This dissertation is concerned with existential experiences of living with obesity. Qualitative research, especially phenomenology, can be used to comprehend such existential matters and lived experiences and is the foundation of this thesis.

Given that the prevalence of obesity (BMI ≥30 kg/m2) nearly doubled worldwide between 1980 and 2014, the World Health Organization (WHO) has identified it as a global health challenge (WHO, 2014). Overweight and obesity are considered one of the foremost health risks connected to developing serious and chronic diseases, including premature mortality (WHO, 2009). In addition, obesity requires both prevention and treatment (WHO, 2000). The dominant approach to obesity seems to be the biomedical, which favours certain physical measurements (Engel & Engel, 2012). The biomedical perspective emphasises weight reduction as a means to health (Bray, Frühbeck, Ryan, & Wilding, 2016; WHO, 2000).

Many people affected by obesity have made repeated attempts to lose weight, (Bombak & Monaghan, 2017; Owen-Smith, Donovan, & Coast, 2014). However, losing weight and maintaining long-term weight loss have proven difficult (Look AHEAD Research Group, 2014). Obesity can place great limitations on everyday life (Christiansen, Borge, & Fagermoen, 2012), contribute to reduced quality of life (Yazdani, Sharif, Elahi, Hosseini, & Ebadi, 2019), diminished well-being (Rand et al., 2017) and cause existential challenges (Glenn, 2013; Toft & Uhrenfeldt,

2015; Westland Barber, 2017). For many, obesity is a lifelong condition, often characterised by repeated fluctuations in weight (Grønning, 2014; Owen-Smith et al., 2014), which reinforce the existential concerns (Rugseth, Groven, & Engelsrud, 2015).

After obesity treatment (whether "successful" or "unsuccessful"), people still struggle with existential issues (Groven, Ahlsen, & Robertson, 2018; Groven, Råheim, & Engelsrud, 2010; Rørtveit, Furnes, Dysvik, & Ueland, 2017). Given the biomedical approach to obesity, health professionals are at risk of overlooking the individuals' potential existential challenges appearing during the treatment of people with obesity (Ueland, Furnes, Dysvik, & Rørtveit, 2019). However, health professionals must be cognizant of the challenges associated with living with obesity (Merrill & Grassley, 2008; Rørtveit et al., 2017).

Living with obesity is more than a health challenge. The view on management of own health has evolved, and has become an individual project (Nettleton, 2013). The dominant societal value in Western culture applauds the strong-willed and disiplined individual who takes responsibility for his/her health (Mik-Meyer, Torp, Kokko, & Ringsberg, 2014). Thus, the moral cultural pressure on the body appears as burdensome and can lead to self-stigma and self-objectification (Grønning, Scambler, & Tjora, 2013; Jutel, 2005; Spahlholz, Baer, König, Riedel-Heller, & Luck-Sikorski, 2016). The increase in overweight and obesity, and the reason for why people fail to lose weight and maintain weight loss, is therefore often associated with personal characteristics, like being weak-willed and lazy (Mik-Meyer et al., 2014; Throsby, 2007). Hence, attitudes towards people with obesity are often characterised by disparagement and stigmatisation (Puhl & Heuer, 2009; Spahlholz et al., 2016). This moral burden of obesity adds to the existential life challenges linked to living with obesity.

Even if existential experiences have been addressed in studies of living with obesity and healthcare towards this group, research that deepens our

knowledge is very limited. When considering how the challenges influence the health of people with obesity, it is relevant to explore what it is like to live with obesity (Glenn, 2013; Rugseth, 2011; Westland Barber, 2017) from an existential perspective (Dahlberg, 2014). Solutions to the obesity challenge are therefore not sufficient if they are based only on a biomedical strategy; they must also resonate with the lived experiences of those affected by it (Thomas, Hyde, Karunaratne, Herbert, & Komesaroff, 2008).

Therefore, by exploring the lifeworld of a person with obesity, we may gain a deeper insight in existential experiences of people living with obesity. Moreover, by shedding light on existential experiences of people with obesity from health professionals' perspective we may expand our knowledge of the phenomenon. This may reveal an additional perspective, a carer's perspective, which will complement our knowledge.

To my knowledge, no previous Norwegian or international studies have explored existential experiences when living with obesity, from the perspective of individuals and that of health professionals and seen them together. Understanding existential experiences of people living with obesity might contribute to advance the current treatment approaches to obesity and may help to provide more optimal support to people struggling from obesity.

The overall aim of this doctoral thesis was to gain a deeper understanding of existential experiences when living with obesity by exploring the perspectives of individuals and those of health professionals.

1.1 Outline of thesis

This thesis comprises two parts.

Part I consists of seven chapters. Chapters 1 and 2 are a broad introduction to existential experiences when living with obesity. They

also offer a short description of the dominant approach to people living with obesity, and some existing alternatives. Chapter 3 provides the theoretical framework of this thesis and concludes with a presentation of aims and research questions of the two substudies that make up this thesis. Chapter 4 describes the research methodology, study design, data analysis, ethical considerations and discusses the trustworthiness of the study. Chapter 5 summarises the findings. Chapter 6 discusses the findings in the light of the chosen theoretical perspectives and previous research. The chapter ends with a discussion of methodological considerations. Chapter 7 concludes with an overview of possible implications of the research findings for practice and further research.

Part II contains the three original research papers and the appendices.

2 Background

The following section will describe the contexts of living with obesity. In addition, the section presents an overview of the literature on the experiences and perspectives of individuals with obesity and those of health professionals. Comprehensive literature searches have been conducted throughout the writing of papers and the "kappe", last in May 2020.

2.1 A biomedical approach to the obesity challenge

The prevailing disease model is the biomedical, grounded in molecular biology (Engel & Engel, 2012). This model understands disease as a deviation from the norm of measurable biological variables (Engel & Engel, 2012). According to this understanding, obesity results from "an imbalance between energy intake and expenditure during an extended period" (Bray et al., 2016 p. 1947) [1]. Within the health care system, measuring obesity has become the standard. A person's body mass index (BMI) is based on the relationship between weight (in kilos) to the square of the height (in square metres) (WHO, 2000). According to the biomedical model, a smaller intake of energy helped by diets, combined with higher expenditure of energy through physical activity can contribute to weight reduction (Bray et al., 2016; Knutsen, 2012).

In 1997 the WHO declared war against "the global obesity epidemic" (WHO, 2000). Today, close to one in five people in the world are considered having obesity (2014). From a medical perspective this is worrying, because obesity is associated with negative physical and mental health outcomes (Carey et al., 2014; Chen, Jiang, & Mao, 2009; Grover et al., 2015). Thus, a comprehensive plan for preventing and

[1] The causes of this imbalance and the causes of the specific participants' obesity are beyond the scope of this thesis.

managing the global obesity epidemic was published in 2000 (WHO). Since then, countries worldwide have heeded WHOs call for collective action against obesity.

All over the world, interventions for people with obesity seem to be guided by a medical paradigm, and situated in the health service (Jepsen, 2015). In Norway, the implementation of the directives from WHO resulted in two plans for prevention and treatment of people with overweight and obesity; one for adults and one for children (The Norwegian Directorate of Health, 2010b; The Norwegian Directorate of Health, 2010a). The Norwegian care plan for adults is organised around primary care and specialist care. The municipalities are responsible for the primary preventive work at individual, group and society level. The general practitioner (GP) normally coordinates the work with individual patients. Patients with a BMI ≥ 40, or a BMI ≥ 35 with weight related concomitant diseases can be referred to treatment through the regional obesity outpatient clinics. Patients can be offered lifestyle treatment, follow-up at a Learning and Mastery health-centre or obesity reducing surgery (The Norwegian Directorate of Health, 2010b).

The current approaches to obesity make primarily weight reduction a goal to reduce risk factors associated with living with obesity and to promote health (Bray et al., 2016; Groven & Heggen, 2018). There has been an attempt the last years to downplay the focus on weight loss by establishing municipal Healthy Life Centres, which have taken a broader approach to the challenge (The Norwegian Directorate of Health, 2019b). However, the person with obesity is still evaluated and treated within the biomedical understanding of obesity. Følling, Solbjør and Helvik's (2015) have explored whether Norway's new Healthy Life Centres can help people with their heavy emotional baggage.

Obesity is easily linked to lifestyle. In principle, obesity can be "cured" by adopting a new lifestyle, but losing weight and maintaining long-term weight loss appear to be very difficult (Look AHEAD Research Group,

2014). Weight reduction is possible, but research shows that most people who try to change their lifestyle, eventually return to their old habits and their weight gradually increases (Grønning, 2014).

2.2 A broader approach to the obesity challenge

In recent years, more researchers and research communities have shed a critical light on the biomedical model in relation to the obesity challenge. Under the assumption that long-term weight loss is difficult to maintain for the long-term and may lead to weight cycling, it is claimed that weight cycling *in itself* may contribute to worse rather than better health (Rugseth et al., 2015; Samdal & Meland, 2018). Researchers question if it is ethical to recommend methods whose success rate is so low and that can be harmful (Samdal & Meland, 2018). Researchers acknowledge that obesity is multifaceted and that the emphasis on weight loss is an overly simplistic solution (Carryer, 2001; Fastenau et al., 2019). It is also claimed that the medical paradigm fails to capture the complexity and depth of life concerns in people with obesity (Kwan, 2011). It is therefore time for a new obesity narrative (Ralston et al., 2018). Together, researchers have advocated for alternative approaches to the obesity challenge (Brown & Wimpenny, 2011; Fastenau et al., 2019; Ralston et al., 2018; Rugseth et al., 2015; Samdal & Meland, 2018).

Some alternative approaches have been tested. The journey towards well-being in individuals with obesity might be supported by non-dietary principles, like respecting one's body shape and size diversity (Clifford et al., 2015; Samdal & Meland, 2018). Interventions based on a holistic model such as "Health at every size" and other non-dieting approaches have been shown to improve multiple health outcomes such as blood pressure and cholesterol (Clifford et al., 2015). A holistic model implies a provision of treatment that pays attention to the whole person and his/her life situation; a care that is responsive to each person's needs (Carryer, 2001; Dossey, Keegan, & Guzzetta, 2005; McBride, 1988). The principle that weight is not the focal point minimises weight-stigma

and makes the patient feel well in the health care setting (Tylka et al., 2014). Rugseth, Groven & Engelsrud (2015) emphasise the importance of paying less attention to the large body and tracking weight, and paying more attention to meaningful and health facilitating activities.

As far as I know, there seems to be no broader approaches to the obesity challenge outside of Norway's health care service. The "fat acceptance movement" seems to have limited appeal. However, within health care a broader approach to the obesity challenge, has been tested. "Broader" approaches combine the existing treatment offer with treatment of the mental health. Helse Nord-Trøndelag (2018) and Helse Stavanger (2019) are both testing such approaches.

2.3 Previous research related to experiences when living with obesity

Previous research on living with obesity has been conducted for instance within the psychological, medical, sociological and ethnographical traditions. Some studies have raised important questions about the way in which people with obesity experience their life. There is also a huge amount of lifeworld research with experiences from treatment as a context. However, as far as I know few studies have deepened the existential experiences with the human being's life experience as context. Chosen parts of those studies that touch the phenomenon, and these that explore existential experiences form the basis of this review.

Interventions and measures of effects as solutions to the problem of obesity dominate the quantitative research on obesity. In addition to measuring BMI, weight loss, energy consumption, activity and biomedical parameters such as blood pressure (Bray et al., 2016), quantitative studies have studied the health-related quality of life, psychosocial functioning, anxiety and depression before and after treatment (Look AHEAD Research Group, 2014; Jakobsen et al., 2018; Karlsson, Taft, Ryden, Sjostrom, & Sullivan, 2007). Some studies call

for more comprehensive qualitative research to shed light on the lives of people with obesity, saying that questionnaires alone are not insufficient (Aasprang, Andersen, Våge, Kolotkin, & Natvig, 2013; Aasprang et al., 2008; Jepsen et al., 2015).

Also within qualitative research much of the focus has been on individuals' experiences with different types of obesity treatment. This research sheds light on some of the challenges that these individuals face when encountering healthcare or treatment programmes based on lifestyle change (Følling et al., 2015; Malterud & Ulriksen, 2010b; Skyrud & Trollvik, 2019) or experiences related to bariatric surgery (Lier, Aastrom, & Rørtveit, 2016). These studies contribute valuable information regarding the patients' anxiety for failing (again), the need for support, feelings of vulnerability and shame, but the focus in these studies is on the patients' experiences with the treatment programme, not on their existential life experiences.

There is a substantial amount of qualitative research on the stigma of obesity. Stigmatisation creates feelings of powerlessness (Mold & Forbes, 2013), loneliness (Lewis, Thomas, Hyde, Castle, & Komesaroff, 2011), shame, blame and guilt (Grønning et al., 2013; Kirk et al., 2014; Pila, Sabiston, Brunet, Castonguay, & O'loughlin, 2015) all of which might have a negative impact on self-worth and the sense of identity (Lewis, Thomas, Blood, et al., 2011; Thomas et al., 2008). Studies show overwhelmingly negative attitudes towards people with obesity in modern society, including medical settings (Puhl & Brownell, 2001; Puhl & Heuer, 2009; Robstad, Westergren, Siebler, Söderhamn, & Fegran, 2019). The perceived prejudice and disrespect that people with obeisty receive from health professionals seems to worsen the sense of stigma (Christiansen, Karlsen, & Larsen, 2017). Previous studies have also shown that people with obesity develop multifaceted coping mechanisms (Bombak, 2015; Puhl & Brownell, 2003). Although these studies are useful in identifying several core themes related to living with obesity, they are limited to the experience of stigma.

Much of the phenomenological lifeworld research on people with obesity's existential experiences have studied their experiences with medical interventions. An academic cluster emerging from Oslo Metropolitan University with branches to the University of Bergen and the university colleges in Sogndal and Molde, have published many studies of peoples lived experiences after treatment; bariatric surgery and lifestyle intervention. These studies highlight the ambivalence the patients report when interviewed after surgery (Groven et al., 2018; Natvik, Råheim, Andersen, & Moltu, 2018; Warholm, Øien, & Råheim, 2014). Moreover, they shed critical light on both the use of weight loss surgery as a means of forcing people to change lifestyle (Groven, Råheim, Braithwaite, & Engelsrud, 2013), and the inherent epistemology of such interventions focusing on effect and outcome, and not the personal process included in such great changes (Natvik et al., 2018). A study from the perspective of health professionals emphasises that the hegemony of biomedicine is a tacit premise for bodily change (Groven & Heggen, 2018). All these studies point to the existential domain, emphasising that the current scientific perspective on obesity "seems not to capture the existential, autonomous, and personal experience of losing weight and maintaining weight loss" (Natvik et al., 2018) p 10. A hermeneutic review based on qualitative studies confirms this picture; people (still) struggle with existential issues and strive for a meaningful life after obesity treatment (Rørtveit et al., 2017). However, the studies do not deepen our understanding of what it is like to live with obesity.

Few studies focus on the existential experiences of the person living with obesity with the person's life experience as context. One issue has been that people with obesity describe the effects of having a huge body and the impact on life (Christiansen et al., 2012; Glenn, 2013; Westland Barber, 2017). Their weight is at the forefront of all experiences and is perceived as an impediment to everything that the participants would like to do (Rugseth, 2011). Moreover, cycles of losing and regaining weight produce feelings of stagnation and resignation, resulting in emotional

distress (Overgaard, 2002; Owen-Smith et al., 2014; Ueland et al., 2019). Participants describe a vicious circle as the emotional distress hinders participation in social and health-related activities, leading to even more emotional distress and weight gain (Owen-Smith et al., 2014).

In this situation while trying to and wanting to lose weight, and in light of modern trends that highlight individualism and self-fulfilment, people with obesity can believe that they have failed to live up to their potential and fulfil their desires (Glenn, 2013; Grønning, 2014; Ueland et al., 2019). Hence, obesity might become life itself (Grønning, 2014).

However, people with obesity cannot escape their bodies; but must find a way to live with them (Malterud & Ulriksen, 2010a). With this as a basis, some lifeworld research shows that people with obesity, within their powerlessness and felt limitations have found a way to handle life (Rugseth, 2011; Rugseth & Standal, 2015). According to this understanding, informants, in addition to describing their body as an impediment to living, also claim that their large body gives them a sense of having good health, strength and stamina (Rugseth, 2011). Not all people with obesity passively internalise social norms, but actively resist them (Grønning et al., 2013), and strive every day to create identity and meaning in life (Bylund, Benzein, & Sandgren, 2017; Groven, Galdas, & Solbrække, 2015; Groven, Råheim, & Natvik, 2017; Natvik, Gjengedal, Moltu, & Råheim, 2015). Toft and Uhrenfeldt's (2015) review describes a dynamic between suffering and well-being and how it influences the experience of existential homecoming when doing physical activity. A recent Danish doctoral thesis has explored the phenomenon of having a large but active body in a more holistic way (Toft, 2019; Toft, Galvin, Nielsen, & Uhrenfeldt, 2020). Grønning et al. (2013) highlight that participants' resistance has been insufficiently studied, and Rand et al. (2017) have called for mental well-being to be better addressed in studies of people living with obesity.

Norway's health professionals have recently become increasingly involved in interventions designed to treat different lifestyle diseases (including overweight and obesity), within primary care and specialist care; in private and public institutions. Health professionals therefore have an important role in the treatment offered to people with obesity (Alvarez, Greene, Hibbard, Overton, & Alvarez, 2016). The clinical encounter between the professional and the patient seems to be of great significance in terms of how patients' existential experiences are understood and met (Salemonsen, Førland, Hansen, & Holm, 2020). However, very little is known about how health professionals can provide high-quality care for people living with obesity (Salemonsen et al., 2020). Still less is known about health professionals' interpretations of existential experiences of people when living with obesity. Health professionals' experiences seem to be related to how patients adapt to or use different treatment options. Research shows that health professionals seem cognizant of the complexity of living with obesity (Brown & Thompson, 2007; Hunter, Rawlings-Anderson, Lindsay, Bowden, & Aitken, 2018; Salemonsen et al., 2020). However, according to health professionals, not all patients are ready to share their experiences and their emotional distress (Groven & Heggen, 2018; Sagsveen, Rise, Grønning, & Bratås, 2018). Some studies report that health professionals regard many of the challenges individuals with obesity have as psychological problems (Dahl, Rise, Kulseng, & Steinsbekk, 2014; Mik-Meyer et al., 2014). However, one study has shown that the patients interviewed in the same study challenged this perception (Dahl et al., 2014). The study concludes that there is a risk that this tension can lead to stigmatisation and stereotyping.

Sagsveen et. al (2018) report from health professionals that some people involved in lifestyle changes seem to lack ownership of their life and to not take responsibility for their plans and goals. According to health professionals, many things in the lives of people with obesity seem to happen by chance (Dahl et al., 2014). This lack of responsibility and

structure has a negative influence on professionals' attitudes to their patients (Brown, 2006; Mold & Forbes, 2013; Schwartz, Chambliss, Brownell, Blair, & Billington, 2003). However, health professionals strive to treat their patients with respect, despite their ambivalence (Robstad, Söderhamn, & Fegran, 2018; Shea & Gagnon, 2015). The health professionals highlight a holistic perspective as well as addressing their patients' psychological challenges and emotional distress (Salemonsen et al., 2020).

Several studies describe the challenges in the relationship between health professionals and individuals with obesity. However, as far as I know, only Groven and Heggen (2018) have explored the encounter as a means to better understand the individual with obesity. Getting insight into existential experiences of people who are living with obesity from the perspective of health professionals might shed light on our understanding of living with obesity.

There therefore seems to be a need to understand people with obesity better in order to provide the support they need. By exploring the existential experiences of living with obesity from the perspectives of individuals and those of health professionals, we assume we will gain insight into existential experiences of people who are living with obesity. Understanding these experiences will complement our knowledge of this group's challenges and lay a foundation for more holistic approaches. The assumption is that if health care providers recognise existential experiences of people living with obesity, they can also offer them the support that they need.

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3 Theoretical framework

A theory is an abstract generalisation that can be used to explain how phenomena are connected, and to interpret research findings (Polit & Beck, 2018). This thesis, including the two substudies has been guided by a lifeworld-oriented philosophy grounded in the phenomenological tradition and particular Merleau-Ponty's (Merleau-Ponty & Smith, 2002) view of the body and experience as lived. This approach illuminates the phenomenon "existential experiences when living with obesity" and provides a context for understanding human experience, including health, well-being, caring and illness. In this respect, the thesis has been based on other existential oriented approaches that focus on these issues, such as found in Dahlberg (2008), Galvin and Todres (2013) and Delmar (2006).

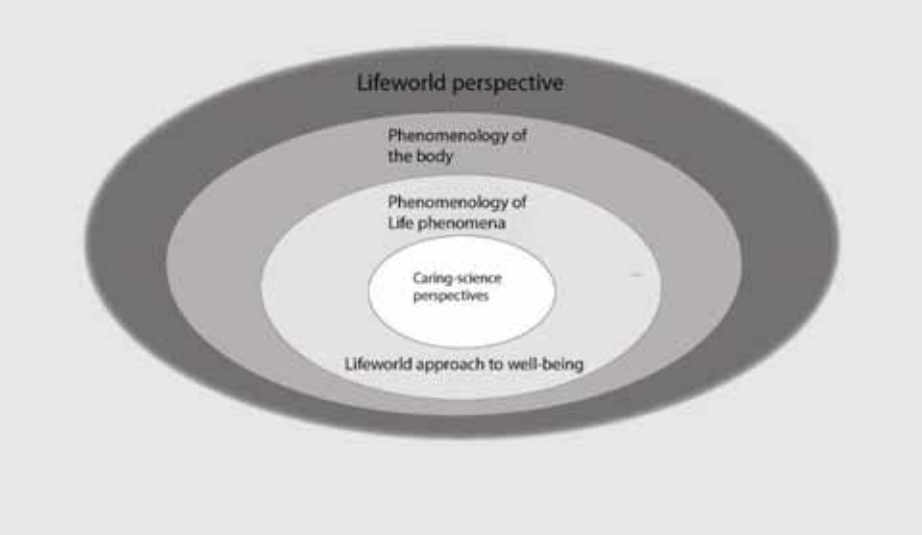

Figure 1- Overview of the theoretical framework

Figure 1 depicts the theoretical framework. It shows how caring science perspectives form the core of this thesis. The phenomenology of life phenomena and the lifeworld approach to well-being are both concerned

with how people, despite having health challenges find meaning and balance in life. The phenomenology of life phenomena and the lifeworld approach to well-being can be linked to the phenomenology of the body and the lifeworld perspective by the coinciding interest for life as it is experienced for the human being.

3.1 The lifeworld as ground

A research approach implies to take a perspective (Bengtsson, 2005). The scientific perspective in qualitative research is the "filter" through which the research is conducted. This "filter" must be made explicit so that other studies can also examine the research (Bengtsson, 2005). This thesis is rooted in a tradition that is based on an empirical application of the lifeworld approach. This tradition relies on the lifeworld theory and methods that allow researchers and practitioners to access the lived world of patients and professionals. The strong philosophic foundation illuminates universal existential issues and provides caring with distinctive knowledge and evidence (Dahlberg, 2011).

The philosophical fundament was developed in the first half of the 20th century. Husserl's notion of the lifeworld, Heidegger's contemplations of human freedom, Merleau-Ponty's ideas about the body as both subject and object, and Gadamer's horizons of interpretation have formed the basis of the lifeworld approach (Dahlberg et al., 2008).

Lifeworld is the world of lived experiences, the world in which we live (Van Manen, 1997). The lived experiences should be examined as the subjects describe them. The phenomenological idea of going "to the things themselves" originates with Husserl (Dahlberg et al., 2008). Phenomenology begins within the lifeworld as the concrete and lived. The purpose of lifeworld research is to elicit and reveal the phenomenon, and thereafter describe it (Dahlberg et al., 2008).

The lifeworld perspective is concerned with the influence of health and illness, suffering and well-being on a person's lifeworld and existence. When healthy, we take our easy and natural access to the world for granted (Dahlberg et al., 2008). However, when ill, our relationship with the world is disturbed, our everyday activities are disrupted, and we cannot reach our goals (Dahlberg et al., 2008). The body in illness becomes an obstacle to immediate engagement with the world.

3.2 The body in a phenomenological perspective

Supported by Merleau-Ponty's (Merleau-Ponty & Smith, 2002) theories of the lived body and lived experience it is possible to develop the meaning of patients' and people's experiences. Merleau-Ponty corrected the duality of the body and mind. He sees the human being as an essential and indivisible unit, one that is in constant interplay with other people and the world. Merleau-Ponty's ideas can therefore be thought of as holistic (Carel, 2018; Merleau-Ponty & Smith, 2002).

Merleau-Ponty (2002) considers the body as central to experiencing and understanding the world. Within this understanding the human being does not *have* a body, he *is* his body through which he has access to the world. Thus, the body is the subject of experience and perception and is the bearer of a human's previous life, meaning and self-image (Westland Barber, 2017) Through the body and the bodily experience the world becomes meaningful.

According to Merleau-Ponty, our bodies are ambiguous, which means that they can never be reduced to a subject or object (Westland Barber, 2017). It both sees and is seen, touch and is touched (Merleau-Ponty & Tin, 2000). The subjective body is characterised by an unreflective awareness of the body. However, a change in the lived body changes the natural access to the world, and one becomes aware of one's body. One might consider one's body as alien to whom one perceives oneself to be.

Obesity might reflect such an interruption, which can keep a person from immediate engagement with one's world and one's life (Toombs, 1993).

Lived experiences are created through the bodily encounter with the world, and the reflections about this bodily encounter. Being-in-the-world is therefore intertwined with the socio-cultural context. Thus, a person with obesity will experience the world and make meaning of it with and through her/his body and bodily actions (Westland Barber, 2017).

3.2.1 Phenomenology of life phenomena

All human beings must relate to basic conditions of their existence. These conditions are universal and fundamental phenomena that we can neither avoid nor escape (Delmar, 2006). As developed by Delmar (2006) within the Nordic caring philosophical discourse, the understanding of life phenomena provides a basis for understanding the existential challenge of living with obesity. Delmar (2006) elaborates on the life phenomena in relation to illness. When a person becomes ill or experiences health challenges, universal life phenomena become more evident. Within Delmar's (2006) understanding, illness is the individuals subjective experience of a health challenge. These experiences can be recognised by concrete expressions on how the condition intervenes in each individual's life, and involves life phenomena such as hope and hopelessness, vulnerability and longing. Depending on one's situation, life phenomena might have life limiting and life facilitating characteristics (Delmar, 2006).

However, life phenomena are at risk of being overlooked in today's health care. Caring for the ill patient entails meeting more than basic needs. It means helping the patient to identify and understand the various expressions of life phenomena; both nuances and diversity, and to make room for the existential possibilities (Delmar, 2006). With its perspective

on living and the lived life, the understanding of life phenomena is relevant to this thesis (Delmar, 2006; Hoeck & Delmar, 2018).

3.2.2 A caring science perspective on health and well-being

In a caring science perspective, caring should focus on strengthening the person's health and well-being (Dahlberg & Segesten, 2010). According to Dahlberg and Segesten (2010) health can be described in terms of experiences of well-being; a condition where the person is able to carry out minor and major life projects (Dahlberg & Segesten, 2010). Well-being is subjective and personal and is expressed in terms of being in the world. Being is a holistic condition, meaning that everyone strives to find his/her own balance in harmony with his/her existence (Dahlberg, Todres, & Galvin, 2009). Finally, health can also be found within illness, as a balance between suffering and well-being, in the endeavour to regain well-being and balance in life (Todres, Galvin, & Dahlberg, 2014). The way people having challenges like obesity, handle life despite their perceived limitations is, according to Dahlberg et.al (2008) considered to have great influence on their well-being, and on the potential to experience health.

However, patients report that they, because of the way care is organised and practised, are often seen more as categories and statistics than as human beings. Health and social service has given primacy to management by objectives or targets, and prioritised narrow and specialised outcomes, technology and efficiency. This points to the assumption that something is missing in health and social care (Galvin & Todres, 2013). There is a risk that humanised care and caring for well-being is being diminished. Within this understanding, care is more than cure, and caring which does not attend to human experiential processes is incomplete (Galvin & Todres, 2013) because caring cannot be understood as separate from life and existence (Hörberg et al., 2011).

Husserl's notion of the lifeworld, and care led from this perspective provides ideas and values which appear to be of the greatest importance to humanise health care, known as lifeworld-led care (Galvin & Todres, 2013). Lifeworld-led care provides a direction for caring by focusing not just on health as the absence of illness, but also on well-being in a positive sense. An existential view of being human means that health is conceptualised in terms of both its limitations and its possibilities for human existence (Galvin & Todres, 2013). Thus, well-being includes the existential dimensions of freedom and vulnerability. Caring within this understanding of the human being means to be open to the lifeworld of the patient by listening to his/her stories, daring to both touch and be touched and not avoid the ambiguities of existence (Galvin & Todres, 2013). However, the carer needs to recognise both the vulnerabilities and the freedoms of the ill patient to support his/her well-being.

3.3 Aims and research questions

The overall aim of this doctoral thesis was to gain a deeper understanding on existential experiences of people living with obesity, by exploring the perspectives of individuals and those of health professionals.

Overarching research question

How do existential experiences unfold in individuals living with obesity?

The thesis consists of two substudies. The findings of Substudy A are presented in two papers; the findings of Substudy B resulted in one. The following section elaborates upon the aims and research questions linked to each paper.

3.3.1 Paper I

The aim was to gain deeper insight into existential experiences when living with obesity. The following research question was addressed:

– What is it like for people to live with obesity?

3.3.2 Paper II

The aim was to gain deeper insight into how people living with obesity handle their life situation. The following research question was addressed:

– In what way does well-being unfold within the struggle of living with obesity?

3.3.3 Paper III

The aim was to gain deeper insight into existential experiences in people with obesity, from the perspective of health professionals. The following research questions were addressed:

– How do health professionals in a healthcare context describe the existential experiences of people with obesity?
– How can the health professionals' experiences related to getting involved in challenges of people with obesity contribute to a deeper understanding of living with obesity?

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4 Methodology

This chapter introduces the philosophical considerations and outlines the study design and methods. Finally, the chapter concludes by addressing issues of trustworthiness and ethics.

4.1 Philosophical considerations

The phenomenological-hermeneutic approach is appropriate for describing and interpreting human experience (Dahlberg et al., 2008). This approach is open to the lived experiences of people and therefore based on a lifeworld perspective. Lifeworld is the world of lived experiences (Dahlberg et al., 2008). The lived experiences should be examined as described by the subjects and represents the phenomenological idea of going “to the things themselves” (Dahlberg et al., 2008 p. 32).

By combining phenomenological and hermeneutic approaches, I sought a deeper understanding of the phenomenon, by developing descriptions and interpretations to answer the overall and the specific aims. Moving between parts of the text and the whole is a dynamic process that leads to new understanding and extended knowledge (Dahlberg et al., 2008). Therefore, the application of the phenomenological and hermeneutic approaches must be seen as intertwined (Dahlberg et al., 2008).

4.2 Study design

An inductive, exploratory and descriptive design was developed. The inductive approach means that the researcher approaches the phenomenon with no predefined hypotheses. The approach is data-driven, unlike the theory-driven deductive approach. In an inductive research design the researcher moves from the data to a theoretical understanding (Graneheim, Lindgren, & Lundman, 2017). An

exploratory design is suitable when little is known about the phenomenon under consideration and the aim is to add nuance and depth (Brinkmann & Kvale, 2015). To our knowledge, there is no similar comprehensive study. The descriptive part of the thesis design presents the matter in question as precisely as possible. Figure 2 presents an overview of the study design.

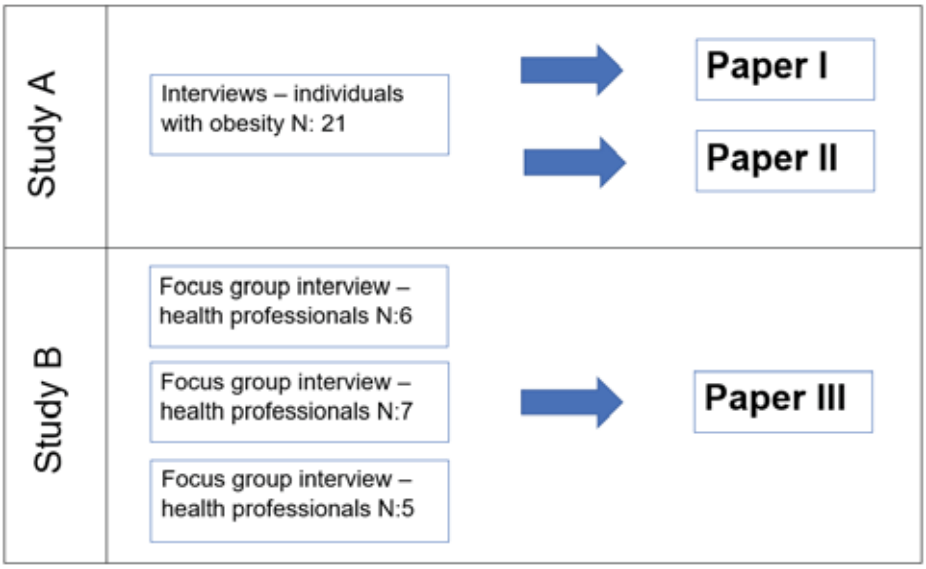

Figure 2 - Overview of the study design

4.2.1 Substudy A

This study used qualitative open-ended in-depth interviews with individuals living with obesity. The data collection was followed by analysis and interpretation inspired by the phenomenological hermeneutic thinking of Ricoeur (Delmar et al., 2005; Furnes & Dysvik, 2011; Ricœur, 1976). This approach captured and interpreted existential experiences in the lives of people with obesity, because the phenomenon is tied to human existence (Dahlberg et al., 2008; Delmar et al., 2006). The analysis of the findings described the perceived limitations linked to living with a large body. However, the analysis also elicited descriptions

about how the individual's handled everyday life. The fact that they handled life despite and within their experienced limitations pointed towards well-being according to the definition by, among others, Dahlberg et al. (2008). It was an insight that we had not fully anticipated. The pre-liminary findings in Substudy A was divided in two parts and analysed separately in the continuation; with different research questions in each part. Moreover, this division resulted in paper I and paper II.

4.2.2 Substudy B

A focus group study was appropriate to gain deeper insight on existential experiences of people living with obesity from the perspective of health professionals. There was a need to find out whether we had missed anything in the in-depth interviews with individuals. Focus groups interviews add to the data that are gathered through individual interviews (Morgan, 1997). Due to the limited research from the perspective of health professionals, we assumed that the topic was relatively unexplored. Focus groups are a useful research method when the aim is to explore phenomena within a group, based on common experiences and meanings (Malterud, 2012). Unlike individual interviews, the interaction in a focus group can stimulate discussions, responses and corrections, and maybe bring forth tacit knowledge (Macnagthen & Myers, 2004). We therefore hoped that focus group interviews with professionals providing daily care for people with obesity could elicit common experiences that would extend and complement our knowledge.

The focus group interviews were followed by analysis of three levels of interpretation of meaning, inspired by Brinkmann and Kvale (2015). This interpretative model was chosen because in these interviews we went a "detour" about the health professionals view to obtain an understanding of existential experiences when living with obesity. We assumed that when taking a "meta-perspective" and not approaching the phenomenon directly, Brinkmann and Kvale's (2015) three interpretation contexts, and especially the possibility of making a

common-sense interpretation would make an analysis of the findings possible.

4.3 Methods

Recruitment, data collection and analysis for the two sub studies were performed separately. Table 1 presents an overview of the two substudies, concerning aims, participants, data collection and analysis.

Table 1 - Overview of aims, participants, data collection and analysis

Aim	Participants	Data collection	Data analysis
A: To gain deeper insight into existential experiences of people with obesity. **To gain deeper insight into how people living with obesity handle their life situation.**	21 individuals with obesity	Individual in- depth interviews	Analytical process in three steps inspired by Ricoeur
B: To gain deeper insight into existential experiences of people with obesity from the perspective of health professionals.	18 health professionals, 6 from municipal health care, 7 from a specialized clinic, 5 from hospital	Focus group interviews	Analytical process on 3 levels of interpretation, inspired by Brinkmann & Kvale

4.3.1 Participants

Substudy A

The study of the individuals with obesity was planned and conducted first. When doing qualitative research, it is important to choose a sample that can answer the research questions (Malterud, 2011). Therefore, we wanted contact with people with obesity who could provide rich descriptions of the phenomenon. We had access to people with obesity through two health promotion programmes. Hence, we decided to use convenience sampling and include participants from these programmes in the study (Malterud, 2011). Given the sensitivity of the topic, we knew that recruiting participants with obesity from a broader population, for example by newspaper advertisement, could be difficult (Westland Barber, 2017). We also left the idea to interview members of the only known organization for people with overweight and obesity, *Landsforeningen for overvektige,* because of its strong patient and right focus (FFO, n.d.). We were afraid that the participants' expressions could be led by this focus, and maybe divert the focus from life as such, something we considered could lead to prejudice in the findings. Based on these considerations, we contacted the leading professionals in two health promotion centres with a request to access their participants. Since the context for the study was the individuals' life experience, the participants should be recruited shortly after their entry into the programme to avoid prejudices related to their treatment. In addition, the programme itself should not be a topic in the interview.

The programmes addressed different groups about medical severity and geographical catchment areas. The Centre managers informed about the study, both orally and in writing, and mediated contact between those who volunteered and the interviewer. In this study we wanted to investigate the existential experiences when living with obesity in the adult population, so the lower age limit was set to >18 years. Other inclusion criteria were inclusion in a health promotion programme, both

genders, ability to speak and write in Norwegian, having a BMI ≥35 kg/m2, and finally, able to provide informed consent on their own behalf. The BMI limit was set to ≥35 kg/m2, because the health authorities has set the same limit as criterion for receiving specialist care (BMI ≥35 kg/m2 including weight-related concomitant diseases), as an indicator of the severity of the condition. The criterion being able to provide informed consent on their own behalf was chosen to exclude those people with severe mental diagnosis at the current moment. The overview of the selection criteria is provided in Table 2.

Table 2 - Selection criteria for participants affected by obesity

Inclusion criteria	Exclusion criteria
Age > 18 years	Not able to communicate in Norwegian, neither oral nor written
Both genders	Severe mental illness
BMI ≥35 kg/m^2	
Able to provide informed consent on their own behalf	
Included in a health promotion programme	

Recruiting participants from two programmes ensured a wide range of participants. One person (a man) did not turn up for the interview because of feeling ill[2], so 21 individuals were included in the study. It was considered a strength that both genders were well represented, and that half of the sample was employed (vs. unemployed). Table 3 outlines the sample characteristics of persons with obesity.

[2] This information was accidentally omitted from paper I.

Table 3 - Sample characteristics individuals with obesity. Papers I and II (N=21)

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

Substudy B

After Substudy A was completed, Substudy B was conducted. Participants for three focus groups interviews were recruited from among

health professionals providing daily care and follow-up of people with obesity in three different treatment options. Three contexts were chosen to obtain variation in the data. We established a purposive sample, with variations in age, gender and health-related occupational background, with at least one year of experience in following up people with obesity (Malterud, 2012). This criterion was set to ensure that the participants had some experience with the topic of interest. Another inclusion criterion was related to clinical tasks. We wanted to exclude people who had only administrative tasks. Table 4 gives an overview of the selection criteria for health professionals.

Table 4 - Selection criteria for health professionals

Inclusion criteria	Exclusion criteria
Providing daily care and follow-up of people living with obesity	
Being a health professional, for example registered nurse, physiotherapist, nutritionist, occupational therapist	
Active in clinical tasks	Only doing administration tasks
	Not able to communicate in Norwegian, neither oral or written
Minimum one year of training	
Both genders	

The Centre managers informed 20 persons about the study both orally and in writing and arranged the focus group meeting. All of them accepted the invitation, but as the day for the interview came, one man and one woman had to withdraw from the study for health reasons. This left 18 health professionals to participate in the study.

Focus group 1 was put together by six health professionals from five Healthy Life Centres. Focus group 2 was established with seven health professionals from a residential camp offering intensive lifestyle programmes among others for people with obesity (BMI ≥40 kg/m2, or

BMI ≥35 kg/m2 with weight-related concomitant diseases). Moreover, focus group 3, counting five persons, was recruited among health professionals linked to the outpatient clinic at a hospital who had the task to follow the patient throughout the treatment route by surgical treatment of morbid obesity. Table 5 gives an overview of the health professionals' characteristics.

Table 5 - Sample characteristics health professionals (N=18)

Sex		
	Male	1
	Female	17
Age, years		
	18-29	3
	30-39	6
	40-49	5
	50-59	4
Education		
	Physiotherapist	7
	Nurse	5
	Clinical dietician	3
	Other relevant education	3
Years of relevant seniority		
	1-3 years	6
	4-6 years	9
	7-15 years	3

It was considered a strength that the health professionals had a varied educational background and many years of relevant seniority.

4.3.2 Data collection and material

The data material for Substudy A was collected through in-depth interviews using a thematic interview guide (Appendix I) with open-ended questions. The interview guide provided some structure to the interviews, but the flexible approach provided room for the full nature of

the phenomenon (Brinkmann & Kvale, 2015). The interview questions covered experiences of existential character when living with obesity, taking basic conditions of human existence as a starting point for each interview. The topics in the interview guide were; living everyday life with obesity, the significance of being a large body and being obese, viewing oneself from the perspective of others and thoughts about a meaningful life and the future[3]. The participants were encouraged to elaborate on their reflections by answering follow-up questions, such as "Can you please tell me more…?" and "What did you feel….?". The interviews were completed by opening for additional comments.

The interviews varied in depth and content. The variation seemed to appear across age, gender, marital status, education and background otherwise. However, older participants seemed more concerned about their future than young participants. Most of the participants had always had overweight and obesity, but some associated their weight gain to pregnancy, illness or injury, unemployment or other life-changing circumstances. The participants also differed in their willingness or ability to reflect upon their life, body and existence. When asked to describe their body, some did so in detail; others just said "large". Some spoke openly about their experiences related to having a large body, others were more reticent.

Each participant was allowed to have the interview in a place they felt safe. Seventeen of the participants were interviewed in an office or a conference room at the health promotion centre. Three interviews were conducted in the first author's workplace and one in the first author's private home. The interviews lasted 40–90 minutes and were conducted by the first author. Since lifeworld phenomena are never completely explored and described (Van Manen, 1997) data saturation was not

[3] In the papers in Sub-study A it is referred to questions in the interview guide that are both overlapping and different. The total interview guide is referred to in the current text and in appendix I. The interview questions which examined the topics in the papers are mentioned in the papers.

sought. Human experience is always too complex to be captured by others (Van Manen, 1997).

The data for Substudy B were obtained by conducting focus groups interviews with health professionals. The sessions were 60 to 90 minutes long and were located at the centres' meeting rooms. The first author initiated and moderated the interviews, using an open-ended question inviting the health professionals to describe their interpretations of existential experiences among people who were living with obesity. The moderator involved herself moderately in the conversation, and gave the participants time and space for reflections and associations (Morgan, 1997). For an unstructured focus group, Morgan recommends only two main topics or questions (Morgan, 1997, p. 47) within one or two hours. The thematic interview guide consisted of main topics as the professionals' interpretations of existential experiences in people with obesity, and the health professionals' experiences related to getting involved in people with obesity's challenges (Appendix II).

An observer made notes and evaluated the atmosphere and interaction during the first focus group interview. The first author conducted the two next group interviews without the observer. Malterud (2012) recommends bringing an observer to follow the interaction to the focus group. The observer's role is to keep track of who says what (Malterud, 2012). When the interviews are transcribed it is important to attribute the correct words to the correct speaker (Malterud 2012). Thus, to avoid confusion, at the start of the interview, each participant spoke his or her name as soon as the recorder was turned on. A seating chart showing where each participant sat around the table was also used when the interviews were transcribed.

The conversation flowed easily in all three focus groups. The health professionals were very engaged in the topic and eager to discuss and reflect upon existential experiences in people with obesity. The discussions within all the groups were characterised by a high degree of

agreement. However, the third group had an additional perspective that the two other groups did not; they had met the person with obesity both before and after bariatric surgery. The professionals described individuals who seemed more comfortable reflecting on their life with obesity *after* surgery (when slim), than they had been before surgery. That is, people's ability to describe their life with obesity seemed easier when they were no longer obese.

Two of the groups seemed characterised by more quiet "wonder" than the other. One group was dominated by two persons, one of whom kept losing sight of the discussion topic. However, the moderator politely intervened to encourage contributions from the other health professionals. The interview start was delayed for almost half an hour, which shortened the interview time. These events might have affected the outcome of the interview.

What appeared as meaning-bearing to the professionals seemed to reflect what had most impressed them, something which seemed to correspond with those they found difficult to help. The professionals highlighted existential experiences that they considered as life-limiting to people living with obesity. This implied that the data material became "heavy loaded" with challenges.

The participants in substudies A and B agreed to have the interviews audio recorded.

4.4 Data analysis

After the interviews, the interviews were transcribed verbatim, some interviews by the first author and some by a professional transcriber who had signed a confidentiality agreement. The first author undertook the preliminary analysis and wrote the first paper drafts. The research team conducted the further analysis. In case of ambiguity the transcribed text was consulted. The interpretations are the most plausible interpretations

based on the consensus among researchers. This means that another research team could have arrived at other results (Graneheim et al., 2017).

4.4.1 Data analysis of Substudy A

The phenomenological-hermeneutic thinking of Ricoeur (1976) inspired the analysis of our data in Substudy A. The method reveals a possibility of staying close to the data without reducing the participants' statements. Our focus was the meaning content, and the data material was filled with meaning. According to Ricœur, reading a text reflects the dialectic between explanation and understanding (Furnes & Dysvik, 2012; Ricœur, 1976). The structural analysis holds these attitudes; both are equally necessary (Ricœur, 1976). Explanation contributes to a richer understanding of the text because it is based on the inner structures and represent distance to the text. Understanding, on the other side, represents closeness and involvement. Hence, they are complementary. The inner structure of a material can reveal contrasts, but it can also reveal metaphors and other linguistic expressions. In this way, one could say that Ricoeur's thinking must be seen in the light of his aim of building bridges between the linguistic, originating from a positivistic approach, and the interpretation, based in the hermeneutic tradition (Furnes, 2008). When it came to the specific stepwise analysis of the interview texts I have used the work of the Danish nurse researcher Birthe Pedersen (1999), together with later research (Delmar et al., 2006; Furnes, 2008; Furnes & Dysvik, 2012; Schultz, Qvist, Mogensen, & Pedersen, 2014) which cite Ricoeur's thinking. The analysis and interpretation followed three steps:

Naïve reading. The interview texts were read and reread to gain a sense of the content. With an open mind, I looked for and listened to what touched me in the interview texts and wrote down my immediate impressions. These impressions said something about what appeared as central in the text. In some way or another, many of the existential

experiences seemed to be about the body. Next, I reflected upon whether there were connections within the content of central issues. The reflection and the open attitude are central to obtain variation within phenomenological analysis (Furnes 2008), and to obtain a holistic understanding of the content.

Structural analysis. A structural analysis clarifies the dialectic between understanding ("what is said?") and explanation ("what is spoken about?") of the text with the purpose of arriving at a deeper critical interpretation. Ricoeur (1976) emphasises the significance of paying attention to the structure in the text, such as identifying metaphors, contradictions and connections, linguistic words and expressions. During this process, moving back and forth between the parts and the whole, led to an explanatory perspective on existential experiences. I went through the texts systematically in search of structures with expressions on feelings and thoughts, thinking that these expressions may say something about the individuals' understanding of their condition. The analysis showed that most individuals' condition was strongly affected by their experiences of both bodily limitations and bodily possibilities. In this phase of the analysis I divided the material between papers I and II in order to bring out the nuances in the material, with the intention to "bring them back to each other" later on. Interpretation of the explanatory structure and an understanding of the content led to the development of themes. The movement from empiric to interpretation was made clear through a schematic presentation.

Critical interpretation and discussion. The critical interpretation aims at developing new understanding. The results from the naïve reading and the structural analysis led to the selection of theory and interpretation. Based on the findings that appeared through the analysis pointing towards ambiguity and movement related to living with obesity, the choice fell on theory that had an embedded movement.

4.4.2 Data analysis of Substudy B

The analysis and interpretation of the material from the focus group study were based on a three-level model for interpretation of meaning inspired by Brinkmann and Kvale (2015): self-understanding, common sense and theoretical understanding. Going from understanding to interpretation appears as a hermeneutical movement, a process of moving among the particular, the universal and the whole (Gadamer, 2013). According to Gadamer (2013), new understanding may arise when we are open to the unknown. Hence, it may challenge our preconceptions.

Self-understanding. The first level was to identify the participants' self-understanding. The first author read the three transcripts thoroughly several times to obtain a holistic understanding of the content. Thereafter, meaning-bearing units were collected and placed in preliminary categories, naming them closely to the quotes. The research team named the preliminary categories to formulate what the participants understood as meaning-bearing in their expressions. Through this process, we sensed the whole.

Common sense. The second level, common sense understanding, builds on a broader frame for understanding than the participants' own, however within the context of what is considered as common sense. This implies that the research team embarked on a critical reading of the content of the expressions. Against this background a new level of abstraction emerged through repeated discussions within the research team, and the preliminary categories were reformulated. At this level, themes were formulated and presented as the findings of the study.

Theoretical understanding. At the third level of interpretation, the empirical data were interpreted in light of a theoretical framework. The abstraction was taken a step further, beyond the participants' self-understanding and common sense to improve the understanding of the

findings. The theoretical understanding and interpretation were elaborated in the discussion section in paper III.

The shift in analysis method between Substudy A and Substudy B was based on the consideration that the material in Substudy B was others' perceptions and interpretations of the existential experiences of people living with obesity. This data material therefore needed more interpretation to elicit meaning from the data. As I see it, there is not much difference between an analysis inspired by Ricoeur (1976) and one based on Brinkmann and Kvale (2015). There seem to be more similarities than differences. Both are based on a phenomenological hermeneutic perspective with a lifeworld approach which address the essence of the phenomenon. However, Brinkmann and Kvale's method (2015) seems to be closer to the hermeneutics. Because we took the "detour" (with the health professionals) it was necessary to stay closer to the meaning units at the common sense level. Moreover, to elicit the meaning there was a need to ask critical questions of the text, by focusing on both content and the person, asking what the expression reveals, in the frame of common sense (Brinkmann & Kvale, 2015). As such, an analysis based on Brinkmann and Kvale's three levels of interpretation (2015) seems best suited to the focus group method.

The reason for not choosing an analytic tool geared towards group interactions was related to the aim of this substudy (Halkier, 2015). The aim was to explore a phenomenon that had not been explored before. Thus, the focus was on *what* was said, not on *who* said it or *how* things were said.

4.5 Research quality

The quality of research findings should be evaluated based on the extent to which one can establish trust and confidence in the findings (Lincoln & Guba, 1985; Polit & Beck, 2018). In qualitative research, the criteria suggested by Lincoln and Guba (1985) are used to evaluate the findings'

trustworthiness; credibility, dependability, conformability and transferability. Trustworthiness should be a continuous process throughout the project, and these criteria were considered in the current thesis.

Credibility is the extent to which the most appropriate approach, context and participants have been chosen for this study (Graneheim & Lundman, 2004; Lincoln & Guba, 1985). Sub-study A was limited to individuals living with obesity. The aim was to seek as wide a range of views as possible by including both men and women of all ages, educations, residencies and affiliations with working life. The participants' understanding of their life in relation to their obesity challenge was the topic of interest. People's interpretations of their lifeworld happen in every context of life, continuously. Therefore, we did not consider it problematic or unproblematic for the research quality that the target group had decided to seek help. We therefore made a request of two treatment programmes that served people with obesity.

While preparing for the study, I presented the project in the research group "Life phenomena and care" at the University of Stavanger, which provided valuable input. I also visited a Healthy Life Centre to present the project and the interview guide. This meeting resulted in some changes in concept use and inclusion/exclusion criteria.

Substudy B was originally planned for two focus groups. During the preparation for the study, the research group considered it important to include another group to supplement the data with more variation and information power (Malterud, Siersma, & Guassora, 2016). The intention was also to recruit more men to the study. This was not successful, but the first seemed to be a valuable consideration as this group both confirmed what the other groups had mediated and complemented the data with new perspectives.

Credibility is also a question of selecting the most suitable meaning units and judging how well the naming of themes covers the data (Graneheim

& Lundman, 2004). In both substudies agreements over the sorting and labelling of meaning units was sought from the research team that contributed to the project. The analysis process included ongoing discussions of alternative interpretations before reaching a consensus. In addition, the research group in the university was presented to and gave feedback on the preliminary findings on several occasions. However, meanings can never be finally complete; they are always open to alternative interpretations (Dahlberg et al., 2008).

Dependability is whether the research can be replicated under similar conditions (Graneheim & Lundman, 2004; Lincoln & Guba, 1985). Time, extensive data and other factors may influence the researcher's consistency. To ensure stability, I made sure that all topics in the interview guide were covered in the interviews. I have also provided a detailed explanation of all steps in the research project. However, duplicating this study would probably be difficult. One explanation is that qualitative interviews are a co-creation between a unique researcher and a unique participant (Brinkmann & Kvale, 2015; Graneheim & Lundman, 2004). Another researcher and another participant would create another interaction and therefore generate other findings (Brinkmann & Kvale, 2015). In addition, follow-up questions may change from person to person and over time according to the researchers' improved knowledge of the phenomenon (Brinkmann & Kvale, 2015).

In focus groups studies, where the diversity of voices is the most important capital (Malterud, 2012) the variations and the nuances in the meanings are of great importance for the final findings. To ensure research quality I made an effort during the interviews to ask clarifying questions with the intention to identify and collate variations (Malterud, 2012).

Confirmability is concerned with whether the findings are determined by the participants or a result of the researcher's prejudices and perspectives (Lincoln & Guba, 1985). The researcher's personal beliefs and theories

may lead to a misunderstanding of meaning. To enhance trustworthiness within qualitative research it is therefore necessary to be aware of and open about the researcher's pre-understandings.

I have a bachelor's in social work, and a major in health science (cand. san), with diakonia as main subject. I have spent my professional life in an inter-professional context on the border of or within a health context as care provider, adviser, planner or university college lecturer. My educational background and these different roles have given me an interest in and insight into the structures and conditions that surround and therefore lead caring. My last job as a health promotion planner gave me a little insight into the phenomenon of living with obesity. Although I had an idea of what life was like for people with obesity, I am also influenced by the social meanings and attitudes surrounding people with obesity. Throughout the research process, I tried to be conscious of and challenge my pre-understandings, and moreover be open to the unknown so new understanding may arise (Gadamer 2013). However, a text can be interpreted from several perspectives and does not hold one single truth.

I believe that these issues are not to be considered as neither limitations or strengths, but as things to be aware of, consider and report to ensure confirmability and transparency (Brinkmann & Kvale, 2015).

Transferability as a criterion for trustworthiness is the extent to which the findings can be transferred to other contexts or other groups (Lincoln & Guba, 1985; Polit & Beck, 2018). In qualitative research, transferability is left to the reader to judge, as long as the researcher openly provides the necessary information. It is reasonable to believe that the findings may be transferred to similar or comparable contexts dealing with existential experiences related to lasting or challenging conditions. In both substudies the cultures and the contexts are clearly described, along with the methods of selection, data collection and analysis. The findings are presented with participants' quotations and a

description of the analytic process together with examples to give the reader access both to the data and the abstraction process. This allows the reader to follow the reasoning throughout the whole study, and also to look for alternative interpretations. As such, research findings in qualitative studies do not imply one single meaning, it is the most probable meaning; the particular researcher(s) interpretation that is presented (Graneheim et al., 2017; Graneheim & Lundman, 2004).

4.6 Ethical considerations

Several ethical aspects were considered while planning and conducting the study. The participants in both substudies were informed, both orally and in writing that their participation was voluntary and that they could leave the project at any time. Confidentiality and anonymity were guaranteed, and a written consent form was completed. The information provided to the individuals with obesity and the health professionals before inclusion in the studies are presented in Appendix III and IV. Each participant's identity was coded directly after finishing the interviews, locked away and kept separate from the collected data material, according to the current guidelines. The project was conducted in accordance with the ethical principles in the Helsinki Declaration (The World Medical Association, 2013). Ethical approval was obtained from the Regional Committees for Medical and Health Research Ethics (reference number 2016/1530), the Norwegian Centre for Research Data (project number 50184) and the Data Protection Office at the hospital (project number 2017/549). The approvals are presented in Appendix V.

People with obesity, especially women, have an increased risk of developing depression (Carey et al., 2014; Chen et al., 2009). People with obesity are a vulnerable research group (Liamputtong, 2007). Researchers should always be aware of the potential harm they can inflict when broaching sensitive topics. Interviewing people with obesity about their existential experiences may bring difficult feelings and thoughts to the surface. Hence, at the end of each interview I asked the participants

how they had experienced the study. In this way, I tried to ensure that the interview had not become a harmful experience. To be certain, I had arranged professional support for follow-up in advance, and passed on this information at the conclusion of the interview.

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5 Findings

Substudy A consists of two papers, based on in-depth interviews with people living with obesity. Substudy B consists of one paper based on focus group interviews with health professionals. Together they fulfill the overall aim of the thesis. This chapter summarises the findings in each paper.

5.1 Paper I

Putting life on hold: lived experiences of people with obesity

The findings revealed individuals' existential experiences related to living with obesity. From the analysis one overarching theme – putting life on hold when struggling with obesity – was developed, based on three themes: the participants' bodies were experienced as impediments to living the desired life, to being oneself and to moving on in life. The phrase "putting life on hold" showed that the participants considered themselves to be in a waiting position. They lived in anticipation of what they understood as their "actual life" at some point in the future. However, "putting life on hold" also implied that they considered their life situation to be temporary and not permanent.

The findings illuminated that obesity had a major impact on participants' life. Some said that instead of living, they just existed. Several held themselves back from activities and relations in anticipation of becoming the person they knew themselves to be. However, they were not ready to reveal their vulnerable bodies or selves. Participants described their life as stagnant and as a failure, as they never seemed to break the circle of weight loss and weight gain. They mentioned hopelessness, powerlessness and uncertainty, but also hope for the future.

The discussion, guided by the the phenomenology of life framework developed by Delmar (2006) and Merleau-Ponty's phenomenology of

the body (2002), deepened the constant fluctuation between life phenomena of life facilitating and life limiting character. Some life phenomena had a twofold character, such as hope.

5.2 Paper II

Aspects of well-being when struggling with obesity

The findings from our study showed that people struggling with obesity, strived towards an experience of balance to make living bearable, within their perceived limitations. This abstraction was based on three themes that were developed through the analysis: coming to terms with the body, restoring the broken relational balance and reorienting the pivot in life. The findings reflected that the participants were in a process of finding a bearable way to live with themselves and the surrounding world, within their perceived limitations. The participants' expressions reflected how they understood themselves and their interaction with the world and other human beings.

The participants, despite seeing their bodies as a limitation understood more about themselves when they considered their bodies as a companion helping them to carry out small and bigger life projects, instead of an enemy. The participants also reported that they, by taking a distance to the experienced degradation from the society, were able to support themselves. In addition, the participants experienced that dwelling on what the body could actually contribute, and not what it could not, taught the participants that life really could be lived in a large body.

With support from Galvin and Todres (2013), discussions revealed that people with obesity's reflections on vulnerability and freedom pointed towards well-being. It was emphasised that limitations in life also involves possibilities and that well-being can be achieved within one's perceived limitations. The movement in existential experiences might

become a health-facilitating experience for people struggling with obesity.

5.3 Paper III

Existential experiences of people with obesity from the perspective of health professionals

The analysis of health professionals' interpretations on existential experiences of people with obesity fell into three themes: sensing self-closure, sensing self-resignation and sensing self-evasion. The health professionals observed that people living with obesity faced major challenges, not only related to their weight. They stated that personal insight and accepting reality was important to change a lifestyle. However, the health professionals described that some individuals with obesity seemed to repress inner struggle and hesitated to accept their challenges. They added that their patients seemed to fail self-care and to lack responsibility for their life. Finally, health professionals described patients who avoided being visible and tried to cover the reality. The health professionals reported that they often felt powerless, ambivalent and astonished when getting involved in people with obesity's challenges and wondered what they did not understand.

Supported by elements from Morse's (2001) theory about enduring suffering and Galvin and Todres (2013) framework about caring for vulnerability, the theoretical understanding of the findings made a deeper interpretation possible. Health professionals seem to sense existential experiences in people living with obesity, but the meaning of the existential experiences might not be fully comprehended. The health professionals' interpretations were therefore developed and nuances in the interpretations appeared: repressing one's vulnerability, resigning one's self-understanding and controlling oneself. These nuances have consequences for the way people with obesity should be met and cared

for. However, if these nuances are overlooked, the individual with obesity might be left to fight a lonely battle with her/his challenges.

6 Discussion

The overall aim of this doctoral thesis was to gain a deeper understanding on existential experiences of people living with obesity, from the perspectives of individuals and those of health professionals. Two substudies were therefore conducted, resulting in three papers. The next chapter discusses the main findings, with emphasis on obesity as an ambiguous and movable experience, found in both substudies, and how the dialectic inherent in these experiences point towards well-being in the individual.

6.1 Living with obesity – an ambiguous and movable experience

This thesis findings are about individuals with obesity's existential experiences related to their bodies, their selves, the world and the impact of these experiences on their life (papers I-III). The phenomenological idea of the lived body forms the basis for understanding the human being, because the human being cannot be reduced into a mental and a physical part, but must be seen as an entity (Merleau-Ponty & Smith, 2002).

The findings from the first part of the in-depth interview study (paper I) show that the obese body is described as an impediment, which hinders access to life. This means that the body's union with life and the embodied reality might be neglected. Many of the participants' descriptions describe a split between body and mind (paper I). The findings in the second part of the interview study (paper II) highlight that in some individuals the experience of a split between body and mind is shifting with an experience of the body as central to their self-understanding. Thus, participants seem to be acknowledging their body's union with life (paper II). These apparently contrasting experiences might point towards a characteristic of living with obesity; it is ambiguous living. This way of describing living with obesity is

confirmed by Rugseth (2011). Health professionals seem to sense existential experiences in people living with obesity, but the meaning of the existential experiences might not be fully comprehended. Thus, health professionals tend towards understanding existential challenges related to obesity in psychological terms; as disturbances of thought, perception and behaviour, indicating that a change in the mindset of the person with obesity is required (paper III). Hence, there seems to be a tension between the health professionals' interpretations of existential experiences in people with obesity and the affected person's experiences. The person's experiences seem to originate in a profound disturbance of the balance in the body/mind relationship, while the professionals' interpretations seem to be marked be a superficial understanding of the problematic body/mind relationship.

In the findings describing an experience of well-being despite limitations in life (paper II) there seems to be an experience of body/mind connectedness. The participants' reflections indicate that their perception of their external and internal selves is about to converge. According to Merleau-Ponty (2002), body *and* perception must be seen as the seat of personhood, or subjectivity. A person *is* his body, an entity of body and mind (Merleau-Ponty & Smith, 2002). Hence, there is no distinction between an external and an internal self (Carel, 2018). As healthy human beings we are embodied; our consciousness of our self overlaps with our body. The individual appears to the world as an intertwined body and self (Carel, 2018).

However, the findings in paper I (the first part of the in-depth interview study) reveals an interrupted embodiment. This is expressed by the fact that participants seem to have put their life on hold; they do not want to live with the body they have. The relationship to one's self unfolds when several individuals claim they have an inner and an outer self. What these participants regard as their real self is somewhere inside themselves. Merleau-Ponty (2002), highlights that the feeling of having an inner and an outer self, embodies the situation of a person in illness. Due to this

split between body and mind, people with obesity seem to lose the ability to interact freely within their social context (Carel, 2018).

Thus, living with obesity express itself as an experience of being limited by descriptions of how that experience intervenes in life (paper I). An illness has consequences for a person's sense of living a full life (Delmar, 2011). It influences life courage, the urge to take on life (Delmar, 2006), and the feeling of being able to carry out minor and major life projects (Dahlberg et al., 2008; Galvin & Todres, 2013). The experience of illness may express itself as "unhomelike being-in-the-world", a fatal change in the meaning-structures, of the self and the world (Svenaeus, 2000). Therefore, living with obesity is not about the body, or the mind per se, but rather about one's entire bodily being in the world (paper I-III). This is in line with what Merleau-Ponty (2002) argues, that an illness can become the complete form of existence and strike "at the heart of subjectivity" (Carel, 2018 p. 37). Thus, basic feelings related to being human may occur when illness strikes (Delmar, 2006). According to paper I, the conflict between wanting to, but not being able to can cause feelings of powerlessness and hopelessness. Such interpretations are also uncovered in research about people's experiences of living with chronic illness (Carel, 2018; Delmar, 2011).

However, as found in both substudies, living with obesity seems to include a continues endeavour to find meaning and balance in existence, suggesting that existential experiences have nuances and are movable, correspondingly with the potential for movement towards well-being found in paper II. This experience must be seen as a response to the disruption of embodiment, involving the mobilisation of resources. As shown in paper I, some life phenomena may be experienced as both life facilitating and life limiting, which seems important for how life takes form (Delmar, 2006). The concept of waiting had a twofold meaning. One is uncertainty, that one's situation could become permanent. But at the same time, it meant hope about normality, which led to feelings of freedom and control. These nuances were also found in the theoretical

understanding of the focus group study (paper III). Repressing one's vulnerability, resigning one's self-understanding and controlling oneself may have a twofold meaning, pointing towards a need to protect oneself to obtain balance and meaning in life. For instance, and according to Delmar (2011) repression of reality must not always be understood as a psychological defence mechanism but also as a way to hold on to hope.

Based on the findings in all papers (I-III), I suggest that living with obesity is ambiguous. In addition, the potential for well-being make living with obesity a movable state. This way of seeing living with obesity is confirmed by Rugseth (2011) and Westland Barber (2017), who also see the life experience as context for their investigation of living with obesity. This description of living with a condition that intrudes upon life is perpetuated by many researchers with an interest in the lifeworld as context for understanding human experience (Carel, 2018; Dahlberg et al., 2008; Galvin & Todres, 2013; Svenaeus, 2000). A characteristic is the focus on well-being resources complementary to a focus on symptoms and disease (Galvin & Todres, 2013). According to these researchers, these insights have the potential to pave the way to health. However, the potential to move towards health is influenced of several elements beyond the body/mind-relationship in the individual. I will now discuss existential experiences when living with obesity in a broader context to shed light on some important elements the existential experiences might be informed by and intertwined with.

6.2 Living with obesity – in a biomedical and socio-cultural context

The in-depth interview study (Substudy A, papers I & II) show that existential experiences in people with obesity are related to the context of their lives. Both individuals with obesity and professionals providing care for people with obesity live and act in a broader cultural context permeated by a particular view of the body (Groven, Råheim, & Engelsrud, 2015; Slatman, 2014). This perspective is relevant in the field

of health and medicine, and particular when discussing issues like obesity because the condition is appearance-related (Slatman, 2014). Merleau-Ponty (2002) claims that body, self and world exist in a dynamic, integrated relationship. In this light, the existential experiences of people with obesity's should be viewed within a broader perspective. Thus, the embodied view on a human being makes it necessary to discuss the individuals and the professionals' experiences as intertwined with and informed by elements in their lifeworld (Slatman, 2014).

In paper I the overarching theme obtained from the analysis, "putting life on hold when struggling with obesity", shows that individuals understand their condition as temporary, even though most of them had been obese all their lives. This indicated that the individuals saw themselves as temporary versions of themselves. Together with socio-cultural norms and values in the Western society, the biomedical paradigm, taking its departure in the dualistic view on the human being, makes a substantial influence on both those who care and those who are cared for (Kwan, 2011). The idea that overweight and obesity are curable and temporary conditions is normalised within the biomedical discourse (Gailey & Harjunen, 2019). As a consequence, having overweight and obesity are thought of as a phase one should leave behind (Gailey & Harjunen, 2019). Within the Norwegian health care, the directives from WHO (2000), the Norwegian governmental guidance through White Papers and directives (The Ministry of Health and Care Services, 2019; The Norwegian Directorate of Health, 2019a), the guidelines for treatment of overweight and obesity on the Norwegian national level (The Norwegian Directorate of Health, 2010b), the origin of health professionals, for example the physiotherapy profession (Nicholls & Gibson, 2010), an extensive amount of research on the obesity field and practice itself, together constitute the biomedical set of factors people with obesity are arranged under.

Obesity is considered a risk factor for serious illnesses (Bray et al., 2016). Doctors and other health professionals label people with obesity

as at risk-individuals (Mik-Meyer et al., 2014). Moreover, the health authorities recommend weight reduction to reduce the risk factor (Norwegian Institute on Public Health, 2017). Against this background, the obese body is measured according to several parameters: BMI, waist circumference and fat mass (The Norwegian Directorate of Health, 2010b; Jepsen, 2015). Measurable variables are used as indicators for disease, predictors for treatment needs and the entrance gate for treatment such as intensive lifestyle intervention and bariatric surgery (The Norwegian Directorate of Health, 2010b). These issues underlie the biomedical idea that obesity is, or should be, curable and therefore temporary.

Moreover, we see in the findings from the in-depth interviews with individuals with obesity that the experiences they have from meeting with their GP leaves the feeling about being met as first and foremost someone who needs to lose weight (paper I). The temporal aspect in "putting life on hold" (paper I) indicate therefore also that at the current moment the individual with obesity is not the one he/she should be; he/she should be another version of him/herself and holds a potential to be thin. According to the literature, seeing oneself as constantly "in-between" affect the sense of agency and how one experiences one's body (Gailey & Harjunen, 2019). The implication is that she/he is not good enough as she/he is but must change.

The health professionals surrounding the individual participants of this research, like those mentioned in paper III, work in a context that promotes lifestyle *change* as a means to health. The biomedical ideas in lifestyle change programmes are perpetuated by among other things that the professional is described as a facilitator for the patients *changing* processes (The Norwegian Directorate of Health, 2010, 2016; Knutsen, 2012). This implies that the health professionals elicit behaviour change by using certain techniques based on, for instance, cognitive behavioural therapy (The Norwegian Directorate of Health, 2019b). Change and transformation of the overweight or obese body has become a prevalent

normative expectation (Gailey & Harjunen, 2019). Based on the weight-related health risks, people with obesity are expected to, and should try to change their lifestyle and lose weight to eliminate their risk factors (Bray et al., 2016; Pausé, 2014; Vieira, Turato, Oliveira, & Gracia-Arnaiz, 2014).

Moreover, between the lines in the findings in paper I, derived from the participants' expressions, we can read that being overweight or obese is not only associated with an unhealthy living and tied to disease and disability, but also with an abnormal and deviant way of living. A "normal" body and a "normal" life are thematised in the findings, together with the issue of self-control, and the notion that life starts only when the weight is right. The dominant societal value set in the contemporary Western culture applauds the rational individual with strong will and self-control who takes responsibility for his/her own health and life (Gailey & Harjunen, 2019; Mik-Meyer et al., 2014). With help from newspapers, magazines and social medias, this has become the prevailing social standard. Patients with obesity are therefore not just met with expectations from health professionals, but also from society. Everyone, especially women, should strive to be young and slender (Malterud & Ulriksen, 2010a). Thus, happiness is connected to a slim body (Bahra, 2018). Trying to lose weight is understood as an attempt to improve one's health and appearance. However, not doing anything about it is not acceptable (Rugseth, 2011). The ongoing disciplinary power of culture over human bodies has been problematized by numerous studies, indicating that the "war on obesity" has increased prejudice (Gailey & Harjunen, 2019; Puhl & Heuer, 2009). People with large bodies feel stigmatised as they for instance, do not fit into the material world and experience disrespect from health professionals (Christiansen et al., 2017).

Thus, the findings in paper I seem to express a desire for what the society has set as a standard. As large amounts of research have documented, many people with obesity internalise the cultural messages and norms

(Malterud & Ulriksen, 2010a; Puhl & Heuer, 2009). The findings in paper I appear as a clear expression of how health for the individual has become a medical and moral project, interwoven with notions of the good life. In agreement with Ueland, Dysvik and Furnes (2020), one could say that the disciplinary pressure from the socio-cultural context has implications for the first-person experience of one's lifeworld. Taken as a whole, the findings of paper I indicate that health professionals and the society are carriers of values and attitudes, which seem to cause an additional suffering in people with obesity. Accordingly, the focus-group study with health professionals (paper III) together with other research, underlines that the professionals (as members of the society) address the patients' morale, such as not taking responsibility for their own life (Robstad et al., 2018; Sagsveen et al., 2018). As a result, the burdensome expectations from society and health professionals become the expectations people with obesity must meet. Therefore, the idea of living a good life with obesity seems impossible (Mik-Meyer et al., 2014).

Against this background, the findings in paper II, describing individuals' journey towards well-being, despite still having a large body and limitations because of it, appear as impossible. This is because the participants' expressions go beyond the usual notion of how someone living with obesity *ought to think*. The findings show that people with obesity seem to be creating their own lives on their own terms (paper II). Rather, the participants' expressions stand in opposition to the prevailing norms and values that are conveyed through biomedical ideas and the culture. The impossibility is also related to individual's own understanding of their condition, which seems to be influenced by the dominant approach that "provide[s] a script for the ways illness "should" be experienced" (Carel, 2012 p. 99). This means that if individuals with obesity learn about their condition only in terms of physiology or psychology at the expense of another understanding, for instance the holistic, it may limit their understanding of their condition. As such, a more holistic understanding of living with obesity is at risk to be

overlooked by the person and the health professional. Thus, the potential a holistic understanding may have for the person's life and health may stay in the background.

In summary, the disciplinary pressure from both biomedical ideas and society's norms and values seems to have a substantial influence on the existential experiences of people with obesity. The message conveyed is that they cannot have a good life without losing weight. However, the findings in the second part of the in-depth interview study (paper II) seem to take an active stand against the disciplinary pressure, which again seem to be one of the elements that pave the way to well-being for the individuals. The next question of interest is therefore in which ways the movement towards well-being in paper II was facilitated, and whether these can provide new insights for understanding existential experiences of people with obesity. The last section in this chapter will shed light on these questions, before summarising the discussion.

6.3 Living with obesity – movements towards well-being

I will draw upon the discussions to examine the glimpses of well-being experiences in paper II as a means to pave the way towards well-being and health in people with obesity.

As stated in section 6.1. living with obesity seems ambiguous and movable. According to section 6.2, a person with obesity lives in a context characterised by biomedical ideas and sociocultural norms and values that depict that obesity is a temporary, abnormal and undesirable condition. How can the individual living with obesity find a way of handling her/his life when the large body and the cultural messages seems impossible to run away from? Seemingly, people with obesity "put their life on hold" while at the same time struggle to find a balance that will make living bearable within their perceived limitations (paper I & II). This dialectic between vulnerability and freedom, which points

towards “dwelling-mobility”, can be described as a way of being in the world (Galvin & Todres, 2013). “Dwelling-mobility” describes a movement towards well-being that includes both the possibility to move forward as well as the possibility to find a place for what is given (Galvin & Todres, 2013). This is in line with Delmar’s (2006) thinking; life phenomena should be contained, not solved.

By creating a space for both vulnerability and freedom, individuals in illness can find a way of being in the world (Delmar, 2006; Svenaeus, 2000). Health professionals therefore hold a great responsibility and possibility to help a person in this process to, with the individual, to identify the nuances in the experiences and thus create space for the existential possibilities (Delmar, 2011). Understanding a person’s “insiderness” is an essential constituent for care (Todres et al., 2014).

However, bringing back homelikeness, or coming as far in this direction as possible, depends on several factors. One factor is the degree to which the health professional is able to recognise the world as the individuals with obesity experience it (Hörberg, Galvin, Ekebergh, & Ozolins, 2019; Svenaeus, 2000). Dependent on this is the individual’s understanding of his/her illness experience and his/her ability to convey that understanding to the health professional in the medical meeting (Svenaeus, 2000). As argued in paper II, the individuals’ self-understanding seemed in that way to be crucial, and the reflection process that supported it appeared to take a key role. Ekebergh (2007) highlights that reflection is strongly related to understanding processes in individuals and may support people in their health processes. Hence, in the same way as experiences moving towards well-being guided the findings in paper II, I suggest that the essence of the same well-being experiences may guide caring for people with obesity (Dahlberg et al., 2008; Galvin & Todres, 2013; Hörberg et al., 2019).

Experiences of well-being may appear as hidden and unreflected if not brought to awareness (Toft et al., 2020). According to Gadamer (1996)

health is silent. As shown in the findings in paper II a conscious and active self-reflection enabled the participants to reflect on a specific experience in their past and become aware of its structure and meaning. With reference to Husserl, Ekebergh (2007) shows that phenomena in the lifeworld (not only well-being) can be brought to awareness through reflection. This experience was evident in paper II. According to the theory of intentionality, real reflection requires that one distances oneself from the experience, something which means that reflection on a phenomenon can only happen *upon* the experience (Ekebergh, 2007). Hence, one of the things the professionals in one of the focus groups commented on was that distance to the experience of living with obesity seemed to enable reflection. As such, there seems to be a huge potential to reflect on one's experiences, something which should be valued therapeutically. Consequently, a reflection can pave the way to a deeper understanding of both the phenomenon and the self (Ekebergh, 2007).

In paper II the participants were about to become aware of and acknowledge their own values and their view of life and existence. However, experiences of well-being and life-facilitating life phenomena are often overlooked in the medical setting (Carel, 2012; Delmar, 2006) and consequently lead the patient to pay little attention to these experiences (Carel, 2012). In line with this, Rugseth (2011) and Natvik et.al (2018) found that the experience of well-being *is* present in people with weight challenges, but the experience is not brought forward in the weight reduction dialogue. In my view, this may indicate that hidden and underlying experiences of well-being in the current treatment offer is left to each single person with obesity to reflect on and therefore dependent on each individual's capability to reflect, or the personal resources the individuals' hold themselves.

Throughout the findings in paper II we see that the participants' experience of being an embodied being seemed to have a central role in the reflection process. Thus, reflections on the intertwining of body and mind seemed to pave the way to well-being. Lifeworld-led reflection

implies that the human being is understood from her/his world and seen as a lived body, including all aspects of human experience (Carel, 2018; Hörberg et al., 2019). Merleau-Ponty (2002) confirms that reflection cannot just merely be a cognitive and intellectual activity, it must include the whole body. Ekebergh (2007) underlines this point, that the whole subjective body should be involved in the reflection process. According to Rugseth (2011) the large body appears as the starting point for expressing oneself in the world. The findings of the focus group study (paper III) in this thesis and those of other research (Dahl et al., 2014; Mik-Meyer et al., 2014) indicate a contradictory view in health care for people with obesity; that the person with obesity first and foremost needs to concentrate on his/her psychological problems. Due to its origin in the biomedical realm the absence of an understanding of embodiment is not new in health care (Nicholls & Gibson, 2010). *Thinking* good about oneself and one's body is not enough, it must be experienced, reflected upon and incorporated as a lived experience, because the large body will always be experienced as contradictory, ambivalent and ambiguous (Rugseth, 2011). The body in a lifeworld view goes beyond physiology and psychology, but is simultaneously physical, mental and existential (Hörberg et al., 2011). This implies that cognition must also be seen as embodied (Carel, 2012). Finally, lifeworld-led care may have the potential for overcoming the consequences of a split between body and mind, subject and object, and health and illness (Hörberg et al., 2019).

The well-being experience "coming to terms with oneself" is, according to Delmar (2011), another expression for finding oneself (again). Hence, based on the findings in paper II we may say that individuals with obesity with such embodied reflections are about to become subjects in the process towards well-being. According to Ueland et al. (2019), staying in a subject position might be necessary to make space for a being in the world that involves the whole human being, including both vulnerabilities and freedom. Being is according to Dahlberg et al. (2009) a holistic condition, where each person finds her/his own balance, in

harmony with existence as it is lived. When having a more balanced view of life, combining ability and inability, one's condition can be met with greater acceptance and become less disruptive. Living one's body in a subject position can lead people with illness to act in the world as embodied beings (Rugseth, 2011). Therefore, accepting oneself with everything that has been given, including one's vulnerable self, may be the first step forward as a subject towards oneself and the world.

Accordingly, the reflections in paper II pointed to experiencing oneself as an entity consisting of both body and mind. As we have seen, such reflections originate from a lifeworld-led perspective and the phenomenological way of seeing the body. However, these expressions stand in sharp opposition to the prevailing assertion within health care that obesity is a curable and temporary condition (Gailey & Harjunen, 2019). This means that when a professional stimulates reflections on the intertwining of body and mind, the professional challenges the "taken for granted" understandings within health care. Previous research indicates that health professionals try to combine both perspectives; the prevailing biomedical discourse and phenomenological insights arising from their encounters with people with obesity (Groven & Heggen, 2018). However, the biomedical view of the human being stands in sharp contrast to the phenomenological view on the human being and it is difficult to see how they can be united. According to Hôrberg et al. (2019), a dualistic view of the human being may be an impediment to fully supporting people's health processes. Thus, a paradigm shift in the approach to obesity may be required, and this study makes a contribution in that direction. Since many people with obesity spend much of their lives feeling that they have their life on hold, an experience that seem to originate from the hegemony of biomedicine on the obesity field and the socio-cultural norms and values, this issue deserves attention.

6.4 Summary of discussion

Figure 3 is a schematic illustration of an extended understanding of existential experiences when living with obesity, which also summarizes this study.

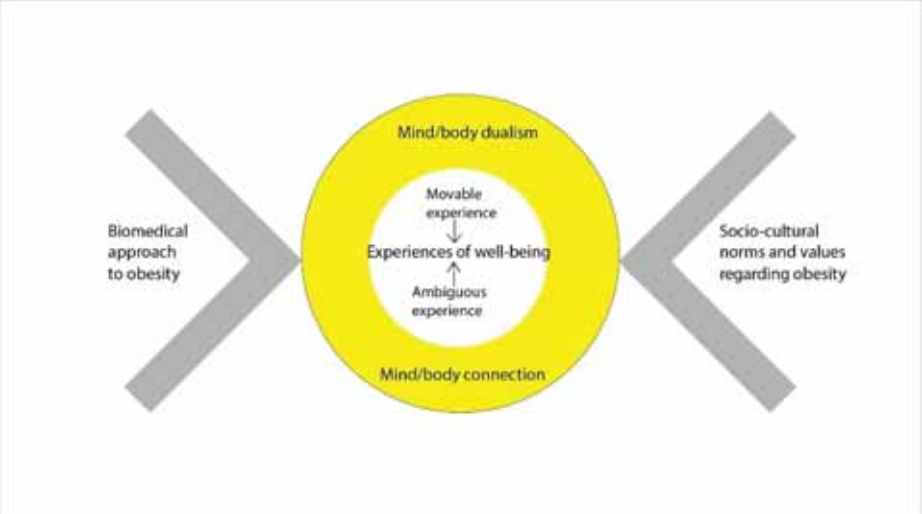

Figure 3 - A schematic illustration of an extended understanding of existential experiences when living with obesity

The double circle is the person living with obesity who is experiencing existential challenges. These challenges are related to the experience of living in a large body. As explained in section 6.1., the person with obesity experiences his/her body, life and existence as ambiguous. There seems to be an experience of a body/mind split as an experience of a body/mind connection (outer circle). As a response to the disruption of embodiment there is a continuous endeavour to find meaning and balance in life, suggesting that the existential experiences have nuances (life phenomena in constant fluctuation) and are movable (potential for well-being). Thus, the dialectic inherent in the experience of ambiguity and movement when living with obesity both point towards experiences of well-being processes in the individual (inner circle). However, the processes in the individuals with obesity as well as the potential to move

towards well-being are again potentially informed by and intertwined with surrounding elements in the individuals' lifeworld (the two arrows).

The discussion of the findings has shed light on how the biomedical approach to obesity and the socio-cultural norms and values exert external pressure on people with obesity, intertwine with and inform their existential experiences and therefore also their potential to move towards well-being (section 6.2). Health professionals are carriers of biomedical values and social values and norms. Consequently, this thesis has shown that there is a risk that the ambiguity of living with obesity, the nuances in the existential experiences and the potential movement towards experiences of well-being is not recognised. Section 6.3 argues that the potential for the individual with obesity to move towards well-being seem to imply a personal process happening in opposition to the disciplinary pressure from the surrounding elements in the individual's lifeworld, with reflections on the intertwining of body and mind as a point of departure.

6.5 Methodological considerations

The strengths and limitations of this thesis must be taken into consideration. This section also discusses methodological issues.

In Substudy A it was decided to recruit a convenience sample of individuals living with obesity. Convenience sampling is a way to recruit participants who are willing to discuss a research topic (Malterud, 2011). However, this approach has been criticised as a simplistic and information-poor way of recruiting participants. The sampling in this substudy drew from participants in health promoting programmes rather than from the general population as a base for recruitment.

One may assume that choosing participants from the general population would mean that they had no prejudices. However, a phenomenological approach asks about life with a certain condition, and does not seek

causal explanations nor how to treat that condition (Carel, 2012). The intersubjective nature of experience is, according to the phenomenological approach, taken as a premise, which means that "the experience of any particular individual will be influenced by, and in constant dialogue with others' experiences" (Carel 2012, p. 100). This means that, from a phenomenological perspective, an expression will never be without prejudices. And in the case of living with obesity it was exactly that intersubjectivity we wanted to elicit.

The concept of "information power" guides sample size in qualitative studies (Malterud et al., 2016). The information power in a study appears strong, given that the sample holds adequate information to develop new knowledge based on the aim of the study, sample specificity, use of established theory, quality of dialogue and analysis strategy (Malterud et al., 2016). In both substudies, the sample size was guided by a specific aim (aiming at getting deeper insight into life with obesity) with dense specificity (existential experiences from the perspectives of individuals and those of health professionals), along with the applied and consistent theoretical frameworks (lifeworld perspective, phenomenology of the body, the phenomenology of life phenomena, lifeworld approach to well-being and caring science perspective). The quality of the dialogue in both substudies is strong. The articulateness of the participants varied. However, in the light of the findings of Substudy B, the lack of articulateness among some individuals with obesity reported by health professionals may also be a kind of finding. The analysis method of both substudies was both well-known and consisted of in-depth analyses inspired by Ricoeur (1976) and Brinkmann and Kvale (2015). Thus, I did not intend to cover the whole range of the phenomenon but to present the relevant patterns. Hence, the convenience sample of 21 participants appears to possess strong information power despite the risk of limited specificity.

One may assume that participants participating in a treatment programme are highly motivated at the beginning of that programme,

and that this may prejudice the findings. The findings in paper II pointing to experiences moving towards well-being might give an impression of highly motivated individuals. When considering the positive "flow" in the findings in paper II one must remember that these findings complement the findings in paper I. The findings in papers I and II originate from the same participants and the same interviews. When merged, they represent the ambiguity of living with obesity, which is a main finding in this thesis.

However, the recruitment also included participants who were unmotivated or barely motivated; some had been "sent" to the programme from their GP as part of a comprehensive plan for example aimed at getting the person to work or back to work. Others had tried weight loss so many times that they were pessimistic about losing weight this time.

The health professionals for the three focus groups (Substudy B) were recruited through purposive sampling to obtain variation and sufficient information power in the data material (Malterud et al., 2016). This ensured representation from three common treatment options for people with obesity; Healthy Life Centres, intensive lifestyle programmes and bariatric surgery. This selection ensured variety in experiences, knowledge and properties. These contexts were chosen based on the assumption that health professionals providing daily care for people with obesity had gained thoughts and impressions about the topic from many meetings with the target group's existential experiences. Health professionals play a key role in treatment offered for people with obesity because they spend much time with the patients and they have a co-ordinating responsibility, in addition to their hands-on care (Alvarez et al., 2016; Salemonsen et al., 2020). One may assume that including other professionals such as physicians and psychologists, may have extended the findings. However, not all of these professionals were available at all the chosen locations. In addition, the latter professions do not spend so much time with individuals with obesity as the chosen group does.

Variation in the recruitment was important to achieve a rich data material (Brinkmann & Kvale, 2015). A reason for recruiting individuals from one health promotion programme at specialist level and one at the community level was to ensure that the participants came from a broad geographical area. Hence, we recruited participants for the in-depth interview study from all over the westcoast of Norway, which is home to both a rural and an urban population.

The participants in Substudy A comprised 14 women and seven men. This was a higher men's representation than in Norwegian Healthy Life Centres that seem to recruit mainly women (Samdal et al., 2018). In the general population, more women than men have a BMI above 35, which was the recruited group in this study. In the Norwegian population 6.7% of women and 5.4% of men have morbid obesity/grade 2 obesity (Norwegian Institute on Public Health, 2017). In addition, more women than men feel pressed by the cultural expectations to be slender and young (Malterud & Ulriksen, 2010a). However, as the findings were abstracted to an existential level that focuses on common human experiences rather than gender, these differences probably would not have prejudiced the findings. One man who was recruited to participate withdrew from the study. According to the health professionals, he was ill on the day for the interview. I remember this man as very large, probably the largest in the sample. In retrospect I think that his insights could have supplemented the findings in a very interesting way.

It might be a limitation that no persons with a different cultural background than the Norwegian were recruited to Substudy A. Another cultural perspective could bring even more variation to the data. However, there were no persons with a different cultural background than the Norwegian available for recruitment.

In Substudy B, the focus group study; of 18 health professionals 17 were women. However, one more man and one more woman was recruited to the study but had to withdraw because of illness. Gender balance was

never an option due to the low representation of men working in the three treatment clinics/centres. The low male representation in the study reflects the gender (im)balance in Healthy Life Centre in Norway (Sagsveen et al., 2018). The gender imbalance may have affected the findings, and therefore may be considered a limitation of the substudy.

The discussion in the focus groups was influenced by the participants' familiarity with each other. Morgan (1997) argues that the interaction in the group has a direct impact on a study's strengths and weaknesses. Familiarity may contribute to a relaxed and free-speaking atmosphere or to the opposite (Halkier, 2015). Two of the groups were put together by professionals who worked daily together, while one group was put together for the occasion. However, the participants in the latter group knew each other and belonged to the same network for employees in the same position in different municipalities. The fact that it was the first time this group had a discussion on the given topic yielded data material with a lot of meaning bearing descriptions from their experiences. The discussions in the two other groups were characterised by more interpretations probably because they met regularly and already had exchanged stories. With hindsight, one might assume that mixing the groups could have generated other findings. However, according to Morgan (1997) it is a myth that focus groups must consist of strangers. The criterion should rely on whether a group of participants can have a useful discussion (for the researcher). Altogether, the findings represented a variety of health professionals' interpretations of existential experiences in people with obesity.

One may assume that the lack of observers implied that the moderator became too occupied with the content of the conversation and paid less attention to the interaction. It is a risk in focus group studies that the interaction can be neglected (Malterud, 2012). However, we considered it likely that it would be possible to both follow the interaction and pay attention to the content. Because of the explorative aim of the study, we planned for an unstructured discussion and low-level involvement from

the moderator (Morgan, 1997). It was also seen as an advantage that the moderator had been trained in leading a focus group conversation during the first focus group interview. We considered a possible postponement of the interviews to delay the project disproportionately due to the challenges linked to making new appointments. Altogether, we found it very important to conduct the focus group interviews, even without an observer.

This thesis has focused on existential experiences when living with obesity. By nature, this is a complex issue. This study is not a comprehensive description of all aspects of living with obesity. Not everyone is affected by obesity in the same way. Many people with obesity will disagree that they have "put their life on hold" pending a slimmer body (paper I), and they are tired of all health-related research that is critical of them. However, the findings in paper I cannot be taken in isolation; they must be seen as complementary to the findings in paper II, revealing another impression and an extended understanding of living with obesity. This study has pinpointed a common experience; life with obesity is neither all "bad" nor all "good", it is ambiguous and movable, like life is for all human beings. As such, this study might have contributed to normalise living with obesity. Thus, this study has contributed substantially to in-depth knowledge about a complex issue, particularly in the Western world.

That being said, one interview per person might not be enough to understand the complexities in individual's lifeworld. An additional interview after a period of time could have represented a strength with regards to both methods and content, also to see how they have handled life since the first interview.

7 Conclusion

This thesis provides deeper insight into existential experiences of people living with obesity from the perspectives of individuals and those of health professionals. The thesis' main findings are that life with obesity is ambiguous and movable living, and that health professionals risk missing or misunderstanding the nuances in the existential experiences, especially those pointing towards well-being experiences. This thesis points out the challenges related to the biomedical hegemony on the obesity field intertwined with socio-cultural norms and values. Within the context of a system aimed at treating obesity, the dualistic view of the body implicit in the biomedical model seems to be of limited use when meeting with the lifeworld of the person with obesity. Simple advices and recommendations conveyed by society and health professionals seem to have more profound implications for the person with obesty when discussed in light of existential experiences. However, the study does not confirm or refute the effectiveness of weight loss as a treatment. Instead I have tried to point to how implicit and explicit expectations about weight loss might manifest in an individual's lived experience.

This thesis suggests that seeing living with obesity as an ambiguous and movable condition may help to overcome the consequences of a split between body and self. A holistic caring approach to obesity takes the breadth and depth of the lifeworld as basis for understanding human experience and may pave the way for well-being within one's experienced limitations. With a greater understanding of the experience of living with obesity health professionals might begin to question the implications of recommending weight loss to their patients. Moreover, this raises another important question: Should we continue to design interventions for people with obesity to improve objective health, or should interventions be aimed at increasing their subjective well-being?

With the findings in this thesis, the study offers a novel perspective on a research topic that is widely studied. Informed by the lifeworld approach, this thesis findings allows for a more extended description of an individual with obesity's relationship to the world, self and existence and a better understanding of how living life with obesity unfolds. Taking the findings into account, a new way of thinking is required.

7.1 Implications for practice

Considering the findings of the two substudies, I offer the following suggestions to improve support for people with obesity. A phenomenological lifeworld approach to living with obesity can inform health professionals' work:

Informed by the lifeworld, health professionals may elicit the individual inherent search for meaning and balance in existence every human being has, also when living with obesity. They might find resources and a potential for well-being within the individuals' perceived limitations.

Reflections grounded in the lifeworld, including reflection processes where the body plays a key role can support people's health processes when living with obesity.

Well-being experiences where the body plays a key role can be highlighted in one-to-one counselling or in peer support. Putting words to and reflecting upon the well-being experiences can strengthen the consciousness related to living with obesity as ambiguous and movable living and may help to incorporate experiences of well-being.

Health professionals should help patients experience their lived bodies as subjects. That would enable them to take on life and act in the world as subjects anchored in their bodies.

The professionals need to be conscious about or even challenge their biomedical mind set to understand the complexity of living with obesity.

Health professionals when meeting with individuals living with obesity should be aware of the twofold meaning in the experience of "putting life on hold".

Health professionals should serve as interlocutors in distinguishing a desire for weight loss that comes from within, from desire that comes from the disciplinary pressure from biomedical ideas and socio-cultural norms and values.

7.2 Implications for further research

This thesis has illuminated existential experiences when living with obesity from the perspectives of individuals as well as health professionals. More research is needed to confirm and elaborate on the findings of this thesis. This section suggests some areas for further research:

This thesis has just provided a glimpse of existential experiences in people with obesity from the perspective of health professionals. More research from the perspective of health professionals is still needed.

This thesis has elaborated on the role of the body in interventions for people with overweight and obesity and the necessity to reflect on the intertwining on body and self. There is a need to find out which role the body has in interventions for people with obesity, for instance by conducting an observation study.

This thesis has indicated that experiences of well-being are overlooked in the current treatments for people with obesity. There is a need to find out more about health professionals' awareness of experiences of well-being in people with obesity, and how well-being unfolds.

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PART II

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Papers

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Paper I

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Putting life on hold: lived experiences of people with obesity

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Putting life on hold: lived experiences of people with obesity

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

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

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Introduction

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

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

Background

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

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

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

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

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

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

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

Methods

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

Recruitment and participants

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

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

Data collection

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

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

Table 1 Sample characteristics (N = 21)

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

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

Ethical considerations

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

Analysis and interpretation

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

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

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

Findings

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

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

Table 2 Steps of the analytic process

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

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

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

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

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

The body as an impediment to living the desired life

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

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

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

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

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

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

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

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

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

The body as an impediment to being oneself

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Discussion

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

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

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

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

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

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

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

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

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

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

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

Methodological considerations

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

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

offered rich and nuanced descriptions of the phenomenon of interest.

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

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

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

Conclusion

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

Implications for practice

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

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Conflict of interest

The authors declare no conflict of interest.

Author contributions

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

Ethical approval

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

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Paper II

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Aspects of well-being when struggling with obesity

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ABSTRACT

Purpose: We aimed to gain deeper insight into how people struggling with obesity handle their life situation by addressing how well-being might unfold. For many people, obesity becomes a lifelong condition characterized by repeated weight fluctuations while their weight increases gradually. From an existential perspective, constantly waiting for weight loss can cause an experience of not reaching one's full potential. How people with obesity experience well-being, within their perceived limitations, is less reflected in previous research.

Methods: We established a qualitative study using in-depth interviews with seven men and 14 women with obesity (body mass index ≥35 kg/m^2) aged 18–59 years. The study had an exploratory design including a phenomenological-hermeneutic perspective, with a lifeworld approach.

Results: Three themes describing aspects of well-being were developed: *coming to terms with the body, restoring the broken relational balance and reorienting the pivot in life*. The thematic findings were abstracted into a main theme: striving to make living bearable. The movement towards well-being can be seen as a struggle towards an experience of balance to make bearable living.

Conclusions: We suggest that well-being as a dialectic between vulnerability and freedom might become a health-facilitating experience for people struggling with obesity.

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Introduction

The worldwide prevalence of people with obesity has nearly doubled since 1980 (World Health Organization [WHO], 2014), and many of those affected make repeated attempts to lose weight (Bombak & Monaghan, 2017; Owen-Smith, Donovan, & Coast, 2014). Losing weight and maintaining weight loss over the long term seems to be difficult (Look AHEAD Research Group, 2014). Hence, obesity becomes a lifelong condition often characterized by repeated weight fluctuations while the weight gradually increases (Grønning, 2014). In the light of modern trends for individualism and striving for self-fulfilment, this life situation while waiting for weight loss, —trying and/or wanting to lose weight,—can cause feelings about not reaching one's full potential and desires in life (Glenn, 2013; Grønning, 2014; Ueland, 2019). People struggling with obesity cannot escape their cultural context, or experienced limitations; they can only find a way of handling them (Malterud & Ulriksen, 2010; Ueland, 2019).

How people challenged with illnesses such as obesity handle life within their experienced limitations is considered to have strong influence on the individual's perceived well-being, and on their potential to move towards health (Dahlberg, Dahlberg, & Nyström, 2008). Health can be found in illnesses as a balance between suffering and well-being (Todres, Galvin, & Dahlberg, 2014). However, well-being as the individual's felt experience of feeling well, that is living the life they desire, and being able to carry out minor and major life projects (Dahlberg & Segesten, 2010), is reflected to a lesser extent by the expanding field of obesity studies.

The current dominant approaches to obesity involve lifestyle changes (diet and exercise modifications) cognitive behavioural therapy, weight loss medication and bariatric surgery (Bray, Frühbeck, Ryan, & Wilding, 2016). However, even after having sought treatment, research has shown that people living with obesity continue to struggle with existential issues (Merrill & Grassley, 2008; Rørtveit, Furnes, Dysvik, & Ueland, 2017). Therefore, these approaches do not seem to capture the existential struggle of living and handling life with obesity. As the long-term maintenance of weight loss is so limited and uncertain, and the implications for physical health are questionable, studies are increasingly addressing other possible approaches to obesity (Logel, Stinson, & Brochu, 2015; Look AHEAD Research Group, 2014; Samdal & Meland, 2018). Some studies suggest that obesity management and policies should better address mental well-being, and even prioritize well-being over weight loss (Rand, Vallis, Aston, Price, Piccinini-Vallis, Rehman & Kirk 2017; Tylka, Annunziato, Burgard, Danielsdóttir, Shuman, Davis & Calogero 2014). People with obesity themselves seem to highlight their health

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outcome as being more important than simple appearance (Sand, Emaus, & Lian, 2015).

Studies have shown that when dedicated to health and well-being, people with obesity develop multifaceted coping mechanisms for dealing with stigma and misunderstanding from society (Bombak, 2015; Puhl & Brownell, 2003). Hence, a holistic approach is considered to optimize health and well-being among people with obesity by turning attention towards their own resources to strengthen empowerment and well-being (Borge, Christiansen, & Fagermoen, 2012; Brown & Wimpenny, 2011; Knutsen, 2012; Kristjansdottir, Stenberg, Mirkovic, Krogseth, Ljosa, Stange & Ruland, 2018).

The importance of well-being outcomes in addition to weight loss in connection with obesity treatment has been underlined in several studies (Palmeira, Pinto-Gouveia, & Cunha, 2017; Willmott & Parkinson, 2017). Positive results from transdisciplinary interventions based on non-dietary principles, focusing on respecting one's body shape, size diversity and promoting a holistic approach towards wellness, might guide future approaches (Clifford, Ozier, Bundros, Moore, Kreiser & Morris, 2015; Samdal & Meland, 2018).

Thus, as a parallel to the obesity field, it seems relevant to compare it to the scientific approach to living with chronic illnesses in general. How people with chronic illnesses handle life and experience well-being despite their suffering has been examined widely (Delmar, Boje, Dylmer, Forup, Jakobsen, Moller & Pedersen, 2005; Johansson, Österberg, Leksell, & Berglund, 2015; Kristjansdottir et al., 2018). The dominant perspective is how people with chronic illnesses find meaningful ways to live with their challenges, despite their perceived limitations. Those people who manage to preserve or create meaning in life, in spite of pain or disabilities, are also able to reformulate their lifeworld and live a full life (Sjöling, Ågren, Olofsson, Hellzén, & Asplund, 2005).

Some recent studies have enhanced the understanding of what it is like to live with obesity as an existential challenge (Haga, Furnes, Dysvik, & Ueland, 2019; Ueland, Furnes, Dysvik, & Rørtveit, 2019; Westland Barber, 2017); however, these studies did not examine how people with obesity live their life in spite of their challenges. As far as we have found, very few studies have provided an existential perspective, describing how people with obesity might experience well-being within their perceived limitations. However, some phenomenological studies highlighting efforts to maintain weight loss are relevant to our study. These have reflected upon how people strive for balance, identity and meaning in life, within their challenges of maintaining long-term weight loss (Groven, Galdas, & Solbrække, 2015; Groven, Råheim, & Natvik, 2017; Natvik, Gjengedal, Moltu, & Råheim, 2015; Toft & Uhrenfeldt, 2015; Warholm, Øien, & Råheim, 2014). We see this striving as a parallel to people's struggle to handle a challenging life when living with obesity. Toft and Uhrenfeldt (2015) suggested addressing the experience of well-being when intervening to deal with obesity.

Todres and Galvin (2010) emphasized that well-being is both a way of being in the world as well as a felt sense. They described the deepest existential well-being as "dwelling-mobility", suggesting that our existence in the world needs both a foundation and a movement forward. Drawing on a conceptual framework, Galvin and Todres (2011) described 18 kinds of well-being experiences in which dwelling and mobility occur with different emphases. The lifeworld constituents elaborated by Heidegger contain the descriptions of spatiality, temporality, intersubjectivity, mood and embodiment (Heidegger, 1962). These 18 kinds of well-being experiences can lead to the formulation of resources that have the potential to give rise to well-being as a felt experience, and thus guide new directions for caring. Hence, an existential theory of well-being is about its structure before it is divided, e.g., into the dimensions of physical, emotional or social well-being (Hörberg, Ozolins, & Ekebergh, 2011; Todres & Galvin, 2010).

Based on the above considerations, we need to develop more knowledge about how people handle their life when struggling with obesity and which aspects of well-being might manifest in such situations. Exploring their ways of handling life can reveal how the person with obesity make a bearable living, within their limitations and vulnerability. Hence, the aim of this study was to gain deeper insight into how people living with obesity handle their life situation by addressing the key question: in what way does well-being unfold within the struggle of living with obesity?

Methods

This qualitative study had an exploratory design including a phenomenological/hermeneutic perspective (Kvale & Brinkmann, 2009). Our approach was open to the lived experiences of people with obesity and was therefore based on a *lifeworld* approach. Lifeworld is defined as the world of lived experiences in which we live our lives (Dahlberg et al., 2008). The lived experiences should be examined as described by the subjects and represents the phenomenological idea of going "to the things themselves" (Dahlberg et al., 2008, p. 32).

Recruitment and participants

A convenient sample of 21 people (seven men and 14 women) was included in the study, representing those to whom we had access, with a willingness to share their life experiences according to the phenomena of interest (Malterud, 2011), which in our study was well-being within the struggle of living with obesity. The participants

were recruited shortly after their entry into one of two different health promotion programmes, promoting lifestyle changes. We emphasized that our study dealt with experiences with life itself when struggling with obesity, and was not aimed at evaluating the programme. The programmes addressed different groups regarding medical severity and geographical catchment areas. The participants needed to meet the following recruitment criteria: age >18 years, both genders, ability to communicate in Norwegian, both orally and in writing, having a body mass index (BMI) ≥35 kg/m^2, and able to provide informed consent on their own behalf. Table I presents the sample characteristics.

Before the inclusion, the leading health professionals in the programmes informed the candidates about the study, both orally and in writing, and a written consent form was completed. The first author contacted those who consented to the study and an appointment for the interview was made. Ethical approval was obtained from the Regional Committees for Medical and Health Research ethics (reference number 2016/1530), and the Norwegian Centre for Research Data (project number 50184) and conducted in accordance with the Helsinki Declaration (The World Medical Association, 2013).

It was emphasized that participation was voluntary and that the participants could leave the project at any time. Confidentiality was guaranteed, together with information about professional support for follow-up if needed.

Data collection

We used qualitative interviews to deepen our insight into the aspects of well-being within the struggle of living with obesity, because this phenomenon is tied to human existence (Dahlberg et al., 2008; Kvale & Brinkmann, 2009). The interviews were conducted using a thematic interview guide with topics including: Everyday life with obesity and handling life with obesity, a meaningful life and future possibilities.

The participants were encouraged to deepen their reflections through follow-up questions, such as "Can you please tell me more … ?" and "What did you feel … .?" Each participant was given a choice to conduct the interview where they felt safe. Seventeen of the participants were interviewed in an office or a conference room at the health promotion centre; three interviews were conducted in the first author's office and one in the first author's private home. The interviews lasted 40–90 minutes. One person did not turn up for the interview. After having interviewed 21 participants, the research team concluded that the sample size probably had sufficient information power to elucidate the aim of the study, so the recruitment process was ended (Malterud, Siersma, & Guassora, 2016).

Table I. Sample characteristics (N = 21).

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

Analysis and interpretation

The interviews were undertaken by the first author, audio-recorded and transcribed verbatim, 16 interviews by the first author and five by a professional transcriber who signed a confidentiality agreement in advance.

The data material was analysed inspired by the phenomenological-hermeneutic thinking of Ricoeur (Delmar et al., 2005; Furnes & Dysvik, 2012; Pedersen, 1999; Ricœur, 1976; Schultz, Qvist, Mogensen, & Pedersen, 2014). The research team independently read and re-read the transcripts of the interviews to become an initial overview after which they met to discuss the material as a whole. Based on the discussion the first author undertook the structural analysis. All authors contributed accordingly to the further analysis and interpretation. As Ricoeur claims, reading a text is the dialectic between two attitudes, explanation and understanding (Furnes & Dysvik, 2012; Ricœur, 1976). In-depth analysis of findings were made by moving back and forth between the empirical level and the analytical level, between understanding and explanation of the text (Ricœur, 1976).

The analysis and interpretation followed three steps:

(1) A naïve reading. Reading and re-reading was carried out to gain an overall view of the interview texts, and to obtain a holistic understanding of the meaning content, i.e., "what is said?"
(2) Structural analysis. A structural analysis clarifies the dialectic between understanding (what is said?) and the explanation (what is spoken

about?) with the purpose of making a deeper critical interpretation possible. Interpretation of the structural analysis and an understanding of the content led to the development of three themes.

(3) Critical interpretation and discussion. The naïve reading and the structural analysis guided the way to the selection of theory. Our critical interpretation aimed at developing new understanding.

A presentation of the themes is presented first, followed by further discussion and interpretation.

Findings

The presentation of our findings illuminates three themes: *coming to terms with the body, restoring the broken relational balance,* and *reorienting the pivot in life,* each of them derived from the abstraction process of the two units of significance for each theme. Quotes are provided to give the participants a clear voice. Table II presents an example from the analysis process.

Coming to terms with the body

The participants described their relationship with their large body in varying terms. They knew that they needed to care about their bodies, but at the same time, they had trouble acknowledging their body fully. Our main impression was that the participants seemed to experience their body and life to be somehow separate. However, the participants' statements expressed that they were in a process of coming to terms with their body, by gaining new insight about their bodies and themselves.

Discovering their body as a prerequisite for life

The participants revealed that they were in a process of discovering their body as a prerequisite for life. At the same time as relating to their body as something they would refrain from, they realized that their body was essential if they were to live the life they wanted. A 54-year old man first described his body as a heavy appendage he had to carry around, which he considered as not necessary to live his life. He stated: "*I don't really need my body in life …* " However, during the interview he reflected further on, realizing that his body was a prerequisite for life and that he had to change his mind set and his attitude to his body. Instead of neglecting it, he should take care of it if he should have the chance to live the life he desired:

> If I don't have my body with me, I don't have my brain either, because they are still connected, to put it like that. So, I must take care of it … You must realise

Table II. Example from the analysis process covering one main theme and three themes.

Striving to make living bearable							
Coming to terms with the body		Restoring the broken relational balance			Reorienting the pivot in life		
Units of meaning (What is said?)	Units of significance (What is being spoken about?)	Units of meaning (What is said?)	Units of significance (What is being spoken about?)	Units of meaning (What is said?)	Units of significance (What is being spoken about?)		
I probably don't choose activities that imply a lot of movement. I frequently go to cafés, that kind of thing. I would rather attend art exhibitions, that's more me. I would rather that than a walk in the woods, because the physical activity becomes too challenging. (Woman A 58 years old)	Negotiating with the body's possibilities	Maybe the people at work see that I struggle with some things that they manage easier. For example, walking down a stone staircase carrying cardboard (packaging) and that kind of thing. I always say "I will just put it (the packaging) here" when I am unpacking goods. I don't take one box down the stairs at a time. The exercise is good for me, but I don't do it because of my hurting knee and the ankles. They laugh then. Oh well. But then I tease them afterwards, « see that you don't do it either». So I get it. (Woman B 58 years old)	Disarming the experience of degradation	I will always be very big, but as long as my body can take me up some mountaintop …, *stops in the middle of the sentence, thinks for a moment before he goes on*), or at least down to the sea and along the beach, I will be very satisfied and happy. (Man 54 years old)	Rethinking how life can be lived		

> that your body is your best friend, because that's what gets you around so that you can do all those fun things.

The statements "they are still connected" and "that's what gets you around so that you can do all those fun things" expressed how the participants realized that they had access to life itself through their bodies. The body, no matter how much it also felt like a limitation for life, was also considered as a sort of companion to carry out minor and major life projects. The participants realized therefore that they had to consider coming to terms with their body and to be aware of it if they wished to achieve a good life.

Another 54-year-old man used a comparison with team play to describe his discovery of his body as a prerequisite for life. He stated: *"Now I'm no longer fighting against my body; I'm fighting with it."* This phrase typified the participants' shifted experience of their bodies. Earlier they had related to their bodies as enemies they had to fight against, but now they had gained the realization that they were members on the same team as their bodies. The body was no longer considered as an opponent to a better living, but a teammate. Teaming up with the body seemed essential for participants to have a good life.

Negotiating with the body's possibilities

The participant's considerations about their body uncovered that they were in a way negotiating with the possibilities of their body when figuring out what their bodies were capable of despite their limitations. A 37-year-old woman with a physically challenging health provider job in a homecare facility for people with mental retardation first referred to the drawbacks of having a large body in her daily work: *"I have some very fit colleagues, and they manage to get things done as easy as anything. Things are perhaps a bit slower for me."*

However, in the next moment she also outlined some benefits, because a strong and powerful body was very helpful when being challenged physically by the residents:

> My colleague and I have found that there are advantages to being large in this job. They (those taken cared for) can't move mountains (laughs)! There are colleagues who have said, when it comes to enduring certain situations, they would not have managed as well as us.

To experience that others recognized their bodies to be strong, seemed to encourage the participants to look at their bodies more positively. This might explain their willingness to experience meaning and coherence in life. They certainly experienced bodily drawbacks, but they were also able to recognize their large body for its benefits.

The participants had tried different leisure activities during life with varying degrees of success due to their large bodies. A feeling of defeat was a common experience. However, some participants explained that during these experiences they had understood more about not only their body's limits and capabilities, but also themselves. During the interview, a 58-year-old woman came to the realization that leisure activities, which made her feel well were more in accordance with the perception she had of who she was as a person:

> I probably don't choose activities that imply a lot of movement. I frequently go to cafés, that kind of thing. I would rather attend art exhibitions, that's more me. I would rather that than a walk in the woods, because the physical activity becomes too challenging.

Making a change in which activities one could participate in according to what the body could manage, did not mean only movement away from one's desires. Movement also occurred towards something new and desirable that had the potential to be of great significance to the individual. These kinds of reflections seemed to indicate that negotiation with the body's possibilities had ended, and been replaced with an experience of harmony.

Restoring the broken relational balance

The participants seemed to have strategies to defend themselves from the perceived spoken or unspoken judgements from others, whether it came from relatives, friends, colleges or the general society. Strategies for defending themselves were highlighted several times during the interviews as a way to handle the underlying judgemental tone and hereby restore the broken relational balance between them and others. It was about an attitude towards how one should react to other's condemnation.

Disarming the experience of degradation

One of the strategies to restore the broken relational balance was obviously to disarm the experience of others' degradation by using humour, self-irony, and by catching up with others. By making responses to others in such ways, the participants took the sting out of any possible degradation, so that the effect more or less "peeled off". Another 58-year-old woman suffering from pain in her knees and ankles, reflected in the interview upon sometimes being teased kindly with laughter when making excuses to her colleges about her limitations in her practical work as a shop assistant. However, she caught up with them and teased them back:

> Maybe the people at work see that I struggle with some things that they manage easier. For example, walking down a stone staircase carrying cardboard (packaging) and that kind of thing. I always say 'I will just put it (the packaging) here' when I am unpacking goods. I don't take one box down the stairs at a time. The exercise is good for me, but I don't do it because of my hurting

> knee and the ankles. They laugh then. Oh well. But then I tease them afterwards, 'I see that you don't do it either'. So, I get it.

Comparing themselves with others brought forth a recognition among participants that they were not so different from others after all. Reciprocal teasing contributed to a feeling of "being in the same boat". These kinds of experiences made the participants feel that they could relate to others on equal footing.

In addition, disarming the experience of others' degradation was also about attempting to influence others' perceptions that had the potential to shape the participants' self-understanding, such as distracting attention. Most of the participants related that they were attempting to downplay the body parts they wanted to hide. However, some were very conscious about distracting the attention of others by highlighting a part of the body they were satisfied with, such as their face. A 46-year-old woman expressed her strategy like this:

> I love to decorate myself! I probably have 50 different pairs of earrings. I change them every day. I never wear the same pair two days in a row … It is probably to do with taking the focus away from my body. They catch your eye … they sparkle a bit, don't they? So then, people look at my face instead of looking at my body.

To decorate themselves, for example with conspicuous earrings was a strategy that enabled the size of their body to move into the background. These small diversionary manoeuvres made the participants feel that they had a degree of control when encountering others, and in this way, they seemed not totally left to devaluation by others. Moreover, they might function to restore the perceived relational unbalance between themselves and the world.

Opposing the internalization of degradation

Another strategy that appeared in the interviews was that the participants seemed to defend themselves by oppose internalization of others' degradation. Among the participants, degradation had the potential to affect their self-understanding negatively, but if not internalized, it would not be "effectuated".

The strategy of participants seemed to be to keep degradation at a distance by letting it bounce off immediately. By challenging others' simplified understanding of what was needed to lose weight, the participants were able to recognize their own and others' efforts to overcome obesity. During the interview a 58-year-old woman established a clear distance from the cultural prejudice that people with obesity have little will-power:

> It seems that most people think it is just a matter of deciding to eat less and exercise more, and then the problem will be fixed. But then it isn't as easy as that. One is perhaps seen as undisciplined, though being on a chronic diet requires a fair amount of discipline. And it takes at least two years to stabilise the weight. And while you are in that stabilising phase, it is pretty tough. It actually demands a lot of will-power to endure that, which I don't think everybody understands.

Western cultures judge those living with obesity as having little will-power. For the participants it was important to support themselves, and stand up against such a judgemental attitude. By keeping the devaluation at a distance, the participants seemed to avoid self-devaluation. Further, self-support meant that the participants felt pride in their inner qualities.

Reorienting the pivot in life

The participants related that their body and weight, and possibilities for weight loss had occupied their attention year after year. This had caused a feeling of stagnation in life and inevitable experience of loss associated with not achieving their goals or dreams. However, participants also expressed being in a process of reorienting their pivot in life, focusing on living well with their condition.

Rethinking how life can be lived

Participants reflected on the possibilities for living a good life, given that they had experiences of loss in life related to their large body. Despite these experiences, they reflected that they could still have a good life, if they could only adjust their dreams. A 56-year-old man realized during the interview that he had to reorient his desire about climbing mountains to another activity that would fit his current body function better.

> I will always be very big, but as long as my body can take me up some mountaintop … (stops in the middle of the sentence, thinks for a moment before he goes on), or at least down to the sea and along the beach, I will be very satisfied and happy.

Dwelling on what the body could actually contribute, turned the participants' lives towards satisfaction and a form of happiness.

Rethinking how life could be lived also seemed to be based on reflections of what life actually should be in the future. They questioned whether their future life should concentrate only on waiting for weight loss. They had started to realize that life now was so much more than that. Participants experienced for example feelings that a long-awaited life had come true, despite having the same bodily limitations as earlier. A young woman, 24 years old, previously could not believe that she would ever have a boyfriend with such a body as she had, but put this in connection with accepting herself and her body.

> I think I am on the right track. I have a boyfriend. I never thought I would have one. And I am starting to accept my body as it is, both the good and the bad .... In a way, I have accepted that this is the size I am right now, and that is who I am.

At the same time, there was recognition that their large body was good, but also had challenging aspects. Nevertheless, participants came to understand what mattered in life. Realizing that life could really be *lived*, while having a large body was an understanding they acquired, as they reflected upon their future possibilities.

Rethinking what is important in life

Reorienting in life also meant changing beliefs of what was important in life. The participants seemed to be in a process where they eventually let go of old ideas about what was important in life, and yet took their life situation to a new assessment. At the time of the interviews, some participants expressed that they had gradually understood that life could be good, even while living with a large body. However, moving from knowing what was good for them to believing in it had been so difficult, that it required them to gain another understanding of what was important. A 24-year old woman's reflections revealed that she now considered *her process* towards long-term lifestyle changes to be more important than simply aiming for a slim body: *"I see that my weight is too high, but when diet and exercise is all in place, I will have a well-proportioned body, which I see as healthy."*

The participants seemed to have realized that they had to decide for themselves what their life and mind should be filled with. Being constantly occupied with slimming for so many years had drawn the focus away from feeling good about themselves. Some valued gradually feeling good about themselves as being more important than having a slim body but coming to that conclusion had been a mental process lasting years. A 55-year-old woman gave the impression that she felt she had lost many years of her life because of constantly feeling sad about herself, while being occupied with losing weight:

> I can remember that when I weighed 60 or 65 kg. I wasn't happy then. When I weighed 70 and 75 kg, I wasn't happy either. And when I was 80 and 85 kg, I wanted to lose weight too. If I was 85 kg now, I would be happy, is what I say now. ... I have decided now that I am not going to have as much focus on dieting. Well, focus, but on myself instead ... on feeling good.

The participants expressed their experience of having suffered for so many years to no avail. In retrospect, they seemed to regret that they had let themselves believe that slimness and happiness were so closely connected.

Discussion

The aim of this study was to gain deeper insight into how people struggling with obesity handle their life situation by addressing how well-being unfolds. We found that handling life with obesity could be seen as an evolving process while experiencing aspects of well-being, including: *coming to terms with the body, restoring the broken relational balance* and *reorienting the pivot in life*. These three thematic findings are now interpreted and discussed in light of earlier research, but mainly in the light of the conceptual framework of Galvin and Todres (2013) about well-being. From this theoretical perspective, the three thematic findings are abstracted into a main theme. We consider the movement towards well-being as a struggle towards an experience of balance to make bearable living. Striving to make living bearable is an expression of how people with obesity struggle to find their own balance and harmony in existence, which is intertwined with one's life situation (Gadamer, 1996). This discussion has been arranged according to the abstracted main theme.

Striving to make living bearable

As we have presented, the abstracted findings from our study show that the participants seemed to struggle towards an experience of balance to make living bearable, within their perceived limitations. It appears that the participants' reflections upon their bodies, relations and selves fluctuated between opposite poles. There also seems to have been movement between not living one's life to the fullest and expanding one's living space. In light of the conceptual framework of Galvin and Todres (2013), this can be seen as moving between illness and health. According to Merleau-Ponty (2002), bodily being involves a certain ambiguity. The ambiguity regarding one's body, relations and self is described in several phenomenological lifeworld studies within the obesity field (Groven et al., 2015, 2017; Westland Barber, 2017). Our research has revealed that aspects of well-being can be found within the struggle of people with obesity to make living bearable. Moreover, our study adds to the literature on how this positive possibility becomes a resource for life when living with obesity. Thus, human beings cannot be seen as finished, but always in a process (Galvin & Todres, 2013) Ambiguity is an essential part of being human (Galvin & Todres, 2013). Therefore, the movement between opposite poles can be understood as a way of being in the world, as the participants seem to strive for the experience of a greater level of well-being in their life.

As shown, the participants in our study seem to be in a process of coming to terms with their bodies, through discovering their body as a prerequisite for

life and by negotiating with the body's possibilities. The concepts "discovering the body" and "negotiating with the body" reveal the participants' realization that life itself can only be experienced through the body, despite experiencing their body as an opponent to living. According to previous research, struggling with obesity can lead to a feeling of not having full access to life, so life can be experienced as being "put on hold" (Haga et al., 2019). However, in the present study, we discovered that the participants found themselves negotiating ongoing tension between restriction and freedom of action because of their perceived bodily limitations. As we see it, this process seems to involve a gradual movement towards adjusting to the reality of their bodies. They gradually learned to live with this tension by acknowledging their bodily experiences as a source of insight and meaning in their life. Further, the findings show an aspect of well-being arising from acknowledgement of their body. The reflections contribute to the participants' consciousness about how they should adjust their life to make living bearable. Our findings are related to a study about making sense of long-term bodily changes following bariatric surgery. In that study, Groven et al. (2015) described the struggle as an inevitable balancing process. According to the terminology of Galvin and Todres (2013), the movement between limitations and possibilities when coming to terms with the body can be referred to as an experience of "abiding expanse". This concept describes an aspect of well-being as stretching between a sense of at-homeness, and a sense of being invited into an exploration of something new. We suggest that the experience of well-being becomes a foundation that enables the person to move further. Hence, the reflections based on the experience of coming home, i.e., being deeply rooted in oneself and one's bodily vulnerabilities, appear as intertwined with the possibilities for life and health. As such, well-being seems to be strengthened by an individual's ability to reflect on their bodily vulnerabilities, which again appear as a foundation for exceeding one's limitations. It seems particularly important that the foundation on which people with obesity stand is to *be in* their body, and to acknowledge what it means to take both possibilities and limitations into account. Furthermore, the important things in life arise from this basis.

This study has revealed participants' reflections and strategies on how they deal with the feeling of degradation. As we see it, their experience of a judging gaze from both individuals and society, reveal a sense of a broken relationship. The participants in our study seem to strive for balance in relation to others by using certain strategies. Moreover, they seem to move against a deeper experience of well being as they manage to defend themselves from the underlying judgemental tone of others.

As previous studies have shown, people with obesity strive to fit in, and yet feel a second-rate citizen and human being, as they do not comply with prevailing social norms in the culture of adequate body weight and shape (Tomiyama, Carr, Granberg, Major, Robinson, Sutin & Brewis, 2018). Forms of intersubjectivity can humanize or dehumanize the individual and have a positive or negative impact on well-being (Hemingway, 2011). Standing outside the accepted fellowship can lead to a sense that one's existence is not wanted (Galvin & Todres, 2013). However, in our study we see that within the feeling of strangeness, the participants aim to disarm or draw the attention away from what is different, or what they want to hide by how they communicate (both said and unsaid). Instead, it seems that they attempt to draw attention towards what unites them with others. Thus, the experiences of familiarity and partnership, contribute to the constitution of a symmetrical relationship. Therefore, an aspect of well-being seems to lie in the participant's reflections between difference and sameness, strangeness and familiarity, which leads attention towards what they have in common with others, and not the opposite (Galvin & Todres, 2013).

Another way of restoring the broken balance in relation to others seems to be when the participants oppose internalization of others' degradation. The participants seem to struggle with the sense of self as being a failure because of the cultural prejudice that people with obesity have little will-power. Other researchers have confirmed that people with obesity seem to develop an identity in the experience of what others mean about them (Malterud & Ulriksen, 2010). However, we can see that the participants in our study seemed to take a meta-perspective. According to Fuchs (2002) this perspective allows a kind of self-distancing, which is crucial to cope with self-devaluation. Therefore, the participants' ability to take a meta-perspective when encountering society's condemnation seems to strengthen their opposition. Moreover, we found traces of pride associated with the person's inner qualities within their reflections. This finding agrees with other studies in the obesity field (Salemonsen, Hansen, Førland, & Holm, 2018; Ueland, 2019). The importance of highlighting these traces as building blocks to liberate oneself from shame is reported to be essential to cope with cultural influences (Ueland, 2019). As we see it, the self-reflective attitude described in the present study might be an aspect of well-being, as reflection as such provides an awareness of oneself in relation to the phenomenon for consideration (Hörberg, Galvin, Ekebergh, & Ozolins, 2019) The aspect of well-being lies in the breakthrough of realizing "I am all this and more" (Galvin & Todres, 2013). Thus, our findings indicate that the reflection process gradually leads to a change in the participant's self-understanding (Hörberg et al., 2019). Earlier research confirmed that the processes related to

developing embodied knowledge is deeply personal and often entail an existential experience of oneself (Natvik, Råheim, Andersen, & Moltu, 2018; Toft & Uhrenfeldt, 2015). What our study offers is that when self-devaluation does not seem to be at stake any longer, a sense of freedom emerges, and creates an interpersonal space for developing an identity rooted in oneself. As we see it, the experience of well-being provides the participants the freedom to build a new understanding of themselves that enables them to keep their dignity in the face of others. Consequently, a transformed relationship to oneself, based on an experience of well-being, seems to be important to people with obesity, to make living bearable in a judgemental society.

Our study strongly emphasizes the participants' considerations regarding a reorienting in their pivot in life. The reflections made by several of the participants in our study seem to reveal that they are in a process of giving their current life and future a new pivot. Therefore, this reorientation in life includes rethinking how their life can be lived in the future. As some of the participants reflected on possibilities for living a good life—within their bodily limitations—at the same time they seemed to adjust their ambitions to their current level of bodily capability to make living bearable. Research on living with a chronical illness confirms that opting for less favourable choices sometimes also means achieving a balance in life (Johansson et al., 2015). Groven et al. (2017) referred to the concept of "flow", which is described as a state in which the lived body feels in tune with the environment, as possibly providing new hope for the future. Galvin and Todres (2013) linked the movement towards the future to being "at one" with the present moment by constitution of a sense of meaningful purpose. As we can see, in our study, meaningful purpose was constituted at the moment the participants experienced a sense of completeness and satisfaction.

In some sense, the adjustment of future ambitions represents a temporal stagnation and a lack of temporal mobility that in one way affects one's understanding of having access to a future with possibilities. However, according to aspects of well-being there seems to be a dialectic between accepting what is lost and orienting towards a meaningful future. This dialectic can be described with the concept *renewal* (Galvin & Todres, 2013). As we have seen in the present study, the feeling of "the future is now" appeared as one of the participants described accepting herself and her body in connection with unexpectedly reaching one of her life goals, without losing weight. The experience of "the future is now" might be seen as renewal, as this well-being experience unifies future orientation and present centeredness. Accepting oneself and one's body seem to give a kind of "aliveness" to a sense of the present and provide a strong base for movement towards the future (Galvin & Todres, 2013).

Furthermore, our findings show that the participants in our study seemed to be in a process of rethinking what was meaningful in their life. They seemed to consider a shift in their life's pivot. They had believed for many years that slimness meant a happier life. Research has shown that if only a fixed ideal of the body is valued, it might appear difficult to be happy outside the norm (Bahra, 2018). Being constantly occupied with slimming led to an experience of having lost many years of life, to no avail. They now concentrated more on living in the present and feeling good about themselves. Self-compassion seems to be pivotal in relation to well-being when confronted with challenges in life (Gustin, 2017). Hence, the literature confirms that the lifeworld perspective highlights that life is not an outcome, it is a process that is deeply personal and points to the existential domain (Natvik et al., 2018). A change in perspective is referred to as a change in attitude towards life, which involves a decision of the self (Natvik et al., 2018). According to Galvin and Todres (2013) the decision of the self seems to point towards an aspect of well-being. The ability to make decisions indicates that the person with obesity holds a certain power and capacity, which might provide life-heading and life-forcing qualities of being an active agent in the world (Galvin & Todres, 2013). As we see it, the well-being experience might enable the person with obesity to concentrate his/her energy more towards living well with their condition.

Methodological considerations

In lifeworld studies, openness and sensitivity is imperative (Dahlberg et al., 2008). We have described how we have approached the phenomenon as it presented itself, instead of imposing preconceived ideas or hypotheses. Three themes were developed as offering interesting perspectives that, in combination, could shed light on the existential experiences of people living with obesity. Moreover, given that we are a mixed group of researchers, the analysis process included ongoing discussions of alternative interpretations before reaching a consensus. This was done to enhance the trustworthiness of our findings. However, meanings are never finally complete, but ambiguous and tentative, leaving the analysis open for other interpretations (Dahlberg et al., 2008).

We have presented the findings together with the participant's quotations, a description of the analytic process, and clarified an example of a structural analysis (Table II). This gives the reader the possibility to follow a researcher's reasoning throughout the whole study and should contribute to strengthen the study's validity (Dahlberg et al., 2008). However, validity in phenomenological studies may also be verified by the writer's ability to create reflections that touch, guide and stir

the reader to the extent that one is able to evoke the reader's recognition (Van Manen, 2014).

The diversity of the sample of 21 participants representing different ages, both men and women of different backgrounds offered rich and nuanced descriptions of the phenomenon of interest. We consider it as a certain strength that both genders are well represented, and that half of the sample were employed (vs. unemployed). The more variations and nuances in the data, the more likely it is to see clear patterns of meanings in the phenomenon (van Wijngaarden, Meide, & Dahlberg, 2017). Together with the descriptions of the existential experiences and the background information, we suggest that the provided meaning structure of the phenomenon gives insight into life-as-it-is-lived, and allow transferability to be discerned, by considering the culture and the context.

The participants were recruited when entering a health-promoting program and that might be a possible limitation. Their utterances expressing aspects of well-being might have been influenced by a "flow" of positivism and strength, as they were filled with hope and expectations and felt that they were standing on the threshold to a new life. However, this program was not a subject for the interviews. Moreover, the participants were recruited in the most appropriate way to find those whose experiences could provide insight into the phenomenon of struggling with obesity, given the sensitive topic and considerations made after other researcher's difficulties in more general recruiting (Westland Barber, 2017). We are nevertheless aware that another sample strategy could have provided other findings.

Conclusions

This study has gained insight into how people struggling with obesity strive to experience well-being. Well-being in our findings is described as a struggle to achieve a bearable living. This struggle is expressed through the study by how people strive towards coming to terms with their bodies, towards restoring the broken relational balance and towards reorienting their pivot in life, focusing on living well with their condition. These movements within the experience of well-being can be understood as a dialectic between vulnerability and freedom.

Freedom emerged as a possibility to orient towards a better life, where the weight is not allowed to become burdensome. However, this freedom takes place in a vulnerable space, where the person living with obesity experience an internal and external devaluing pressure. The dialectic between experiencing freedom and experiencing vulnerability coincide, and points towards "dwelling-mobility", as a way of being-in-the-world. We suggest that well-being as a dialectic between vulnerability and freedom might become a health-facilitating experience for people struggling with obesity.

Implications for practice

We suggest a change in focus towards health and well-being when approaching the challenge of people struggling with obesity. As mentioned, the standard biomedical approach to obesity primarily involves an illness perspective. In particular, our findings point towards the need to understand the individual efforts of people with obesity to regain balance and well-being in their lives, including the dialectic between vulnerability and freedom. Health professionals have possibilities to support their patients' health-facilitating processes. However, they need to be aware of their patient's expressions of well-being if they can support them. Therefore, we suggest that people with obesity involved in treatment processes should be invited into a dialogue, with the purpose of reflecting on how they handle their challenges and make sense of their ongoing bodily challenges in everyday life. We believe that reflections on possibilities and obstacles in a patient's lifeworld can give rise to a deeper understanding of what really matters for the person with obesity. Further research should focus on what health professionals experience when encountering people with obesity, and how they understand the existential struggle of living and handling life with obesity.

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Paper III

Haga, B.M., Furnes, B. & Ueland, V. (Ready for submission)

Existential experiences of people with obesity from the perspective of health professionals.

This paper is not included in Brage.

Appendices

Appendix 1 – Interview guide persons with obesity

Intervjuguide – personer med overvekt/fedme

- Hvordan vil du si det er å leve med overvekt i hverdagen?
- Hvordan håndterer/takler du hverdagen?
- Hvordan vil du beskrive/hvordan erfarer du kroppen din?
- Hvordan tror du andre vil beskrive deg? Hvordan oppfatter du andre ser på deg?
  - Familie
  - Venner
  - Ansatte i helsevesenet
  - Ukjente – «samfunnet»
- Hva innebærer det å leve med overvekt i vårt samfunn?
- Fortell om en/flere erfaringer/hendelser knyttet til det å ha en stor kropp.
- Hvordan ser du for deg fremtiden? Hva lengter du etter?
- Hva er et meningsfullt liv for deg?
- Er det noe du vil tilføye?

Oppfølgingsspørsmål

- Hva tenkte du da?
- Hvordan opplevde du det?
- Hvordan reagerte kroppen din?
- Hvordan reagerte du følelsesmessig på det?
- Hva gjør det med deg når…?
- Kan du si noe mer om det? Mer detaljert beskrivelse? Noen eksempler?
- Du mener altså at….? Er det riktig at…..?

Appendix 2 – Interview guide focus group interviews with health professionals

Intervjuguide – fokusgrupper med helsepersonell

Introduksjon og bakgrunn for studien

- Prosjektet: Eksistensielle erfaringer når en lever med fedme.
- Fokusgruppeintervju – hva er det?
- Fokusgruppeintervju - roller
- Gjensidig taushetsplikt.

Hoveddel

- Hva er det som slår dere /kommer til uttrykk når det gjelder hvordan deltakerne deres har det i livet? Hvordan leves livet når en har fedme?
    - Kan dere huske en konkret erfaring med en konkret person?
    - Hva tror dere det gjør med dem å ha det slik?

- Hva gjør det med dere å ta del i/møte slike eksistensielle erfaringer?
    - Hvilke tanker og følelser gjør dere dere?

Avslutning

- Er det noe mer dere vil tilføye?
    - Hvordan har det vært for dere å snakke om disse tingene?

Appendix 3 – Information given to persons with obesity

Universitetet i Stavanger

FORESPØRSEL OM DELTAKELSE I FORSKNINGSPROSJEKTET

EKSISTENSIELLE ERFARINGER VED Å LEVE MED OVERVEKT

Dette er et spørsmål til deg om å delta i en forskningsprosjekt der hensikten er å få dypere innsikt i hvordan det er å leve med overvekt. Spørsmålet går til deg fordi vi tror du har gjort deg mange tanker og erfaringer som kan ha betydning for helsevesenets møte med og tilbud til gruppen. Universitetet i Stavanger, Institutt for helsefag, er ansvarlig for denne doktorgradsstudien. Studien er delt i to deler, første del består av intervjuer med personer som har overvekt, andre del består av fokusgruppeintervjuer med fagpersoner som arbeider med livsstilsveiledning og behandling.

HVA INNEBÆRER PROSJEKTET?

Dersom du ønsker å delta i prosjektet avtaler vi et tidspunkt for en samtale/intervju. Samtalen vil ha en varighet på 1 – 1 1/2 time. I samtalen vil jeg spørre deg om hvordan du opplever å leve med overvekt. Du bestemmer selv hvor detaljert du vil være, men enkelte sentrale temaer er hvordan det er å leve med overvekt i hverdagen, i møte med andre (nære/fjerne relasjoner, helsepersonell m.m.), i samfunnet, kroppsbilde/selvbilde og tanker om fremtiden.

Hvis du ikke har noe imot det, vil jeg gjøre lydopptak av samtalen. I tillegg vil jeg registrere noen bakgrunnsopplysninger om deg (alder, kjønn, sivil status, utdanningsnivå, arbeidsforhold, bosted, religion/livssyn, tidligere erfaring med livsstilsveiledning/ behandling).

MULIGE FORDELER OG ULEMPER

Forskningstemaet tilhører et sensitivt område, både kropp og eksistens. Det kan innebære en merbelastning å delta i slik forskning, fordi det medfører at en må gå inn i egne erfaringer og opplevelser knyttet til et sårbart tema. Til tross for at deltagelse i forskningsprosjektet kan medføre en merbelastning, anses likevel fordelene som større enn ulempene. Det å dele vanskelige opplevelser og erfaringer kan virke avlastende. Det kan også være nyttig å reflektere over den veien en har gått, og hva det har gjort med en å leve med overvekt. Forsker ønsker kontakt med mennesker som ønsker å dele både gode og mindre gode erfaringer. Ut over dette vil ikke studien ha noen direkte fordeler for deg, men på sikt vil helsevesenets tilbud til denne gruppen kunne bli forbedret. Forsker har lang yrkesfaglig erfaring med å samtale med mennesker i vanskelige livssituasjoner.

Eksistensielle erfaringer ved å leve med overvekt

FRIVILLIG DELTAKELSE OG MULIGHET FOR Å TREKKE SITT SAMTYKKE

Det er frivillig å delta i prosjektet. Dersom du ønsker å delta, undertegner du samtykkeerklæringen på siste side. Du kan når som helst og uten å oppgi noen grunn trekke ditt samtykke. Dette vil ikke få noen konsekvenser for deg. Dersom du trekker deg fra prosjektet, kan du kreve å få slettet opplysningene, med mindre opplysningene allerede er inngått i analyser eller brukt i vitenskapelige publikasjoner. Dersom du senere ønsker å trekke deg eller har spørsmål til prosjektet, kan du kontakte Britt Marit Haga på epost: britt.m.haga@uis.no, eller på telefon +47 930 57 898/+47 51 83 39 10

HVA SKJER MED INFORMASJONEN OM DEG?

Informasjonen som registreres fra samtalen med deg skal kun brukes slik som beskrevet i hensikten med studien. Det er bare jeg som prosjektleder og hovedveileder som har adgang til samtalen med deg. Du har rett til innsyn i hvilke opplysninger som er registrert om deg og rett til å få korrigert eventuelle feil i de opplysningene som er registrert.

Alle opplysningene vil bli behandlet uten navn og fødselsnummer eller andre direkte gjenkjennende opplysninger. Det vil ikke være mulig å identifisere deg i resultatene når disse publiseres, også ord og uttrykk som kan skape gjenkjennelse blir omformet. En kode knytter deg til dine opplysninger gjennom en navneliste.

Undertegnede har ansvar for den daglige driften av forskningsprosjektet og at opplysninger om deg blir behandlet på en sikker måte. Informasjon om deg vil bli anonymisert eller slettet senest 31.12.2017.

GODKJENNING

Prosjektet er meldt til Personvernombudet for forskning, NSD - Norsk senter for forskningsdata AS, og klarert med Regional Etisk Komité for medisinsk og helsefaglig forskning (REK).

Med vennlig hilsen

Britt Marit Haga
Stipendiat i helsevitenskap
Institutt for helsefag
Universitetet i Stavanger

Eksistensielle erfaringer ved å leve med overvekt

SAMTYKKE TIL DELTAKELSE I PROSJEKTET

JEG HAR MOTTATT INFORMASJON OM PROSJEKTET OG ER VILLIG TIL Å DELTA

Sted og dato

Deltakers signatur

Deltakers navn med trykte bokstaver

☐ Jeg samtykker til at forsker kan ta kontakt med meg i etterkant hvis det er behov for utfyllende opplysninger.

Jeg bekrefter å ha gitt informasjon om prosjektet:

Sted og dato

Signatur

Rolle

Appendix 4 – Information given to health professionals

Universitetet i Stavanger

FORESPØRSEL OM DELTAKELSE I FORSKNINGSPROSJEKTET

EKSISTENSIELLE ERFARINGER VED Å LEVE MED OVERVEKT

Dette er et spørsmål til deg som fagperson om å delta i et forskningsprosjekt som har til hensikt å få dypere innsikt i menneskers eksistensielle situasjon når en lever med overvekt. Spørsmålet om deltagelse går til deg fordi vi tror du gjennom ditt arbeid har gjort deg mange tanker og erfaringer som kan gi kunnskaper som kan ha betydning for helsevesenets møte med og tilbud til gruppen. Universitetet i Stavanger, Institutt for helsefag, er ansvarlig for denne doktorgradsstudien. Studien er delt i to deler, første del består av intervjuer med personer som har overvekt, andre del består av fokusgruppeintervjuer med fagpersoner som arbeider med livsstilsveiledning og behandling.

HVA INNEBÆRER PROSJEKTET?

Dersom du ønsker å delta i prosjektet avtales et tidspunkt for gruppeintervjuet. Fokusgruppeintervjuer er egnet når man ønsker å studere fenomener som bygger på felles erfaringer. Gruppen for øvrig vil være tverrfaglig sammensatt, og bestå av inntil 8 fagpersoner som du trolig kjenner mer eller mindre fra før. Samtalen vil ha en varighet på 1 – 1 1/2 time, og fokuset vil være deres erfaringer med eksistensielle livsfenomeners betydning hos deltakere som lever med overvekt. Prosjektleder vil lede samtalen.

Det vil bli gjort lydopptak av samtalen. I tillegg vil vi registrere noen bakgrunnsopplysninger om hver enkelt deltaker (alder, kjønn, utdanningsretning, erfaringslengde). Avtale om gjensidig taushetsplikt undertegnes ved starten av intervjuet. Det som fortelles i fokusgruppen skal ikke deles med personer som ikke var der. Dette gjelder ikke bare for innholdet av samtalen, men også om hvem som har vært deltakere.

Eksistensielle erfaringer ved å leve med overvekt - fagpersoner

MULIGE FORDELER OG ULEMPER

Forskningstemaet tilhører et sensitivt område, både kropp og eksistens. Det kan innebære en merbelastning å delta i slik forskning, fordi det utfordrer ens egen fagforståelse, profesjonalitet og verdier. Det kan være en risiko for å tape anseelse og respekt dersom man deler erfaringer der man kanskje ikke har fulgt gjeldende normer. Til tross for at deltagelse i forskningsprosjektet kan medføre en merbelastning, anses likevel fordelene som større enn ulempene. Det å dele vanskelige yrkeserfaringer kan virke avlastende. Det kan også være faglig utviklende å reflektere over egen yrkespraksis og hva det gjør med en å arbeide tett med personer som lever med overvekt. Forsker ønsker kontakt med fagpersoner som ønsker å dele både gode og mindre gode erfaringer, og erfaringer som bidrar til å øke mangfoldet i diskusjonen vil bli særlig godt mottatt. Ut over dette vil ikke studien ha noen direkte fordeler for deg, men på sikt vil helsevesenets tilbud til denne gruppen kunne bli forbedret.

FRIVILLIG DELTAKELSE OG MULIGHET FOR Å TREKKE SITT SAMTYKKE

Det er frivillig å delta i prosjektet. Dersom du ønsker å delta, undertegner du samtykkeerklæringen på siste side. Du kan når som helst og uten å oppgi noen grunn trekke ditt samtykke. Dersom du trekker deg fra prosjektet, kan du kreve å få slettet opplysningene, med mindre opplysningene allerede er inngått i analyser eller brukt i vitenskapelige publikasjoner. Dersom du senere ønsker å trekke deg eller har spørsmål til prosjektet, kan du kontakte Britt Marit Haga på epost: britt.m.haga@uis.no, eller på telefon +47 930 57 898/+47 51 83 39 10

HVA SKJER MED INFORMASJONEN OM DEG?

Informasjonen som registreres fra fokusgruppeintervjuet skal kun brukes slik som beskrevet i hensikten med studien. Det er bare jeg som prosjektleder og en av prosjektmedarbeiderne (hovedveileder) som har adgang til fokusgruppeintervjuet. Du har rett til innsyn i hvilke opplysninger som er registrert om deg og rett til å få korrigert eventuelle feil i de opplysningene som er registrert.

Alle opplysningene vil bli behandlet uten navn og fødselsnummer eller andre direkte gjenkjennende opplysninger. Det vil ikke være mulig å identifisere deg i resultatene når disse publiseres, også ord og uttrykk som kan skape gjenkjennelse blir omformet. En kode knytter deg til dine opplysninger gjennom en navneliste.

Prosjektleder har ansvar for den daglige driften av forskningsprosjektet og at opplysninger om deg blir behandlet på en sikker måte. Informasjon om deg vil bli anonymisert eller slettet senest 31.12.17.

GODKJENNING

Prosjektet er meldt til Personvernombudet for forskning (NSD) og klarert med Regional Etisk Komité for medisinsk og helsefaglig forskning (REK).

Med vennlig hilsen

Britt Marit Haga
Stipendiat i helsevitenskap
Institutt for helsefag
Universitetet i Stavanger

Eksistensielle erfaringer ved å leve med overvekt - fagpersoner

SAMTYKKE TIL DELTAKELSE I PROSJEKTET OG GJENSIDIG TAUSHETSPLIKT

JEG ER VILLIG TIL Å DELTA I PROSJEKTET

Sted og dato

Deltakers signatur

Deltakers navn med trykte bokstaver

____ Jeg samtykker til at forsker kan ta kontakt med meg i etterkant dersom det er behov for utfyllende opplysninger.

JEG HAR TAUSHETSPLIKT BÅDE OM INNHOLDET I SAMTALEN OG OM HVEM SOM DELTAR

Sted og dato

Deltakers signatur

Jeg bekrefter å ha gitt informasjon om prosjektet:

Sted og dato

Signatur

Rolle

Appendix 5 – Ethical approvals

REK
REGIONALE KOMITEER FOR MEDISINSK OG HELSEFAGLIG FORSKNINGSETIKK

Vår dato:	Vår referanse:
19.09.2016	2016/1530/REK nord
Deres dato:	**Deres referanse:**
09.08.2016	

Vår referanse må oppgis ved alle henvendelser

Britt Marit Haga
Institutt for helsefag

2016/1530 Eksistensielle erfaringer ved å leve med overvekt og fedme

Vi viser til søknad om forhåndsgodkjenning av ovennevnte forskningsprosjekt. Søknaden ble behandlet av Regional komité for medisinsk og helsefaglig forskningsetikk (REK nord) i møtet 08.09.2016. Vurderingen er gjort med hjemmel i helseforskningsloven § 10, jf. forskningsetikkloven § 4.

Forskningsansvarlig: UiS
Prosjektleder: Britt Marit Haga

Prosjektleders prosjektomtale
Denne kvalitative doktorgradsstudien retter sin interesse mot menneskers eksistensielle erfaringer når en lever med overvekt og fedme. Prosjektet er todelt og skal undersøke hvordan eksistensielle erfaringer/livsfenomener erfares og beskrives av personer som lever med overvekt og fedme, og hvordan de eksistensielle livsfenomenene beskrives av fagpersoner som arbeider med behandling og livsstilsveiledning i kommune- og/eller spesialisthelsetjenesten. Hensikten er å få en dypere innsikt i menneskers eksistensielle situasjon, noe som kan gi kunnskaper som har betydning for hvordan de som rammes kan bli møtt av helsevesenet, slik at helse fremmes. Studien vil ha et kvalitativt, eksplorativt og deskriptivt design, med en fenomenologisk-hermeneutisk tilnærming. Studien vil bli publisert i tre vitenskapelige artikler i anerkjente internasjonale tidsskrift.

Framleggingsplikt
De prosjektene som skal framlegges for REK er prosjekt som dreier seg om "medisinsk og helsefaglig forskning på mennesker, humant biologisk materiale eller helseopplysninger", jf. helseforskningsloven (h) § 2. "Medisinsk og helsefaglig forskning" er i h § 4 a) definert som "virksomhet som utføres med vitenskapelig metodikk for å skaffe til veie ny kunnskap om helse og sykdom". Det er altså formålet med studien som avgjør om et prosjekt skal anses som framleggelsespliktig for REK eller ikke.

I dette prosjektet beskrives formålet som å få en dypere innsikt i menneskers eksistensielle situasjon, både gjennom deltagelse fra overvektige og helsepersonell som arbeider med overvektige mennesker. Hypotesen er at dette kan gi kunnskaper som har betydning for hvordan de som rammes kan bli møtt av helsevesenet, slik at helse fremmes.

Selv om dette er en helsefaglig studie og funnene i studien indirekte vil kunne gi en helsemessig gevinst faller ikke prosjektet inn under definisjonen av de prosjekt som skal vurderes etter helseforskningsloven.

Godkjenning fra andre instanser
Det påhviler prosjektleder å undersøke hvilke eventuelle godkjenninger som er nødvendige fra eksempelvis

Besøksadresse: MH-bygget UiT Norges arktiske universitet 9037 Tromsø
Telefon: 77646140
E-post: rek-nord@sesp.uit.no
Web: http://helseforskning.etikkom.no/

All post og e-post som inngår i saksbehandlingen, bes adressert til REK nord og ikke til enkelte personer

Kindly address all mail and e-mails to the Regional Ethics Committee, REK nord, not to individual staff

personvernombudet ved den aktuelle institusjon eller Norsk senter for forskningsdata (NSD).

Vedtak
Etter søknaden fremstår prosjektet ikke som et medisinsk og helsefaglig forskningsprosjekt som faller innenfor helseforskningsloven. Prosjektet er ikke framleggingspliktig, jf. hfl § *2.*

Klageadgang
Du kan klage på komiteens vedtak, jf. forvaltningsloven § 28 flg. Klagen sendes til REK nord. Klagefristen er tre uker fra du mottar dette brevet. Dersom vedtaket opprettholdes av REK nord, sendes klagen videre til Den nasjonale forskningsetiske komité for medisin og helsefag for endelig vurdering.

Med vennlig hilsen

May Britt Rossvoll
sekretariatsleder

Kopi til:anne.k.aarstad@uis.no; post@uis.no

Britt Marit Haga
Institutt for helsefag Universitetet i Stavanger
Ullandhaug
4036 STAVANGER

Vår dato: 11.10.2016 Vår ref: 50184 / 3 / HIT Deres dato: Deres ref:

TILBAKEMELDING PÅ MELDING OM BEHANDLING AV PERSONOPPLYSNINGER

Vi viser til melding om behandling av personopplysninger, mottatt 23.09.2016. Meldingen gjelder prosjektet:

50184	*Eksistensielle erfaringer ved å leve med overvekt*
Behandlingsansvarlig	*Universitetet i Stavanger, ved institusjonens øverste leder*
Daglig ansvarlig	*Britt Marit Haga*

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, 31.12.2017, rette en henvendelse angående status for behandlingen av personopplysninger.

Vennlig hilsen

Katrine Utaaker Segadal

Hildur Thorarensen

Kontaktperson: Hildur Thorarensen tlf: 55 58 26 54
Vedlegg: Prosjektvurdering

Dokumentet er elektronisk produsert og godkjent ved NSDs rutiner for elektronisk godkjenning.

Personvernombudet for forskning

Prosjektvurdering - Kommentar

Prosjektnr: 50184

FORMÅL

Denne kvalitative studien retter sin interesse mot menneskers eksistensielle erfaringer når en lever med overvekt og fedme. Prosjektet skal undersøke hvordan eksistensielle erfaringer/livsfenomener erfares og beskrives av personer som lever med overvekt og fedme, og hvordan de eksistensielle livsfenomenene beskrives av fagpersoner som arbeider med behandling og livsstilsveiledning i kommune- og spesialisthelsetjenesten. Studien vil rette oppmerksomheten mot pasientens erfarte lidelse, for å få kunnskap om hva som er essensielt for individet selv. Hensikten er å få en dypere innsikt i menneskers eksistensielle situasjon, noe som kan gi kunnskaper som har betydning for hvordan de som rammes kan bli møtt av helsevesenet, slik at helse fremmes.

INFORMASJON OG SAMTYKKE

Utvalget informeres skriftlig og muntlig om prosjektet og samtykker til deltakelse. Informasjonsskrivene er i utgangspunktet godt utformet, men vi legger til grunn at følgende endringer utføres:
- dato for prosjektslutt og anonymisering må rettes til 31.12.2017, jf. meldeskjema.
- ordet "innhente" bør slettes fra siste setning under "Hva innebærer prosjektet?", dette for å gjøre det tydelig at det er kun snakk om å registrere opplysninger fra personen selv og data om dem ikke hentes fra andre kilder.
- ordet "prøver" bør slettes fra fjerde setning under "Frivillig deltakelse og mulighet for å trekke sitt samtykke", da det ikke er snakk om innhenting av prøver i prosjektet.

DATAMATERIALETS INNHOLD

Det behandles sensitive personopplysninger om filosofisk/religiøs oppfatning, samt helseforhold.

TAUSHETSPLIKT

Vi minner om at det av hensyn til ansattes taushetsplikt, ikke kan fremkomme identifiserbare opplysninger om enkeltpasienter. Vi anbefaler at forsker minner informanten om dette ifm. intervjuet.

INFORMASJONSSIKKERHET

Personvernombudet legger til grunn at forsker etterfølger Universitetet i Stavanger sine interne rutiner for datasikkerhet.

PROSJEKTSLUTT

Forventet prosjektslutt er 31.12.2017. Ifølge prosjektmeldingen skal innsamlede opplysninger da anonymiseres. Anonymisering innebærer å bearbeide datamaterialet slik at ingen enkeltpersoner kan gjenkjennes. Det gjøres ved å:
- slette direkte personopplysninger (som navn/koblingsnøkkel)
- slette/omskrive indirekte personopplysninger (identifiserende sammenstilling av bakgrunnsopplysninger som f.eks. bosted/arbeidssted, alder og kjønn)
- slette digitale lydopptak

Personvernombudet

Til

Intern ID	Ephorte saksnr	Saksbehandler:	Dato:
2017/29	2017/549		16.08.17

Tilbakemelding på melding om behandling av personopplysninger i forbindelse med prosjektet;
«Eksistensielle erfaringer ved å leve med overvekt og fedme«

Det vises til innsendt melding om behandling av personopplysninger, med bilag.

Det vises videre til NSD sin tilrådning datert 11.10.16 der NSD tilrår at prosjektet gjennomføres.

Personvernombudet er enig i NSD sin vurdering av prosjektet og legger denne til grunn med like vilkår.

Personvernombudet i ..... ingen innvendinger til at prosjektet gjennomføres forutsatt at;

- Prosjektet godkjennes av klinikksjef før oppstart.
- Behandling av helse- og personopplysningene skjer i samsvar med og innenfor det formål som er oppgitt i meldingen, jf. personopplysningsloven § 11 c).
- Prosjektet gjennomføres i tråd med personopplysningsloven og helseregisterloven med Forskrifter.
- Prosjektet gjennomføres i henhold til vilkår satt av NSD, jf tilrådning av 11.10.16.
- Det forutsettes at en følger UIS sine rutiner for sikker lagring av prosjektdata.

Vennlig hilsen

....
Personvernombud

Kopi:
Klinikksjef

Britt Marit Haga

Fra: Siri Tenden Myklebust <Siri.Myklebust@nsd.no>
Sendt: tirsdag 16. januar 2018 08:34
Til: Britt Marit Haga
Emne: Prosjektnr: 50184. Eksistensielle erfaringer ved å leve med overvekt

Bekreftelse på status

Vi viser til statusmelding registrert hos personvernombudet 15.01.2018.

Personvernombudet har nå registrert 31.12.2019 som ny dato for prosjektslutt.

Utvalget ble opprinnelig informert om at opplysningene om dem skulle anonymiseres innen 31.12.2017. Vi gjør derfor oppmerksom på at ytterligere forlengelse ikke kan påregnes uten at utvalget informeres.

Ved ny prosjektslutt vil personvernombudet rette en henvendelse angående status for behandlingen av personopplysninger.

Med vennlig hilsen,
Siri Tenden Myklebust
seniorrådgiver | Senior Adviser
Seksjon for personverntjenester | Data Protection Services
T: (+47) 55 58 22 68

NSD – Norsk senter for forskningsdata AS | NSD – Norwegian Centre for Research Data
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