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Being a large body in activity: experiences of lifestyle change over an 18 month period

PhD dissertation

Bente Skovsby Toft

Health

Aarhus University

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You can't do anything with philosophy…

- might not philosophy… do something with us?
(Heidegger, 1961; 10)

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Paper 3

Toft BS, Nielsen CV & Uhrenfeldt L. Balancing one's mood: experiences of physical activity in severely obese adults.
In manuscript.

The papers were found in appendices A-C in the original dissertation, but are not attached in this version. The papers are planned for publication later this year.

Abbreviations

BMI	Body Mass Index
FGI	Focus Group Interview
GP	General Practitioner
HCP	Health Care Provider
PA	Physical Activity
PT	Physiotherapist
WHO	World Health Organisation

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Chapter 1

Introduction

Lifestyle intervention is found appropriate for supporting people who wants to establish long-term changes. In Denmark, a national centre for tax-financed lifestyle intervention exists at the Department of Lifestyle Rehabilitation, Horsens Regional Hospital, Central Region Denmark. The centre follows the national guidelines and the best available evidence and has an experience-based practice. The treatment is delivered by an interdisciplinary team of health care providers (HCPs). Physiotherapists (PTs) promote PA in a group setting with a variety of activities and types of exercises to provide patients with different experiences of bodily movement. The patients referred to intervention include severely obese adults, whose negative experiences of PA may make them inactive and require a holistic approach.

Based on three qualitative interviews studies, this dissertation explored severely obese patients' experiences of well-being or absence of well-being in relation to PA before, during and after lifestyle intervention.

Background

In this chapter, I present the connection between the discursive position and health challenges of living with severe obesity, receiving PA intervention and the knowledge gaps of patient's experiences of PA. This leads to the statement of the aims and research questions of the dissertation.

Discursive position

The word "obesity" has two different discursive positions; the bio-medical position of excess weight or the humanistic position of the patient's lived body (Nutter et al., 2016).
The discursive position of obesity is evident in language which replicates either a scientific tradition or humanness, i.e. epistemological or ontological language.
In general the term "obesity" is used to characterise the accumulation of excess body fat and is classified by body mass index (BMI), a person's weight divided by the square of the person's height. The words "morbidly obese" and "severely obese" specifically describe the most obese individuals, who are living with BMI of 40 kg/m^2 or more. The word obesity originally meaning "fattened by eating" and the word morbid belongs to the medical weight-centric discourse referring to death and disease (Nutter et al., 2016). The discursive position in this dissertation took its starting point in language informed by epistemological modes of thoughts and developed from using "morbidly obese" to using "severely obese" when communicating into the context of health care practice and research. The discursive position was further developed towards a merely ontological based language during the research process to describe the participants as "individuals with large bodies". Each discursive position raises different problems and different solutions (Nutter et al., 2016).
The discursive position is visible in the the prevailing bio-medical discourse of the Western societies, who present the problems of obesity in terms of biological dysfunction, diseases or risk factors, which can be prevented or cured (Booth et al., 2000) and the suggested solutions to obesity are weight loss and exercise (Tate et al., 2007). Great emphasis is directed at the health risks and problems of obesity (World Health Organization, 2000), which has led to a considerable interest in the processes of changing PA behaviour (Dalle Grave et al., 2013, Hills et al., 2013) by addressing physical, psychological and external barriers (McIntosh, Hunter & Royce, 2016) as well as techniques to increase PA levels (Olander et al., 2013). Little attention has been paid to the existential perspectives of being severely obese and how it may influence PA participation.

Severe obesity in a health context

According to the World Health Organisation (WHO), the incidence of obesity in general has grown worldwide and is perceived as an epidemic of great economic costs for the society (Finkelstein et al., 2012). Obesity is considered a public health issue involving a complex and incompletely understood disease (WHO, 2000). The prevalence of obesity in Denmark is similar to that in the rest of continental Europe (Seidell, 2007) and severe obesity, typically exists in a minority of a population (Seidell, 2000). In Denmark approximately 41,000 individuals are estimated to live with severe obesity (Danske regioner [Danish Regions], 2012). (See Table 1).

Table 1: Estimated numbers of severely obese female and males in the Danish population (2012)

	BMI 40-44 kg/m^2	**BMI 45-49 kg/m^2**	**BMI ≥50 kg/m^2**
Females	20,091	4,635	1,781
Males	12,326	1,679	251
Total	32,417	6,314	2,032

Obesity in general is related to age, gender, socio-economic status, nationality and race-ethnicity (Centers for disease control and prevention, 2012) and in Denmark obesity is more frequent among those outside the labour market with relatively low socio-economic status and short education and and living in rural areas (Hvass, 2014).

Specifically, severe obesity has been described as a chronic and relapsing condition, i.e. one that is slowly progressive and sustained (Booth et al., 2000)(Dalle Grave et al., 2010), with a 90% risk of weight relapse within two years after major weight loss (Wing, Phelan, 2005, Stubbs, Lavin, 2013). Being severely obese is classified as belonging to an "at-risk" group with reduced life expectancy (Ogden et al., 2014), increased severity of health problems (World Health Organisation, 2000) including impaired sexual functioning, body image dissatisfaction, depression and lowered quality of life (Sarwer, Steffen, 2015); moreover, obesity may be related to increased suicidal ideation (Behnezhad, 2018), suicidal behaviour and attempts (Wagner et al., 2013).

PA intervention for severely obese patients

This study is based on the patients living with severe obesity, as they experience higher disability and reduced health related quality of life than obese, overweight or normal weight individuals (Sirtori et al., 2012), and they are considered especially vulnerable to stigma and discrimination (Goldberg, 2014).

Therefore, specialised health care approaches to severely obese individuals are requested that incorporate interventions to reduce prejudice (Gloor, Puhl, 2016) and meet the various challenges these people encounter in life.

Severe obesity is associated with an increased prevalence of inactivity (WHO, 2014) and PA interventions aim to increase activity level among inactive individuals (Stubbs, Lavin, 2013) and have moved the focus away from a practice directed towards weight outcomes (Dikareva et al., 2016). It has been known for years that exercise is associated with improvement of secondary health outcomes that are independent of weight loss (Stubbs, Lavin, 2013)(Shaw et al., 2006). This is important for severely obese individuals, who are the most unlikely to obtain weight loss through PA (Christiansen et al., 2007), but are still most likely to obtain health benefits (Hills, Byrne, 2004) or weight maintenance through PA (Donnelly et al., 2009). PA standard guidelines for weight management exist (Danish Health and Medicines Authority/Sundhedsstyrelsen, 2012), but severely obese individuals may perceive the requirements of 60 min/day of moderate intensity exercise impossible to fulfil (Zabatiero et al., 2016). Thus, the guidelines are found inappropriate for people living with severe obesity (Hills, Byrne, 2006), and a revision of the guidelines has been suggested (de Souto Barreto, 2015). Using the guidelines as a goal in a literal sense may be unrealistic and lack an individualised and tailored approach to PA in severely obese individuals, and "small changes" to PA behaviour have been introduced (Hills et al., 2013).

Facilitators and barriers to PA

Obese individuals have numerous and complex weight related and/or non-weight-related barriers to PA (Zabatiero et al., 2016). Particularly, severely obese individuals may experience that weight stigmatisation becomes a barrier to PA (Vartanian, Novak, 2011). The assessment of PA barriers has been found to be a prerequisite for appropriate tailoring of behavioural PA interventions (Napolitano et al., 2011) because reducing barriers may be an effective way to increase patients' activity levels (Carroll, Dollman & Daniel, 2014, Coelho et al., 2015). Even with successful intervention with increased PA levels, maintenance of the higher levels of PA is an on-going challenge in most people, and the PA level often decline after intervention (Tate et al., 2007) just as weight is often regained despite intervention (Butryn, Webb & Wadden, 2011). Additionally, some barriers to PA seem to persist despite of weight loss and interfere with the experience of PA as a natural part of daily living (Stenmark Tullberg et al., 2017). The barriers related to existential suffering in relation to PA are unexplored in severely obese individuals' aiming for a sustained

healthy life. Furthermore, knowledge about existential facilitators in relation to experiencing comfortable, light-hearted and enjoyable activities is lacking.

A comprehensive systematic review and meta-synthesis of qualitative evidence on severely obese individuals' experiences of facilitators and barriers to PA provided a knowledge base for the empirical exploration of in-depth understanding of severely obese adults' experiences of PA. The experiences reported in the review were found to have an existential character of suffering and well-being. The review found that the experiences of a person´s own identity interacted with intersubjective and embodied dimensions of experience where suffering from discomfort and discontentment brought feelings of 'homelessness' in PA participation, and seeking 'homecoming' in one´s own identity was an important aspect of improving well-being in PA. Homecoming was used as a metaphor for becoming comfortable and content, aiming for a change or development of identity. In particular the idea of an ideal body size related to the individual's sense of self and seemed to affect the experiences of PA (Toft, Uhrenfeldt, 2015). Both the systematic review and additional qualitative studies showed an underrepresentation of males' perspectives. Most studies identified were on females only (Dikareva et al., 2016, Bowen et al., 2015, Denison et al., 2015) or with only few male participants (Danielsen, Sundgot-Borgen & Rugseth, 2016, Zabatiero J. et al., 2018).

Gender in healthcare

Gender-specific facilitators and barriers may exist, which would be beneficial to address in health interventions (Mosca, McGillen & Rubenfire, 1998). In Denmark marginalised subgroups of men, e.g. severely obese men, are identified as a specific population group when planning health initiatives (Danish National Board of Health, 2010). Risk factors may be related to stereotypical ‘masculine’ and 'feminine' behaviour (Hunt et al., 2007), meaning that health initiatives may benefit from challenging the "masculine" lifestyles that tend to result in men being less engaged with health and well-being issues than women (White et al., 2011). The gender differences are likely to occur in rehabilitation and may play a role for the outcomes of the rehabilitation (Côté, Coutu, 2010), therefore planned programs are suggested to take the socio-cultural roles and expectations for females and males into account to differentiate the interventions (Alexander, Walker, 2015). With regard to lifestyle intervention approaching different gender groups may establish effective techniques for improving recruitment to interventions and to address gender imbalances during intervention (Greaves et al., 2011). HCP must be aware of risk of enacting gendered norms when

recommending rehabilitation (Stålnacke et al., 2015, Colameco, Becker & Simpson, 1983) and recognise when they encounter patients' gendered requests, i.e. females more often request help and advice, whereas males request medical tests (Ahlgren, Hammarström, 2000).

Development of traditional interventions

PA participation and stigmatisation are interacting factors, and research points to a "weight bias" in the present health care approaches (Phelan et al., 2015), i.e. a stigma with detrimental effects on the health and well-being of individuals with large bodies (Lewis et al., 2011), e.g. avoidance of exercise as well as weight gain (Vartanian, Novak, 2011). The weight bias occurs when weight is positioned as being within individual control as presented in a bio-medical discourse (Nutter et al., 2016). Therefore, strategies for improving the care of and conversation with obese patients are needed (Phelan et al., 2015) to establish an ethical approach to uphold beneficence. The approach suggested is to view health and well-being as multifaceted instead of prescribing weight loss to patients (Tylka et al., 2014). The severely obese individuals may be affected by perceived stigmatisation and discrimination in the context of lifestyle intervention, which has been criticised for directing patients towards a morally acceptable way of living (Knutsen, Terragni & Foss, 2011). The health care practices counteracting obesity are found ethically dubious, and research regarding more complex and comprehensive approaches to health are emerging (Ulian et al., 2018). The discourse regarding PA and obesity has been claimed to include the societal values of self-responsibility and self-control that may lead health promotion into becoming a moral endeavour (Mik-Meyer, 2014). An increasing body of qualitative evidence is accumulating regarding the approach of ethical aspects of severe obesity and PA. The aim is to improve the interventions targeted towards individuals vulnerable to stigma and discrimination (Gloor, Puhl, 2016, Danielsdottir, O'Brien & Ciao, 2010) because it is acknowledged that major changes and great efforts are required to establish successful long-term behavioural changes (Ekkekakis, Lind & Vazou, 2010, Hill, 2009).

Through the humanistic lens, more nuanced approaches seem needed to prevent weight bias in health care practice (Phelan et al., 2015), which otherwise may cause harmful health consequences (Nutter et al., 2016). Severely obese individuals' experiences go beyond weight and physical abilities and may be a resource when aiming to increase PA level. Physical health cannot be addressed without addressing existential experiences of people living in the world among other people (Dahlberg, Segesten, 2010). Exploring the existential experiences of the severely obese

individuals may add to the existing bio-psycho-social research among these patients and provide novel understanding of their experiences of well-being. This may link treatment and prevention of obesity to the patients' everyday life and bring insights into inactivity that can guide HCPs. This dissertation is based on the assumption that it is possible to increase health and well-being without losing weight or exercising vigorously (Penney, Kirk, 2015) and that biological health and the existential experience of health must be understood in an entity (Dahlberg, Segesten, 2010).

Human experience of health

The experience of health includes a sense of well-being, which is usually hidden from us, concealed in the background of our lives. In phenomenology, the body and the world are intertwined, and it is impossible to separate our bodies from who we are and what we do in the world. Mostly, we live our body-world interconnection without paying much attention to the body (Finlay, 2011); however, in severely obese individuals the body may be constantly present in the mind and disturb well-being by constantly reminding them about discomfort and limitations (Gadamer, 1996). The physical, the psycho-social factors and the existential experiences must be understood in an entity by patients and HCPs, when striving for increased health and well-being. The experiences of health are related to who you are, how well you know yourself and how well you understand yourself and your interactions with others (Dahlberg, Segesten, 2010). Being severely obese may entail the feeling of being unable to move and unable to make true and valued choices in life in relation to existential questions, e.g. "What is a good life?"; "How do I live my life?" and "Do I spend my time in the right way?" (Alvesson, Sköldberg, 2008: 242). HCPs' and obese patients' collaboration and conversations are essential to prevent conflicting views on, e.g., responsibility for a healthy life (Malterud, Ulriksen, 2011).

Knowledge gaps in the existing literature are addressed in this dissertation. Severely obese individuals may live a sedentary lifestyle, but little attention has been paid towards understanding their perspectives of PA, and in-depth research on severely obese females' and males' experiences of facilitators and barriers to PA are poor. The severely obese individuals may benefit from undertaking PA, but may lack well-being in doing so, but research on severely obese patients' existential experiences of PA are non-existent. Obesity may persist after lifestyle intervention, but the process and the possibilities of establishing well-being in everyday life in the long run are unexplored.

Chapter 2

Aims and research questions

The overall purpose of this dissertation was to explore and describe adults' lived experiences and gender-specific aspects of being active, when living within a large body – before, during and after lifestyle intervention. The project had separate aims for each of the four studies. This leads to the methodology and methods chosen for exploration.

Study 1: Aimed to explore and describe adults' existential experiences of being active, when living within a large body – before and during a lifestyle intervention.
The research question was:

- How do severely obese adults experience PA before and during lifestyle intervention?

Study 2: Aimed to explore how severely obese adults experience being with others during PA.
The three research questions were:

- How do severely obese female and males address, talk about and refer to their experiences of being in relation to others during PA, while undergoing lifestyle intervention?
- What gendered experiences exist?
- What implications do such lifeworld experiences have for HCPs' practice?

Study 3: Aimed to explore severely obese individuals' experiences of being physically active in everyday life.
The three research questions were:

- How do severely obese females and males experience physical activity?
- What gender-specific aspects exist?
- What are their experiences 18 months after engaging in lifestyle intervention?

Chapter 3

In this chapter, I present the methodological and philosophical foundation in hermeneutic phenomenology, the hermeneutic process of understanding and interpretation, and elaborate on the selected theoretical framework. Finally, I present the design, context of the study and ethics.

Methodology

Qualitative research is suitable for approaching and understanding the human experience of a subject matter and to explore a few individuals' over a period of time. In qualitative research epistemology, methodology, and method are fundamental concepts (Carter, Little, 2007) and the ontology and/or different theoretical foundations can be added. Qualitative data generation is an interactive process with a relationship growing between the researcher, the participants and the subject matter (Manning et al., 1994), which is context sensitive (Holloway, Galvin, 2016).
The dissertation explores the hidden meanings of well-being and suffering, which are experientially lived and felt before they are consciously known by the participants in everyday life (Heidegger, 2002). The approach to patients' experiences of PA was founded in the traditions of German existential philosophy. It is mainly based on the ontology of being of Martin Heidegger (1889-1976) (Heidegger, 2002) and his philosophy of how the lifeworld is a way of being-in-the-world, a taken-for-granted world as experienced without distinguishing between subject and object (Finlay, 2011). Being-in-the-world comprises a seamless everydayness, i.e. everyday life is inescapable and experienced from day to day. Being and how an everyday being exist in the world is prior to biological, psychological or social categories (Heidegger, 2002). The experiences carry an already existing truth within themselves (Gadamer, 2013) and they are considered “The house of Being” (Heidegger, 2011:193), which enables insights and interpretation of different kinds of well-being within the individual (Mulhall, 2013). Heidegger's hermeneutic approach was further developed in the writings of Hans-Georg Gadamer (1900-2002)(Gadamer, 2013) on the phenomenon of understanding and correct interpretation. The four elements of the hermeneutic circle were consulted to "understand the whole in terms of the detail and the detail in terms of the whole" (Gadamer, 2013:302). According to the hermeneutic circle, understanding is elicited through language and interpretation of the spoken word by putting one's pre-understandings and prejudices at stake in a circular or spiral process of understanding of what is 'in-between' the known and unknown of the subject matter (Gadamer, 2013:306). This study is directed at understanding humans from a living "whole" of lifeworld experiences (Heidegger, 2002:148). Language is the medium in which understanding between people can be reached as the spoken word holds the

person's whole horizon of the subject matter. In dialogue the sharing of understanding can take place between my horizons and the participants' horizons. One's horizon is thought to include a historical and traditional based pre-understanding of the subject matter, which is essential for developing new understanding of the past and the present (Gadamer, 2013).
Being is fundamentally interlinked with time as an ever-present horizon for us which fuses with the experiences of the past and the future in a temporal mode of Being. A person's horizon is the field of vision that comprises everything what can be experienced from the perspective of the present, but the horizon is continuously developing and may enable an outlook beyond what is up at close in the present, and one's life should be viewed as a whole in a greater perspective. According to Gadamer: "experience is valid only so long as it is not contradicted by new experience" (Gadamer, 2013:358), and human beings are thought to bring mobility to life by always striving for 'becoming' by means of doing and being in this world (Heidegger, 2002).

In the process of coming to understanding a temporal distance between dialogues support the process of “filtering out the true meaning” (Gadamer et al., 1988:77) and enables a better identification of prejudices that may influence understanding because the most obvious may not be seen at close (Heidegger, 2002) and it is considered an advantage to distance oneself from the dialogue to promote a hermeneutic reflection (Gadamer, 2013). The temporal aspects hold a historical awareness that enable a different understanding of the participants' whole situation including the ever-changing experiences of PA (Gadamer, 2013). Although understanding is directed towards a fusion of horizons of the researcher's expert pre-knowledge and participants' human experiences (Gadamer et al., 1988), it is unlikely for a researcher to fully understand another's horizon (Gadamer, 2013).

Theoretical framework

In this section, I briefly present the theoretical framework which was part of my philosophical and methodological pre-understanding and which guided the data analysis in the search for existential meanings of well-being and suffering.
The theoretical framework is based on existential philosophy and an elaboration of the experiential modes identified by Heidegger (Galvin, Todres, 2013). The framework presents six domains of the lifeworld: space, time, relations, mood, identity and embodiment as a set of interrelated dimensions or domains to approach and understand in 'wholeness'. These lifeworld domains are balanced between dwelling, mobility and dwelling-mobility (Todres, Galvin, 2010) and provide a total of 36

variations of well-being and suffering (Galvin, Todres, 2013). According to the framework mobility in well-being is to seek the freedom and possibilities of movement with regard to meaningful life projects, i.e. a sense of movement towards development and future horizons. Dwelling in well-being is a kind of settlement or "letting-be-ness" (Heidegger, 2001:55), i.e. feeling of peace in the present situation. The metaphor of homecoming is understood as well-being in our daily lives and a way of being-at-home with what has been given; feeling comfortable and content in one's present situation. Human beings who suffer can still find possibilities for well-being and a good life (Todres, Galvin, 2010), when finding home within the homeless (Galvin, Todres, 2013). The lifeworld domains implicate one another and interact by the way they are foregrounded as lifeworld experiences, i.e. they are dynamically intertwined and layered and always in relation to one another (Todres, Galvin, 2010) .

Design

The dissertation consists of three empirical studies and has a longitudinal research design (Balmer, Richards, 2017) with a series of repeated individual interviews and repeated gendered focus group interviews (FGIs) conducted in rounds within a sample of participants over an 18 month period of time. (See Table 2).

Table 2: Study design

Study 1		**Study 2**		**Study 3**
Individual interviews (n=16)	Individual interviews (n=10)	Focus group interviews (n=2)	Focus group interviews (n=2)	Individual interviews (n=10)
Prior to first admission	After the last admission	During first admission	During last admission	18 months follow-up
Summer 2016	Winter 2016	Summer 2016	Winter 2016	Winter 2017

The longitudinal design was chosen to allow the exploration of the temporal dimensions of the phenomenon of interest in a relatively small group of individuals, e.g. changes and continuities in their lives as well as changes in put forward in the two rounds of FGI with the gendered groups (Balmer, Richards, 2017). Moreover, the engagement with participants over time should provide the possibility of building a relationship with potentially vulnerable participants.

Context of the study

The empirical data generation was conducted in Denmark, where lifestyle interventions for severely obese individuals are situated in the health sector. Treatment is mainly guided by a medical paradigm (Penney, Kirk, 2015) and include goal setting, identification of factors facilitating or hindering the achievement of goals, and a plan for making behavioural changes (Foster, Makris & Bailer, 2005).

The Department of Lifestyle Rehabilitation at Horsens Regional Hospital, Central Denmark Region, Denmark is a national public tax-financed service for adults. Each year approximately 600 patients, of which 80% are estimated to be overweight or obese, undergo intervention. The intervention is not specifically designed for patients living with severe obesity, but is targeted towards patients living with complex life situations and health challenges, e.g. chronic diseases, multi morbidities and/or psychosocial problem. In the general public, they would be called "lifestyle diseases".

The patients are referred by general practitioner (GP) with the purpose to promote healthy living and prevent disease, e.g. to increase PA level or lose weight; however mental and social health are also approached. To be referred to lifestyle intervention, patients' must be mobile and able of taking care of their own personal hygiene. The intervention is a residential intervention with three modules consisting of four days of hospital stay during a six-month period. Health promotion and prevention treatment is directed towards behavioural factors (diet, smoking, alcohol and physical activity) and human factors such as competences, respect, accept and coping (Thybo, 2016). Identification of own values, goal setting and planning are important aspects of the intervention, which are revised via a collaboration between patients and HCP in telephone counselling between modules. Between modules, patients are expected to practice the planned lifestyle changes in everyday life. The intervention is primarily based on group activities, discussion and exercise combined with individual counselling and/or coaching. The group formation is based on diagnosis, i.e. obese individual may be distributed into groups of non-obese patients if admitted with diagnose such as diabetes or cardio-vascular disease. At the end of each module a discharge summery is sent to the GP to enable follow-up actions.

The interdisciplinary team of HCPs consists of registered nurses, nutritionists, occupational and physiotherapist and cognitive psychologists. The HCPs use Motivational Interviewing (Miller, Rollnick, 2013), Acceptance and Commitment Therapy (Hayes, Strosahl & Wilson, 1999) and systemic coaching (Moltke, 2009) as a communication tools.

The PA intervention offers a palette of in-door and out-doors activities including hot pool, playful games, structured and purposeful exercises as well as yoga and mindfulness.

Ethics

In this section, I present my ethical considerations in relation to preparing and performing the interviews including my relationship with the participants and the ethical approvals.

Relationship with participants

In the hermeneutics process of searching for new knowledge, I was personally and actively involved in the data generation, e.g. through the relationship with the participants. A positive relationship was considered of great importance for getting access to their experiences through the research interview (Brinkmann, Kvale, 2014). A prerequisite establishing a relationship and gaining access to their experiences of PA was that the research topic was found interesting and important to the participant (Kvale, 1983) and that I could take on the role of an attentive listener. This was done by being aware of how I could ask for further descriptions of the participants' experiences or use of pauses and probes to facilitate their talking (Krueger, Casey, 2009). Hearing is a constituent of talking and involves silence (Inwood, 1999), and I aimed to listen with increased sensitivity to interpret the participants' world beyond the spoken word to understand implicit meanings and contradictive statements (Kvale, 1983). During the interview I strived to pay attention to the participants' emotions through eye contact and by observing their facial expressions (Churchill, 2012); this added to my interpretation of the spoken word as did the manner of speaking, the tone of voice, the tempo and the circumstances in which a word was spoken (Gadamer, 2013). 'Being-with' the participants entailed sharing emotional moments, e.g. sadness, and crying would affect the interview situation because it would influence on breaks and questions.

My role in the FGIs was different. As a moderator, I led the dialogue by introducing the topics for discussion and keeping the conversation on track and making sure everyone had a chance to share their experiences, e.g. by inviting a silent man into the discussion (Krueger, Casey, 2009). The use of pictures influenced on the dynamics of the discussion and made my role less dominant in the second FGI.

After each interview, I made reflective commentaries on my non-verbal experiences, including my observations of the participants' and and my own emotional state. The notes were considered part of the data that contributed to the sense of the whole (Brinkmann, Kvale, 2014).

Ethical approval

The study was performed in compliance with the Helsinki Declaration (World Medical Association, 2002) and the standards of responsible research (Aarhus University, 2015). The project was approved by The Danish Data Protection Agency (J. no. 1-16-02-425-15)(Appendix E). The empirical studies did not require ethical approval by The Central Denmark Region Committees on Health Research Ethics due to the qualitative inquiry.

Methods

In this section, I present the process of data generation with regard to preparing and preforming the qualitative interviews including the interview guides. Moreover, I describe the sampling and recruitment process.

Preparing and performing qualitative interviews

To Gadamer, hermeneutics was purely philosophical, and he found understanding posited as the fundamental mode of being for humans (Gadamer, 2013). Inspired by Gadamer's skepticism against fixed methods in human science, I aimed to meet the phenomenon of interst with an openness and flexibility, and used five steps to guide the process; 1) decide upon a question, 2) identify pre-understandings, 3) gain understanding through dialogue with participants, 4) gain understanding through dialogue with text and 5) establish trustworthiness (Fleming, Gaidys & Robb, 2003).
Reporting the steps used:
Step 1) The research questions in this dissertation were raised to develop an understanding of the unknown and strange aspects of the subject matter by allowing the participants' horizon to immerse in the dialogues (Gadamer, 2013). When deciding upon a question I was not naive about the world of the participants. In fact, in order to ask questions I benefitted from having some understanding of the phenomenon of interest and the questions posed were based on my pre-understandings or fore-structures of understanding obtained by being with severely obese patients in PA (Heidegger, 2011). In Heidegger's words "Every inquiry is a seeking. Every seeking gets guided beforehand by what is sought" (Heidegger, 2002:24).
To start with, I will retell a personal anecdote representing the questions, which initiated the research topic of severely obese patient's facilitators and barriers to PA:

> *"I had repeatedly been in the gym among patients with large bodies and watched them play and exercise. It made me wonder: What is the reason for their having a good time? It was obviously not only a matter of body size determining the enjoyment of movement…or why they avoided participation".*

My questioning holds both a personal and a professional interest in understanding the severely obese patients' experiences of PA by assuming that experiences are complex and relevant to understand in order to meet patients' needs in health care practice (Koch, Vallgårda, 2008)

My reflections made it clear that it was appropriate to know more about what was considered pleasant and fun and what was to be avoided, so I decided to explore the patients' experiences of well-being or suffering in relation to PA by asking about their perspectives. In that way, I already had a pre-understanding of the topic in question, which was the starting point for further understanding (Gadamer, 2013).

Step 2) I strived to identify my own pre-understanding from a theoretical, professional and personal stance as well as philosophically.
My theoretical pre-understanding was originally developed through being educated in sports science and physiotherapy, which predominantly hold biomedical scientific perspectives (Praestegaard, Gard, 2013); however it provided me with broad concepts of PA and a gendered approach to sports. Additionally, the humanistic perspectives of health and well-being were gained from empirical studies and theoretical literature in health science. My professional pre-understanding was based on experiences from years of engagement in lifestyle intervention and rehabilitation in my role as of a physiotherapist, where training, teaching and talking to a considerably number of severely obese patients was a part of the scope of my practice (Nicholls, Gibson, 2010). My personal pre-understanding was formed from the perspective of a middle aged and non-slim woman with a moderate sporty identity. In Gadamer's conceptions of hermeneutical experience, research is lived by researcher because understanding is a mode of being (Smythe et al., 2008), which made the awareness of my own belonging to the world and my relationship with others relevant (Gadamer, 2013). Therefore, to better understand the participants' horizons through the dialogues, I expected to meet and be open to their 'otherness' and was prepared to let my own pre-understanding become discernible through confrontation with their horizons (Gadamer, 2013). Through the interplay of the whole and the parts in the hermeneutic circle, my prejudices that may lead to misunderstandings were sought to be filtered out by me asking questions to reveal if my interpretation was sound (Debesay, Nåden & Slettebø, 2008).

Moreover, my pre-understanding was enacted when conducting the interviews, e.g. deciding on the questions to ask, choosing images for the FGIs related to both 'doing' and 'being', and as well as selecting meaning units in the transcripts for analysis and quotes to illustrate the findings (Sandelowski, 1994).

Step 3) Understanding the participants' lifeworld through continuous dialogues was thought possible as our being-in-the-world may become manifest and understood through language

(Heidegger, 2001). The combination of individual qualitative research interviews and FGIs were chosen to understand the world from the participants' point of view, i.e. their horizon, and I sought to capture and unfold the phenomenon of being severely obese and physically active in its existential meaning without reducing its complexity (Brinkmann, Kvale, 2014). Every experience has implicit horizons, but a prerequisite for me to access the participants' present horizons was to get their consent to openly and willingly share their experiences in dialogues conducted in an individual and a group setting (Gadamer, 2013). The sharing of experiences built on a trustful relationship between me and participants and among the participants in the group setting (Heidegger, 2002), that allowed the participant to speak freely and made it feel natural for me to put my pre-opinion and prejudice into play (Gadamer, 2013). Letting horizons meet repeatedly in both individual and focus group interviews was a way of identifying, challenging and expanding my and the participants' previous understanding as a mutually related movement. The conduction of interviews is considered a craft that cannot be learned through fixed methods (Gadamer, 2013), my experiences with regard to establish relationships and conduct dialogues with patients may be an advantage for the quality of the research interviews.

Step 4) Gaining understanding through dialogue with text was done through the interpretation of the transcripts. The transcripts were used as a means for preserving the shifting horizons as well as my own and were interpreted in a circle of dialectic of question and answer. Dealing with a text was similar to the effort to come to an understanding during the dialogues (Gadamer, 2013). A more detailed stepwise description of the interpretation of the individual interviews is provided in the "Data analysis"-section.

Step 5) The establishment of trustworthiness was sought in more ways through the research process. My horizon of the present was in a constant process of being formed and to establish trustworthiness and avoid a reproduction of my previous knowledge, I reflected upon how my pre-understanding may influence the data analysis and research findings (Gadamer et al., 1988). I continuously strived to make active evaluations of my own experiences, location and stance in relation to meeting the participants' horizon (Finlay, 2011) and to judge how my interaction with the research could become a resource (Holloway, Galvin, 2016). Regular dialogues with research supervisors kept me thinking and struggling to understand. The dialogues helped me to identify changes in my pre-understanding (Smythe et al., 2008) and findings of the interviews were discussed and challenged by co-authors.

Practically, I started by describing my prejudices with a critical attitude in relation to the health, obesity, PA and lifestyle as well as the aim and the intentions of the research. I prepared the interview guides and conducted the interviews with questions reflecting my present understanding; thereafter I revised questions in the interview guides in accordance with newly gained understanding (Gadamer, 2013).

Interview guides

As mentioned above, the interviews were based on interview guides, which were developed prior to each individual interview (Brinkmann, Kvale, 2014) and FGI round (Krueger, Casey, 2009) in collaboration with co-researcher with the purpose of focusing and facilitating the interviews. According to the interview guides, an initial briefing was undertaken to establishing contact with the participants through small talk and to introduce the interview session and the purpose of the study (Brinkmann, Kvale, 2014). Agreements were made with regard to time limit, the use of recording equipment, anonymity and confidentiality of data, and all participants signed the informed consent forms (Appendix F) at the start of the first interview. In the briefing for the FGIs, the ground rules were agreed on, e.g. to speak individually, not to interrupt or speak over each other, preserve confidentiality among participants and ask questions afterwards, and finally my role as a moderator was explained (Krueger, Casey, 2009).

The individual interview guides (Appendix G) were built upon the aims of the study and the theory of six lifeworld domains including the specific findings from a literature review (Toft, Uhrenfeldt, 2015). The interview guides held open-ended questions and served mainly as preparation for the interviews in order to structure and guide questions and enable active listening in an informal way (Dempsey et al., 2016). I tried not to confuse the focus of the research by sending adverse messages; questions regarding participants' specific weight status were deliberately left out. Insights gained in the interviews informed the following interview guide in relation to identifying topics to be explored in greater depth with the participants in the next interview. The overall focus of the interviews developed over time from being focused on experiences of PA towards existential experiences of being active. For the third individual interview, two figures illustrating preliminary findings from the first and second individual interviews were made (See paper 3), then shown to the participants to get their comments (Kvale, 1983).

As a preparation for the FGIs the participants' thinking was facilitated by asking them beforehand to be aware of their experiences of being active with others (Morgan, 1997). The questions in the

interview guide for the first FGI (Appendix H) were phrased and sequenced to be easily understandable and logical to the participants to encourage the participants to answer the questions spontaneously (Krueger, Casey, 2009). The second round FGI was based on the "picture sorting" method (Colucci, 2007), and the procedure was implemented in the interview guide (Appendix I) as a step-by-step description with additional questions for discussion. The use of pictures was chosen to increase the involvement and participation in the discussion in a more reflective and enjoyable way, assuming it could add breadth to the research findings gained from individual interviews as images are often more concrete and tangible than spoken language (Colucci, 2007). The pictures were a combination of images related to "being" (Who am I?) and images associated with various types of movement and exercise. The pictures illustrated different situations, places or items with or without people in them (Engelund, 2012). The picture sorting method was piloted with patients before its use in the FGI.

Finally, at the end of each interview an informal debriefing was held with the recorder turned off (Brinkmann, Kvale, 2014). After the individual interviews, I aimed to get a sense of the participants' emotional state by remaining a short time and asking them how they felt, if they had questions and to get permission to contact them again. After each FGI refreshments were served and the participants stayed and engaged in small talk before leaving the room.

The duration of the first and second individual interviews was about 60 minutes, and the third interviews lasted on average for 50 minutes. The FGIs lasted for 90 minutes each. All interviews were audio recorded, and the FGIs were video recorded with one stationary camera in the room to enable review of the person speaking, the group interactions and my moderation of the FGIs (Morgan, 1996).

Sampling and recruitment

At the initial stage of the study, 16 participant equally distributed between gender were purposefully sampled from a waiting list of referred patients awaiting admission to the treatment programme (Coyne, 1997) according to the inclusion and exclusion criteria.

The inclusion criteria for participation were:

- Adults ≥18 years
- BMI≥40 kg/m^2
- Referred to lifestyle intervention

The exclusion criteria were:

- Serious psychiatric conditions, such as schizophrenia or psychosis
- Poor Danish language skills, such as unable to understand and to speak Danish

Data on body weight were only used for the inclusion process, as emphasis was on the participants' experiences rather than on physical measurements. Therefore, the study did not include measurable parameters, e.g. weight, diagnosis, medicine, other than those coincidentally mentioned by the participants during the interviews.

Patients were selected for the purpose of the study through a gate keeper, who contacted potential participants by telephone (Dempsey et al., 2016). The gate keeper was an experienced department secretary, who knew me, the aim and scope of the project as well as the group of severely obese patients and their potential vulnerabilities. She willingly provided access to suitable participants in accordance with the inclusion and exclusion criteria of the project and distributed oral and written information (Appendix J) about the research project prior to getting permission for me to make contact. Patients who accepted to be interviewed were contacted by telephone by me and asked to confirm or refuse participation, and they received an invitation letter with practical information and contact information (See example Appendix K). The time and location for the individual interview appointments were determined by the participants to make it most suitable and comfortable for them.

The two rounds of FGIs were conducted during or immediately after a module in a meeting room at the hospital. Repeated FGIs using different methods were chosen to provide rich data. The participants had met as they followed the same intervention program and have mutual experiences before the first FGI. Four gender segregated group of four to eight participants were planned to ensure an ideal numbers of participants (Jones, Brown & Holloway, 2013), who had previously been included for the individual interviews, hence they knew me beforehand. The groups were constructed with heterogeneity in regard to age, family status, education, housing and place of living (Morgan, 1997). Gender segregation was performed to increase homogeneity and provide comfort in discussing of personal and sensitive topics as well as to enable the identification of similarities and differences between the groups (Morgan, 1997) as topics for discussion may differ by gender (Côté, Coutu, 2010).

Data analysis

In this section, I present the process of the two data analysis methods of the individual interviews and the FGIs.

All interviews were transcribed verbatim. The individual interviews consisted of 610 pages of transcribed text, and the FGI transcripts 131 pages (all in Danish). Data were collected, transcribed and analysed in Danish, and selected extracts were translated into English for the development of themes and writing up of the findings as well as to enable the collaboration with an English-speaking researcher and co-author.

Data analysis was conducted step-wise (See example Table 4) with a contemporary horizontal and vertical movement through the whole and the parts of data. Previous data was considered an important contribution to the sense of whole (Kvale, 1996). An open phenomenological approach to the meanings of a phenomenon in the everyday world was sought through meaning condensation. The method involved a condensation of the expressed meanings into more and more essential meanings, which were discussed in relation to the theory of well-being and suffering (Kvale, 1996). The meaning condensation built on coding and entailed abridgements of the meanings expressed by the participants into shorter formulations. Long statements were compressed into briefer statements in which the main sense of "what is said" was rephrased in a few words close to the participants' everyday language (Brinkmann, Kvale, 2014). Reflections of the meaning units were taking up the more or less hidden meanings of PA in relation and the research question and watching it as a figure against a background of other meanings such as body weight and size (Dahlberg, 2006). After the last step and in-depth descriptions of the participants' existential experiences of PA, excerpts of the transcripts were chosen to illustrate and validate these findings (Sandelowski, 1994).

Breadth description (Todres, Galvin, 2005) supplemented the view of the whole twice: after the first round of individual interview to get a broad sense of the multiple levels of tasks and challenges that characterised the group of severely obese individuals, and after the last round of individual interviews to sense each individual's personal journey through 18 months.

Table 4: Stepwise data analysis based within a hermeneutic understanding (Kvale, 1996)

Step/ Analytical unit:	**1) Spoken language (Interview/ text transcripts)**	**2-3) Transcripts (language close to the words of the participants)**		**4) Condensed meaning units**	**5) Reformulated statements**	**Themes and the sense of the "whole"**
Reaching for:	The sense of the whole	The selection of meaning units according to the aims of the study	The condensation of long statements	The reflections of the meaning units to the research questions	The development of sub-themes and themes	The essential meaning of the participants' voices
Movement:	Repeated listening/reading of all individual interviews with openness to their horizon	Determining and abbreviating natural meaning units	Reducing meaning units as simply as possible with no prejudice	Reformulating by seeking meaning	Tying essential, non-redundant themes of one and all interviews together	Extensive interpreting and theoretical analysis of parts and whole
A new whole:	Breadth descriptions across all the first individual interviews	Dominant meaning units (of what stands out)	Condensed meaning units	New phrases related to the phenomenon of interest	Description of the statements as themes	In-depth descriptions of the participants' experiences

The analysis of language of the FGI transcripts was conducted through what we established as three concepts for our inquiry in regard to what the participants addressed, talked about and referred to. In that way we combined experience language, the spoken words and knowledge language. "Address" was used to identify what the participants designated as "the subject matter", when openly asked about their experiences and horizons of PA. "Talk" was the explicit spoken words directly used and reproduced in the transcripts excerpts as meaning units, which were related to a meaningful whole. I perceived the meaning units and quotes to include the worldview behind them as the spoken language was thought to represent the individuals' thoughts (Gadamer, 2013). "Refer" was the part of the analysis based on experience and knowledge, i.e. interpretation through interaction with my pre-understanding of the subject matter including the framework of well-being and suffering.
The analysis was conducted one FGI at a time in relation to step 1 and 2 and merged in step 3. First round FGI was analysed before round two, which enabled an elaboration of the findings in the second round.

Chapter 4
Findings

In this chapter, I briefly present the findings of studies including participants' characteristics and contribution and drop-out. I elaborate on how the studies add to and supplement each other by covering and interacting with the six lifeworld domains of well-being and suffering. The findings are synthesised and illustrated in a figure.

Participants

The initial inclusion counted 16 participants. All were Caucasians and native Danish speakers. The females (n=8) were aged 27-59 years (median 38) with a BMI of 40-48 kg/m^2 (mean 41) and the males (n=8) were aged 25-68 years (median 47) with a BMI of 41-55 kg/m^2 (mean 44) at the time of inclusion (See Table 7).

Table 7: Characteristics of included participants and interview participation

Female/Male	Age/ year	BMI/ kg m^{-2}	Individual interview 1,2 and 3	FGI1 and FGI2
F	27	40	1	
F	30	40	1+2	1+2
F	30	40	1+2+3	
F	35	42	1+2+3	1+2
F	41	48	1+3	1+2
F	53	40	1	
F	55	46	1+2+3	1
F	59	43	1+2	
M	25	47	1+2+3	1+2
M	39	43	1	
M	42	55	1+3	1
M	45	44	1+2+3	1+2
M	49	42	1	1
M	53	41	1+2+3	1
M	60	45	1+2+3	1
M	68	46	1+2	1+2

The participants' educational level was mainly at low (compulsory schooling) or middle level (high school, craftsman, or clerk). Only one female had a high level of education (academic degree) (Eurostat, 2017). The males were generally less educated that the females. Two of the females were employed, whereas four of the males were full time, part time employed or studying. The remaining participants were on early retirement/retirement, on sick leave or unemployed. In each paper the specific participant is further characterised.

The number of participants varied within each study due to drop-out (See Table 8). Additional, three females (aged 30-57) and one male aged 61 were included in the second FGI among the patients currently admitted at the hospital at the time of the FGI.

Table 8: Number of participants in the empirical studies

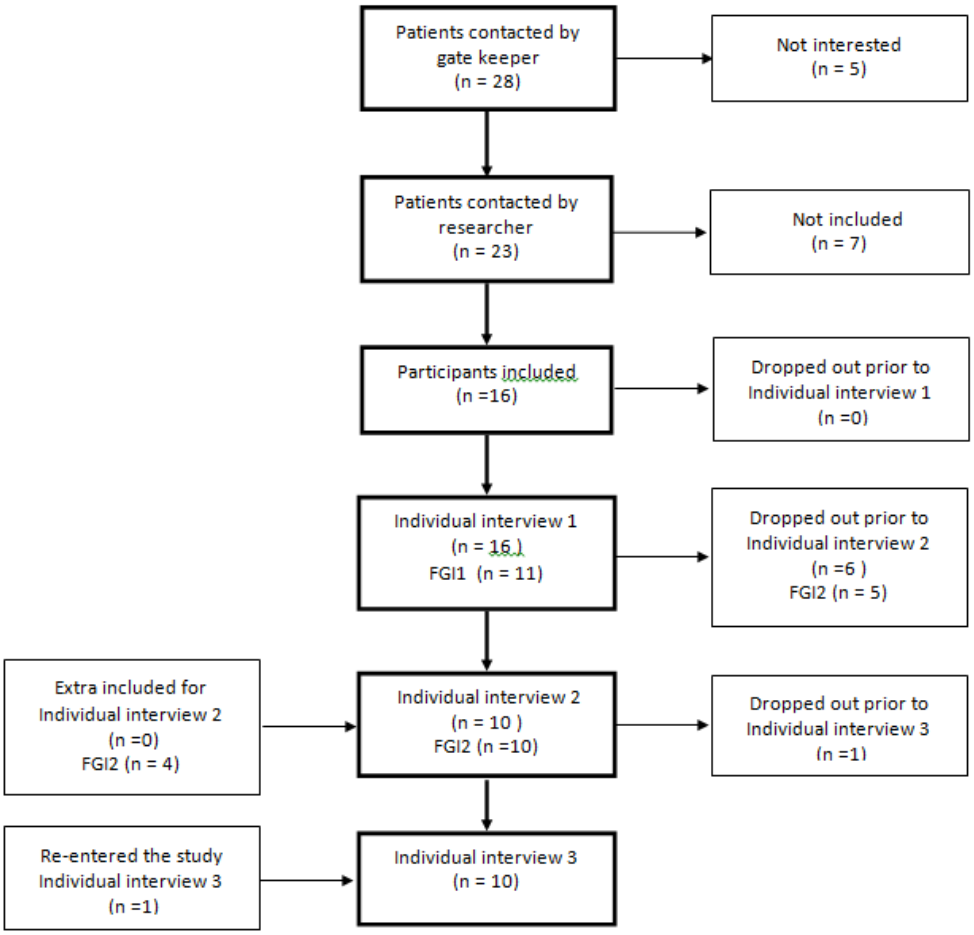
	Participants individual interview			FGI participants	
#	1	2	3	1 (FGI1)	2 (FGI2)
Females	8	5	5	4	6
Males	8	5	5	7	4
Total	16	10	10	11	10

The flow of participant is shown in Figure 1.

Drop-out

Six participants dropped out after the first individual interviews for the following reasons: lacking interest; not feeling within the target group of severely obese; planned surgery, pregnancy, and one remained unknown. Drop-out of the study was mainly seen among the participants with a low level education. Five of the six who dropped out stated present or previous stress and/or depression symptoms. Drop-out from the FGI was due to the following reasons; personal issues, change of hospitalisation dates or not present at the time of the FGI (paper 2). Because of drop outs from the FGIs, an additional inclusion of participants was required for the second FGI to ensure an adequate group size of minimum four participants (Jones, Brown & Holloway, 2013). Prior to the third individual interview one female dropped out due to bad mental condition, whereas one female with previous bad mental condition had recovered and re-entered the study (See Figure 1).

Figure 1: Diagram of participant flow and drop-out



Findings paper 1

Paper 1 titled: "Being active when living within a large body: experiences during lifestyle intervention" aimed to explore and describe how severely obese adults existentially experience being active before and during a lifestyle intervention.

Before intervention the starting point for the participants was characterised by suffering in their present situation, i.e. feelings of hopelessness, powerlessness and loneliness. A male stated, what could represent the feelings of several participants by saying that he felt like "a man who hates himself, his looks, and his life". The suffering provided the mobility to engage in lifestyle intervention as "a last possibility" as failure in previous attempts to live healthy had failed. However, acknowledging own incapability to escape from 'living in a downward spiral' was experienced as a defeat. The downward spiral was characterised by feelings of failure and exhaustion as well as shame and lowered mood; and the feelings of being thwarted in being active. During the six months of intervention experiences of suffering persisted, however new experiences and being active with others brought experiences of fun, enjoyment, contentment and harmony. The experiences brought well-being in terms of a better balance of dwelling and mobility, which influenced on the participants engagement in activities and priority of own needs.

The study revealed existential issues in relation experiences of being active when living within a large body with in-depth descriptions of their development of self, regarding fighting, settling or giving up upon PA. The findings pointed to possibilities of well-being or relief of suffering in relation to be physically active during lifestyle intervention.

The findings on the participants lived relationships confirmed the relevance of further exploration of the intersubjective dimensions of being active in paper 2, and findings related to mood and hope informed paper 3.

Findings paper 2

Paper 2 titled: "Severely obese adults' lifeworld experiences of being with others during physical activity: a gendered focus group study" aimed to explore how severely obese females and males address, talk about and refer to their experiences of being active with others while undergoing lifestyle intervention, and what gendered experiences existed and what implications lifeworld experiences could have for HCPs' practice.

The study found that intersubjective experiences developed the patients' judgment of own values and possibilities for well-being while being active with others. The feeling of belonging among

peers during the intervention offered a temporal relief of loneliness by feeling comfortable and safe among others and relieved the embarrassment of one's embodied deficiencies. Suffering in intersubjective experiences was related to feeling pressurised to participate and feeling a 'moral obligation of being active' in order act responsibly. The participants told how they would compare themselves to others of the same gender and how they felt judged by appearance by others. Moreover, spatial experiences, e.g. experiences of certain places and environments, emerged to be linked to the intersubjective experiences of well-being or suffering. Aversion towards other people and places would make some avoid PA participation and some would stay at home to protect themselves from embarrassment and shame.

Different topics were discussed among females and males and they had different ways of talking about being active with others. The gender differences provided a new understanding of experiences presented in the individual interviews. The findings indicated that the experiences of being active and the process of lifestyle change may be gendered and therefore relevant for further exploration in paper 3.

Findings paper 3

Paper 3 titled: "Balancing one's mood: experiences of physical activity in severely obese adults" aimed to explore how severely obese females and males experiences PA and what gendered experiences exist 18 months after engaging in lifestyle intervention.

The participants foregrounded experiences of 'fluctuating mood' to influence on their ability to outlive their intension of healthy lifestyle. Mood was continuously balanced between well-being and suffering. Elevated mood influenced on energy and vitality, faith in own efforts and future hope, whereas lowered mood mainly was due to defeats of the past and present worries. The experiences of mood influenced the individual's capability to enact the intensions of preserving an active living in everyday life. Being mobile and active was wanted and well-being was experienced when feeling capable and content when being physically active.

The findings were an expansion of the understanding in paper 1, where being active was linked to fighting, settling and giving up and feelings of lacking energy and lowered mood. In that way the experiences of mood held the temporal aspects of past, present and future. Mood was most important for staying or becoming active. The females and the males had different experiences of dwelling and mobility in life. The females expressed great appreciation of the process of lifestyle change, which brought well-being. The males also experienced increased well-being, however they seemed to struggle to balance healthy and joyful living in order to fulfil their own and others

expectations. Everyone experienced being disappointed by themselves or others from time to time. The study found that sustained lifestyle changes were depending on the capability of staying in an on-going process balancing well-being and suffering in mood. Being active was challenged by life's changing conditions and circumstances, which required continuously adjustments in relation to expectations, efforts and need of support.

Synthesised empirical findings

I this section, the findings from papers 1, 2 and 3 are synthesised to show the interacting lifeworld domains in relation to experiences of being active over an 18 months period.

Experiences of well-being and suffering were found within all six lifeworld domains: spatiality; temporality; intersubjectivity; mood; identity and embodiment across the three studies. The papers contributed in different ways by foregrounding well-being and suffering within the different domains.

The characteristics of severely obese females' and males' experiences of well-being and/or suffering are briefly listed below within each of the lifeworld domains (*in brackets*) in accordance with the theoretical framework of different kinds of well-being and suffering (Galvin, Todres, 2013) to provide further insights into existential experiences of living within a large body and being active.

The well-being experiences described by the female and male participants were related to:

1. Places associated with feeling **safe** and relaxed (*spatiality*). (Presented in paper 2).
2. Feeling **in progress** and finding new challenges meaningful (*temporality*). (Presented in paper 1 and 3).
3. Feeling the **courage to participate** and the ability to reduce loneliness by engaging with other people (*intersubjectivity*). (Presented in paper 1 and 2).
4. Feeling **desire** and in possession of **energy** and harmony (*mood*). (Presented in paper 1, 2 and 3).
5. **Pride of self** in feeling capable and successful in doing and being (*identity*). (Presented in paper 1 and 3).
6. Feeling **vitality in life** in terms of bodily strength and power to do joyful activities in everyday life (*embodiment*). (Presented in paper 1, 2 and 3).

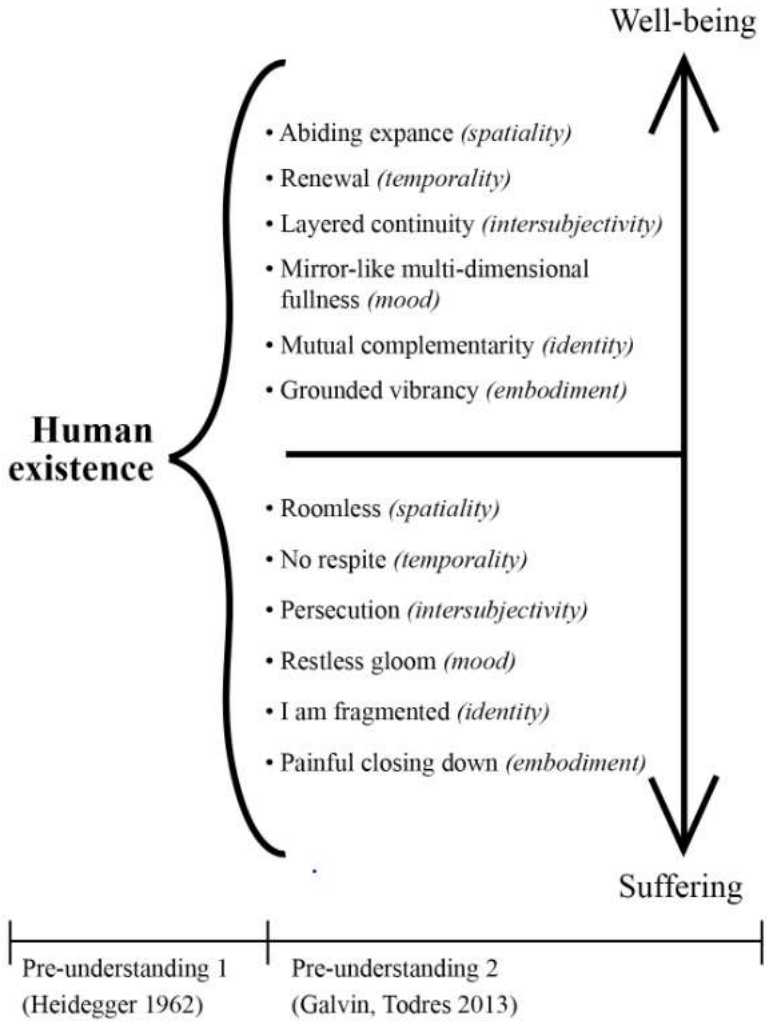
The suffering experiences described by the female and male participants were related to:

1. Feeling **unwelcome**, isolated and uncomfortable in the room (*spatiality*). (Presented in paper 1 and 2).
2. Feeling **hopelessness** in being stuck and unable to make changes (*temporality*). (Presented in paper 1).
3. Feeling **shamefulness** and loneliness due to fear the humiliation of being judged flawed and imperfect (*intersubjectivity*). (Presented in paper 1, 2 and 3).
4. Feeling depressed mood, **weighed down** and restless (*mood*). (Presented in paper 1, 2 and 3).
5. Feeling **fear of failure** due to being useless, incompetent and defined by weight (*identity*). (Presented in paper 1 and 2).
6. Feeling **exhaustion in efforts** due to powerlessness and limited possibilities for being active (*embodiment*). (Presented in paper 1, 2 and 3).

Analysing the contribution of each paper to the lifeworld domain show that different emphasis is put on the experiences related to well-being and suffering in relation to being active. Renewed hope is described as a kind of well-being in paper 3, whereas the suffering in the domain of temporal domain is maily described in paper 1 as an experience of hopelessness,. Experiences within the domain of spatiality was the domain most sparsely unfolded in the studies and well-being within the spatial domain is mainly described in paper 2. Papers 1, 2 and 3 address experiences within the domain of intersubjectivity, however the experiences of being active in a group setting is primarily foregrounded in paper 2. The most recurring domains were within mood and embodiment, which influenced the participants' sense of self.

The synthesis of findings across the three papers represents the six lifeworld domains and based on the pre-understandings of Heidegger's ontology (Heidegger, 1962) and theoretical framework of different kinds of suffering and well-being (Galvin, Todres, 2013). An initial model was created to show my pre-understandings of human being's dwelling-mobility in well-being and suffering (See Figure 2).

Figure 2: Initial model of pre-understandings of being active



The initial pre-understanding (pre-understanding 1) relates both to the theoretical framework (pre-understanding 2) and my empirical work, which served as the starting point for the development of a new figure based on the synthesised findings. The new figure (See Figure 3) summarise the synthesised empirical findings by adapting a few key words into a graph.

Figure 3: Existential experiences of being active when living within a large body

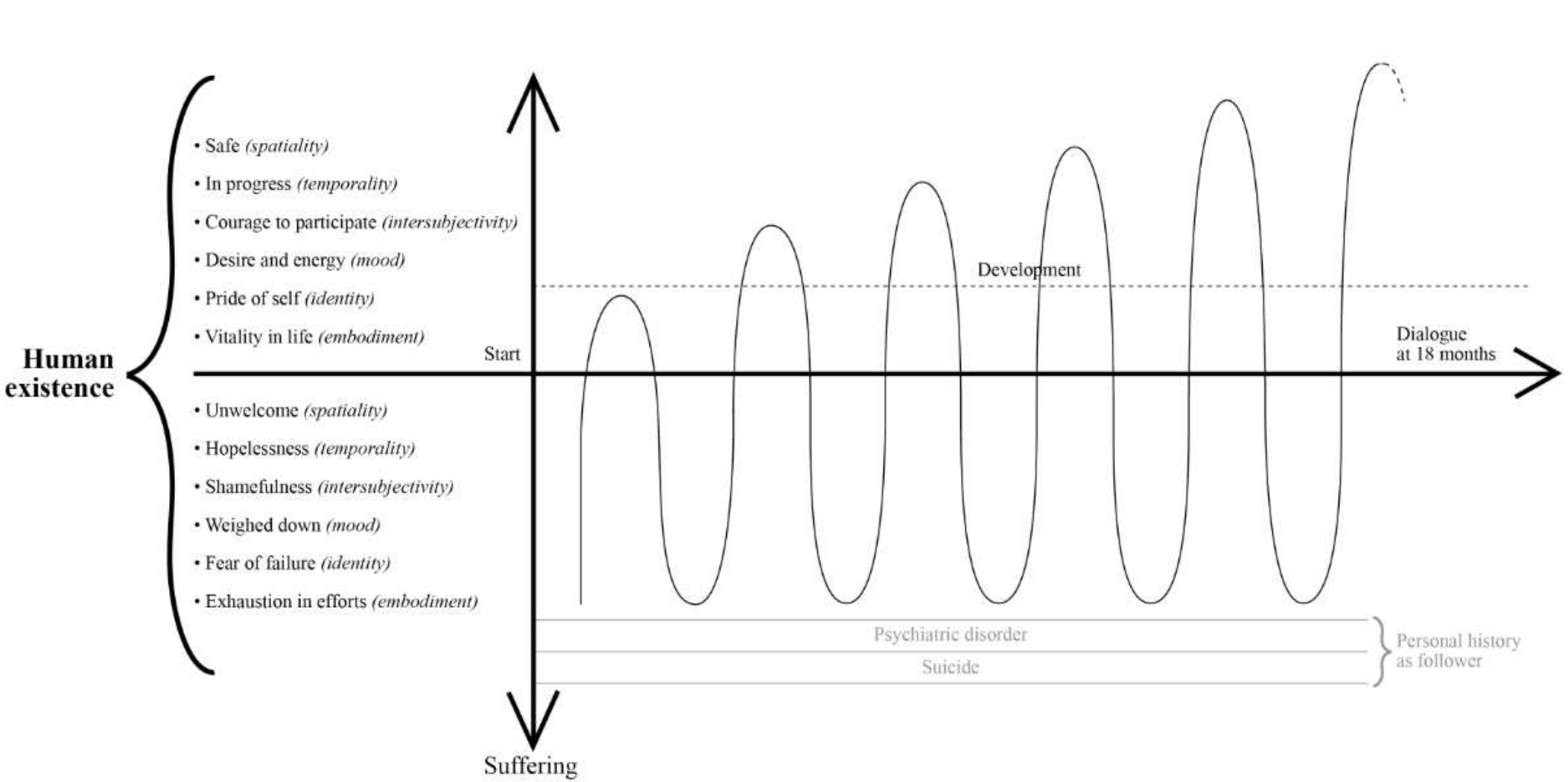


Figure 3 shows the existential experiences of being active when living within a large body over an 18 month period. The shape of the graph shows upward and downward sloping lines, which is to be considered an illustration of the shape of the severely obese individuals' dynamically and fluctuating experiences of well-being and suffering over time (Sandelowski, 1999). Experiences of well-being and suffering were counterbalancing each other (paper 1). The "Development" of well-being (the upper horizontal line) increased over time (paper 3), however suffering was always present as a human condition and historical experiences of suffering from "Psychiatric disorders" and/or thoughts of committing "Suicide" (the lower horizontal lines) and suffering was in the background as a personal follower of the individual ("Personal history as a follower").

The synthesised findings provide a better understanding of the existential experiences of living with severe obesity and being physically active, and give insights into how they are part of a human condition, which contains some possibility as well as psychiatric disorder and the risk of suicide. According to the synthesised findings the process of being active and mobile seems to be an on-going process in the future, where different experiences of well-being and suffering related to being active will persist.

Chapter 5
Discussion of findings

In this chapter, I discuss some of the essential findings with regard to the three papers' aims and research questions. Then, I discuss some strengths and limitations in relation to methodology, ethics, sampling and methods used. Finally, I discuss the trustworthiness of the dissertation.

Well-being and suffering when active in a large body: identity and embodiment

Paper 1 explored how severely obese adults experienced the existential aspects of being physically active before and during a lifestyle intervention.

Before intervention the participants experienced certain places to be unwelcoming, feeling powerlessness and exhaustion in doing PA, hopelessness in relation to making changes and feeling weighed down because of shamefulness of being a human failure. From a lifeworld perspective these experiences are to be considered an existential suffering relevant to approach and relieve in a healthcare settings (Galvin, Todres, 2013).

During the time of intervention new experiences and relations with other patients and HCPs gave the participants insights, which developed their sense of self and some of the existential suffering was counterbalanced by increased awareness of possibilities of well-being, which will always exist despite being in a large body living with some physical limitations (Heidegger, 1962). Yet, body size and weight were of great importance for the participants' experiences of being active and a specific barrier to PA. Their history of experiencing discomfort, failure or the feeling loss of identity were sources of lacking well-being. The identity of being severely obese made the vast majority of the participants feel vulnerable to weight stigma, and being vulnerable may be another threat to their well-being (Sellman, 2005).

Our study revealed how suffering was interacting with PA, which adds to previous findings of depression, negative sense of self and suicidality lead to avoidance of PA (Gloor, Puhl, 2016). Moreover, we elaborated on how suffering was counterbalanced during the time of intervention by experiences of well-being by letting go of pressure and unrealistic expectations, which seemed to increase the individual's experience of being capable of doing and enduring PA. It seems that the participants' benefitted from emphasising well-being rather than weight or amount of PA in practice, yet this emphasis may be considered rare and untraditional in health research (Burgard, 2009). It has been shown that severely obese individuals' barriers to PA may not be removed with weight loss as others barriers still persist (Zabatiero J. et al., 2018) and the problems of inactivity will remain unsolved (Groven, Glenn, 2016) if the unilateral weight focus in health promotion

among obese patients does not change (Dikareva et al., 2016). According to our study an alternative approach may be emphasising well-being within the different lifeworld domains that may provide new possibilities for breaking the vicious circle of inactivity and move into a positive process of progression in terms of developing well-being and prevent the blaming oneself. Blame and feelings of being irresponsibility has previously been related to incapability of controlling weight and participate in PA in severely obese individuals (Guess, 2012), as well as feeling different from others who manage a healthy life (Christiansen, Borge & Fagermoen, 2012). In our study, progress seemed to be related to the acknowledgement of one's own possibilities and limitations in order to settle with one's own PA efforts and accepting the value of making an effort however small. Being content with oneself and one's activity level may be regarded as an experience of dwelling in life (Todres, Galvin, 2010).

This draws attention to the importance of being sensitive to the patients´ experiences of both dwelling and mobility, which includes their living conditions and circumstances and especially their worries and concerns in life. Paper 1 provided insights into how experiences of well-being and suffering were integrated in the experiences of being physically active in particular in relation to the domains of embodiment and identity. It also gave initial insight into existential experiences of loneliness, shame and guilt, which was further explored in paper 2. The findings of mood and energy were essential for being active and for having hope for the future and these aspects were further explored in paper 3.

Being with others during PA: intersubjectivity and spatiality

Paper 2 explored how severely obese females and males addressed, talked about and referred to their experiences of being with others during PA; what gender-specific experiences existed; and what implications the lifeworld experiences would have for HCPs' practice.

The participants experienced well-being with peers during PA, which provided them with the desire and the courage to participate in different types of activities both in the hospital and in everyday life. However, being with others during PA also brought experiences of suffering when feeling excluded or shameful. During lifestyle intervention the participants developed their own judgment in relation to knowing their way around PA without it being a moral project. That seemed to relieve the suffering of accusations and guilt of one's mode of living, e.g. the need of making excuses for not living in accordance to other's practical reasoning of what ought to be done (Heidegger, 1962).

Our study add in-depth descriptions to the few existing studies on severely obese individuals' experiences of being active with others, which had previously been found to influence PA participation (Groven, Engelsrud, 2010). We confirmed the importance of experiencing belonging in PA and how it existed in a group of peers and brought vitality. Furthermore, our study supported a study on severely obese individuals' ambivalence towards attending PA because of the experiences of a bodily "otherness" in a typical exercise context, yet having positive experiences of PA being with others in a different setting (Danielsen, Sundgot-Borgen & Rugseth, 2016). The feeling of belonging was interacting with the spatial experiences of well-being, i.e. feeling safe, relaxed and welcome in the PA setting and influenced on the desire and courage to participate in PA.

The spatial experiences have received little attention in PA research. The above mentioned experiences of well-being in certain places are related to the domain of spatiality, e.g. 'feeling at home' and comfortable in the setting (Galvin, Todres, 2013). Feeling stigmatized in the PA setting may prevent individuals from engaging in and benefitting from regular PA, therefore the creation of body-inclusive spaces to increase well-being in PA has been suggested (Pickett, Cunningham, 2016). Recently, an interview study found that the experiences of the space were influenced by the language used and the sense of community established by the instructor (Pickett, Cunningham, 2017). This concurs with our findings of interrelatedness of spatial and intersubjective experiences identified in the health care setting led by HCPs. Our participants experienced the hospital setting and the group of peers to provide a feeling of belonging and a kind of protection from the usual stigmatising experiences of most other places. The sharing of experiences with others may provide increased well-being and better coping skills relating to health challenges, than if the severely obese participants had shared their weight loss achievements (Tarrant et al., 2017). Likewise, the experience of positive group dynamics may increase the effectiveness of the intervention (Burke et al., 2006), whereas frustrations of disrupted interactions and a competitive setting have been found to bring feelings of intimidation and discouragement in PA participation (McVay et al., 2018). In our study, few conflicts and frustrations were expressed by the participants. Still, HCPs' attention and judgment of the group interactions seem important in order to provide well-being as well as the possibility of withdrawing from the social and physical activities during the in-patient stay. Especially among strangers, the more vulnerable patients were feeling aversion or alienation and females would scan the room to see if they were the largest woman, whereas males would compare themselves to other men in their performance.

In this way, gender-specific experiences were put forward in the way females and males shared different topics and talked differently about being active with others. Experiences may be shaped according to cultural discourses of gender and obesity (Werner, Malterud, 2005) and it has previously been discussed that specific issues in relation to health are not necessarily common for females and males (Côté, Coutu, 2010). Research has found that the motives (Molanorouzi, Khoo & Morris, 2015) and the actual PA participation differ according to gender in adults (Carroll, Dollman & Daniel, 2014, Coelho et al., 2015) and data suggest that gender differences exist in barriers to lifestyle change (Mosca, McGillen & Rubenfire, 1998) across various stages of change (Sørensen, Gill, 2008) as well as in the need of social support (Elfhag, Rössner, 2005).

Our findings concurs with previous findings of gendered experiences, which influenced on PA outcomes because of negative body image (Schwartz et al., 2003) and stigma experiences (Mensinger, Meadows, 2017). Moreover, paper 2 provided insight into the intersubjective dimensions regarding severely obese adults' experiences of being active with others in different settings, i.e. spatial dimensions, and pointed to potential gendered differences. This insight may inform HCPs´ practice in regard to emphasising the importance of the relations to others in group activities and in patients´ everyday life and draw attention to the social gendered roles of for instance marriage, parenthood and employment, which may exist in the patients' lives (O'Neil, 1982)(Wingard, 1984). The gendered perspectives were further elaborated upon in paper 3.

Being physically active in everyday life: mood and hope

Paper 3 explored how severely obese females and males experienced PA in everyday life 18 months after engaging in lifestyle intervention, and what gender-specific aspects existed. The existential experiences in the domains of mood and temporality in terms of developing hope were foregrounded in this study.

The findings of the paper showed that the participants PA levels were influenced by the fluctuating nature of mood and the ability to find settlement within different kinds of suffering, e.g. shamefulness due to exhaustion in efforts. Experiences of well-being in the existential domain of mood were found to increase vitality and hope, which previously had been found to provide the participants with the resoluteness to continue the fight for well-being (paper 1). The ability to pull oneself together to exercise may be a way of 'becoming' and the experiences of mood may reveal how one gets on with living a meaningful life (Inwood, 1999). Mood may colour one´s life and be

experienced as something "given", however mood affects others and is affected by others, which makes the individual vulnerable to others and open to suffering (Mulhall, 2013:75).

The relevance of approaching hope in health care interventions has recently been put forward (Graven, Brødslev Olsen, 2018). Yet, there are two ways of understanding hope; the existential understanding: "to hope" and the everyday understanding: "to hope for" something specific (Stempsey, 2015). This clear distinction has not been applied in the initial approach to the concept of hope in this dissertation. However, we found that the experiences of hope in both understandings were overarching the existential experiences of the 18 months the project lasted. A feeling of hopelessness was the starting point before intervention, however new hope developed over time and was emphasised by the participants to be most important one year after the end of intervention. Still, our findings confirm that feelings of disappointment can escalate into a feeling of hopelessness (Stempsey, 2015), like it has been found in patients, who experienced weight regain (Groven, Glenn, 2016). We additionally found that being prevented from being active brought a sense of lacking freedom. Moreover, the participants in our studies were struggling with disappointments experienced in the past. The disappointments of the past led to lowered mood and lack of hope in their present situation, which may add to a future vulnerability towards disappointments. This can be considered an example of how past, present and future fuses (Heidegger, 1962) and brings a temporal suffering.

Lowered mood has been found to reduce the ability to imagine one's possibilities and the development of hope, which is known to make a person more likely to give up rather than take action of the situation (Simpson, 2004). Gadamer would claim that the challenge is, that a person with no or limited horizon cannot see future possibilities and may overvalue what is nearest at hand unable to see beyond the present situation (Laverty, 2003).

Our findings support the claim that existential experiences of well-being influence the individual's choices and actions even if it is in an unreflected manner (Heidegger, 1962). It is found relevant to address hope in lifestyle intervention, because of the interaction with mood, energy and vitality in severely obese adults regarding PA in everyday life. Moreover, this study illustrates how the lifeworld approach to patient's experiences may facilitate the dialogue about hope and mood in health care practice (Graven, Brødslev Olsen, 2018). Individuals may become able to alter or overcome a mood if their mood allows it, and if they are able to establish themselves in a new "mood" (Mulhall, 2013).

Discussion of synthesised findings

The model of the synthesised findings (Figure 3) illustrates how being active within well-being and suffering when severely obese can be considered a human condition. The process of lifestyle change over an 18 months period can be described as a non-linear and unpredictable on-going trajectory related to the individuals experiences (Paterson, 2001). Human beings can be considered to always be in process, and 'not finished', therefore the participants must constantly respond to changes within a 'situated freedom' where they are being limited or are free in different ways (Dahlberg, Todres & Galvin, 2009). The complex way that the severely obese participants in this study feel thwarted when physically active holds existential experiences, which must be taken into account when aiming for increased well-being including their experiences of the past.

According to Heidegger an experience is rounded into the unity of a significant whole, distinguished from other experiences and constituted in memory in a lasting meaning for the person who experienced it (Heidegger, 1962:61). This meaning can be put forward and be understood by others and provide new insights (Gadamer, 2013). The insights from this study may assist HCPs in helping individuals to counterbalance experiences of suffering by identifying some possibility and sense of well-being, as suggested in relation to identifying and understanding a person's perspectives of optimism and pessimism (Paterson, 2001). According to the synthesised findings the suffering and fighting persist in the individuals' living with severe obesity in relation to being physically active after intervention, which support the claim that long term behavioural changes require on-going attention and interaction with HCPs or others, who emphasise the process rather than the outcome (Hall, Kahan, 2018).

The model of synthesised findings is a contribution of empirical findings to the theoretical framework of different kinds of well-being and suffering (Galvin, Todres, 2013). The participant's "personal history" of psychiatric disorder and suicidal thought has been added to the existing theoretical framework. The participants' experiences of hopelessness in life, are examples of how committing suicide was considered an option to relieve suffering. However, they must have renewed their sense of being-in-the-world to choose to undergo lifestyle intervention. When life becomes meaningless and there are no more possibilities or future horizon, then death may become present (Sarvimäki, 2006). In this way lifestyle intervention and being active may become existential to the individual.

The qualitative findings of this dissertation confirms that lifestyle intervention may not benefit from solely be planned and conducted on behalf of wilful, practical and rational behavioural choices, but must also engage with patients' existential experiences in a person-oriented way (Uhrenfeldt et al., 2018).

Methodological discussion

In this section, I discuss some of the ethical issues about exploring existential perspectives in a group of severely obese individuals and the qualitative inquiry and the lifeworld approach. Then, I discuss the gendered perspectives in relation to some methodological strengths and limitations of this dissertation.

Living with severe obesity is to belong to a more-than–ordinarily vulnerable group of people (Sellman, 2005) with different risks and degrees of harm, e.g. weight discrimination, stigma and condescending language use (Nutter et al., 2016). Asking the patients to participate in the project was basically to ask them to talk about personal and sensitive issues that may elicit emotional reactions and become a process of acknowledging one's own life situation. For that reason, the gatekeeper was asked to contact potential participants, thereby allowing them to retain their autonomy and refuse participation after being informed about the study (Dempsey et al., 2016). At the time of my first contact with the participants, I provided information about the study and the interview before the consent forms were signed. At the start of the interview, it was made clear that the participants had the right to refuse to answer my questions, ask for breaks or to leave the study at any time without any consequences for themselves. The interview appointments were only made for one interview at a time to make withdrawal easier. Consents and rights were orally repeated for each interview and at the end of the interview the participants were asked to confirm that I was allowed to contact them for follow-up interviews.

Anonymity and confidentiality were guaranteed by not disclosing any names or individual characteristics that could be recognised in the description of the sample or in the findings. The rationale for video recording the FGIs was explained to ensure that there was no doubt about the purpose. Knowing that this group of participants had issues about their appearance, I assured participants that the video recordings could only to be accessed by me, and I ensured that no one felt intimidated about the way they looked and sounded.

A conscious distinction was made between the professional terms (severe obesity and physical activity) by applying an everyday language (large body and movement) in the interviews (Galvin,

Todres, 2013). The professional language may from a patient's perspective be perceived to be a stigmatising language use (Setchell et al., 2016). I aimed for using respectful and supporting language during the dialogues to preserve the dignity of the participants (Thomas, Lee-Fong, 2010) by avoiding potentially derogatory terms, e.g. fatness and obesity (Wadden, Butryn & Byrne, 2004). Moreover, I aimed to adjust my actions and questions to meet the participants' emotional state, and to be open towards their agenda and for whatever was put forward, e.g. their priorities in life. I was aware of the risk of being intrusive by taking advantage of the trust and willingness the participants showed which might make them reveal things they would regret afterwards (Fog, 1992). I strived for being sensitive towards the individual's vulnerabilities when approaching their lifeworld (Gadamer, 2013) and to protect the participant from harm. I would refrain from asking for details of painful life events if I judged it would be better not to (Fog, 1992). Still, the interview participation seemed to make some participants become reflective about their life. Several participants experienced the interviews positively and appreciated having an attentive listener, e.g. a woman had a "heart felt wish" to participate for her "own sake". I strived to end all interviews in a positive atmosphere and was sensitive to the participants' emotional state in the debriefing sessions. According to the participants verbal and non-verbal feedback after the interviews I concluded that no harm was done to them during the interviews. However, several of the participants may have faced their vulnerability by daring to fail by exposing themselves during the interviews. At the end of the last individual interview, the participants were asked to comment upon their experiences of being interviewed as I wanted to end our contact and leaving them in a proper way. For safety reasons, I gave contact information to the participants and encouraged them to call me or the Department of Lifestyle Rehabilitation if any concerns arose after the interview. None of the participants used that possibility. The participants did not receive any payment or compensation for their participation, but I did express my gratitude for their contribution and time.

Qualitative inquiry and lifeworld approach

Qualitative research is considered undervalued and underutilized by the medical research establishment (Greenhalgh et al., 2016), however this dissertation contributes with evidence, which could not have been provided quantitatively. The hermeneutic research approach was found appropriate for exploring lifeworld experiences in a group of severely obese patients. However, the qualitative research interview was not neutral, as it affected the participants and became similar to the therapeutic interview (Dempsey et al., 2016), though it was not the purpose of the dialogues.

The qualitative inquiry contributed with a theoretical and analytic approach to PA by considering the whole of a patient's complex world of existential experiences. The philosophical stance contributed to a greater understanding of the phenomenon of interest, extended the language use of human experience and drew attention to lifeworld domains. Moreover, the theoretical framework was found useful for the philosophical examination and the general discussion of findings after the empirical analysis (Lindberg, Osterberg & Horberg, 2016) and was challenging ingrained assumptions of the meaning of PA in severely obese patients (Nicholls, Gibson, 2012). The methodology used in this dissertation was found appropriate for meeting the patients in their vulnerabilities and possibilities (Lindberg, Osterberg & Horberg, 2016) and the representation of all six lifeworld domains of well-being and suffering regarding PA indicated that the domains each had their relevance for a better understanding of the severely obese individuals´ struggles in a process of tackling lifestyle changes. The qualitative approach may enhance HCPs' possibility of establishing relationships with the patient in practice, and emphasise that it is important to talk about and collaborate with the patient on what is important (Dahl et al., 2014) in order to develop individually tailored interventions (Beck et al., 2010).

The philosophical founded lifeworld approach is rare in physiotherapy and this dissertation may facilitate a person-centred approach among PTs (Wikström-Grotell, Eriksson, 2012) and expand their view of the body and their understanding of lived experiences of PA and obesity in their practice (Nicholls, Gibson, 2010, Nicholls, Gibson, 2012). Finally, the qualitative approach to well-being seems to be in line with the political agenda of WHO, which states that health "goes beyond healthy lifestyles to well-being" (World Health Organization, 1986) and this dissertation provide specific examples of what constitutes well-being in severely obese individuals. Moreover, the exploration of individuals' experiences supports the European and Danish health strategies of addressing people as distinct individuals and aiming for increased user involvement in health care (European Commission, 2014)(Sundhedsministeriet [Ministry of Health], 2013/14).

Discussion of gender

In this section, I discuss how engaging with gender in this dissertation has been problematic.

In a phenomenological study Bullington (2006) claims that identity is rooted in our experience of gender, and she argues that gender differences are relevant to investigate to provide different aspects of a phenomenon (Bullington, 2006). Likewise, Mayoh (2015) explored existential experiences of sports and suggests that future qualitative research should explore the gendered

experiences (Mayoh, Jones, 2015). On the other hand, according to Heidegger's ontology one's being-in-the-world is independent of gender, however he has been criticised for not addressing sexual differences in his works (Derrida, 1983). Hence, it has been discussed if females and males have different lifeworld and if gender segregation should be performed in research on participants' experiences or if the participants should be encountered as human beings, rather than females and males (Martinsen et al., 2013). It has been argued that the ontological understanding of the freedom of a human being holds freedom and the possibility to construct oneself and choose how one engages and acts in one's own way in relation to unchosen facts (facticity) (Young, 2002). Health practices in everyday life have been claimed to hold gendered differences, guided and constrained by social norms and situations. Hence, health can be considered a lived experience, which involves being active in the world, e.g. PA, and gender is an integral aspect of this process (Saltonstall, 1993).
In this way, the relevance of gender has been discussed for years, mainly criticized for being founded in a nature-culture distinction rather than founded in the concept of the lived body deriving from existential phenomenology (Young, 2002). However, it is argued that the concept of gender is important to retain as a tool for theorizing social structures and their implications for the freedom and well-being of a person in their particular form of social positioning (Young, 2002).

My pre-understanding was based on the assumption that gender is socially constructed and distinguished in sports, where activities may be labelled feminine, masculine or gender-neutral (Koivula, 2001). A person's gendered identity derives from gendered roles and can be divided into feminine and masculine gendered experiences, which implicate the lives of females and males and their interaction with one another (Young, 2002). The gendered norms have been claimed to influence the individual's body image and behaviour, e.g. PA participation and how one is supposed to act, think, and feel about PA (Steinfeldt et al., 2011). Based on my pre-understanding of gender being socially, historically and culturally constructed and lived, it was found appropriate to explore gendered perspectives through the hermeneutic phenomenological approach (Oksala, 2006).

The gender segregated analysis in papers 2 and 3 was chosen to explore the gendered perspectives in order to embrace different dimensions of personal experience that would allow me to reflect both subjectively and critically on the experiences put forward and how to respond to them. Moreover, the gender segregation of the FGIs was chosen to capture the differences and similarities of the dialogues of the females and the males (Krueger, Casey, 2009) and the diversity of their

experiences discussed in a group characterised by confidentiality and comfort between group members of the same gender (Jayasekara, 2012).

The gendered findings of this dissertation may be perceived to present stereotypical beliefs about the female and male gender (White et al., 2011). However, the gendered perspectives of severely obese adults' experiences of PA were chosen to provide an awareness of the potential stereotypes of gender that otherwise may be taken for granted in practice. Understanding patients' different identities in rehabilitation may provide a better understanding of the gender-specific issues, e.g. in relation to different social and family roles (Côté, Coutu, 2010).

A limitation in this dissertation may be that the gendered experiences are presented in a classic maleness and femaleness, and therefore it disregards more genders that may exist. However, the research represents the common practice of comparing females and males, which is often the case in relation to health practices (Lorber, 1996). Moreover, it may be a limitation that the language used in the dissertation and in the papers lacks a distinction between sex (female/male) and gender (woman/man), i.e. the biological aspects and the person's social self-representation, however the two classifications may be perceived as entangled phenomena (Springer, Stellman & Jordan-Young, 2012).

Methodological strengths and limitations

In this section, I discuss the issues of strength and limitations related to the methodology and theoretical approach of the dissertation.

This dissertation presents empirical research findings which contributes to a philosophical approach to well-being where body, soul and spirit are not separated but understood as human existence and analysed as a seamless whole in a holistic way to understand well-being when "Being a large body in activity" (Galvin, 2010). However, in hermeneutic phenomenology, no method or set framework exist to clarify the conditions of understanding (Holroyd, 2007), and there may be certain weaknesses and limitation in the methodology of the dissertation.

Different interpretations could have been made by other researchers as understanding is a mode of being (Smythe et al., 2008) and different methodology and theory could have been used. For example, the philosophy of Maurice Merleau-Ponty (1908-1961) could have inspired the methodological background for the exploration of how humans live and engage in the world in a bodily way (Merleau-Ponty, 2012). However, his philosophy is implemented in the theoretical

framework and represented within the lifeworld domain 'embodiment' (Galvin, Todres, 2013). The Dutch-Canadian Max Van Manen's (1942-) methods and approach could have led to an alternative data analysis as he developed the hermeneutic phenomenology from Gadamer (Van Manen, 1997). However, I have chosen to stay within the methodology founded in the German tradition of Heidegger and Gadamer and the Nordic qualitative context as described by Brinkmann and Kvale (2014)(Brinkmann, Kvale, 2014), which seems to be closely connected to the hermeneutic phenomenology as described by Heidegger and supports the methodological foundation of the theoretical framework.

A part of the hermeneutic interpretation was to put my pre-understanding at stake to ensure that my existing horizon was expanded and to prevent the taken for granted aspects of existence (Holroyd, 2007). However, the subjective nature of hermeneutics may question if my pre-understanding was put sufficiently at stake during the interviews and if any misunderstandings or stereotyped conceptions occurred in the interpretation. To challenge my pre-understanding and interpretation, two co-authors read the themes I had developed and compared them with selected interview texts and quotes. The quotes presented were used to illustrate variations of language used by the participants' to describe their experiences, e.g. vicious circles (paper 1), and it was discussed if they were characteristic for the experiences of PA or also were part of other phenomena (Dahlberg, 2007).

The aim of getting a sense of the 'whole' and add breadth to the understanding (Todres, Galvin, 2005) may not be accessible through few hours of interview at a given time, therefore I acknowledge, that I will never fully understand the other person, but only reach a better understanding (Gadamer, 2013). However, the setting of FGIs was providing group dynamics that made the participants comment and question each other's experiences of being active with others and elaborate on topics raised by group members. The use of pictures seemed to facilitate interaction and the discussion of new topics among the group members.

In hermeneutic interpretation language is pivotal "as researchers stand and fall with their own and others' language ability" (Dahlberg, 2006:17). As a novice researcher, my language may have been a limitation, despite my awareness of different discourses and language use.

Ontology may only indirectly contribute to practice working with human beings (Sarvimäki, 2006), however the findings of this qualitative research on existential experiences provide a direction for clinical practice as the use of the theoretical framework in the analysis allows for some

generalisation (Halkier, 2011) in order to suggest the appropriateness of approaching well-being in severely obese individuals when addressing PA.

Discussion of methods

In this section, I discuss the issues of strength and limitations related to the design, methods and sampling.

The longitudinal design was considered a strenght of the study to explore experiences of PA before, during and after lifestyle intervention. The timeframe of 18 months was considered appropriate for the study to serve as one year follow-up after the end of lifestyle intervention (Stern, 2002). The timeframe of the design was chosen to enable the participants to make health behaviour changes in everyday life and acknowledge the considerable variation that exist in how long it takes a person to establish new habits (Lally et al., 2010).

Moreover, the longitudinal design helped integrate the temporal aspects of the participants' experiences and was a way of conducting a diachronic analysis of data and studying the transformation of the experiences of PA by comparing moments in time in order to validate and deepen the data obtained from previous interviews and FGIs (Sandelowski, 1999). The design provided time between interviews for hermeneutic reflection (Gadamer, 2013). Despite, the duration of the study was limited to18 months the prolonged engagement and the repeated interviews with the participants enabled a deeper understanding of their whole situation in the context of their everydayness (Pitney, Parker, 2009). Furthermore, I asked the permission to contact the participants of paper 3 for a three year follow-up interview in the summer of 2019, which they all agreed to.

The combination of the empirical methods of individual interviews and FGIs were designed to supplement each other (Morgan, 1997). The context of group-based intervention provided some shared experiences of PA, which gave a common starting point for the discussion. Moreover, the FGIs were found useful for clarification or cross-checking of findings as the group setting stimulated and opened up new perspectives (Bradbury-Jones, Sambrook & Irvine, 2009), e.g. the second round FGI brought up issues only slightly addressed in the individual interviews, e.g. sexual activity, places of well-being and aversion towards other people.

The FGIs were constructed for the purpose of data collection as it was found congruent with exploring lifeworld experiences (Bradbury-Jones, Sambrook & Irvine, 2009), however it may be

perceived a limitation that the group interactions were not part of the analysis, which is common in sociological research analysis of FGIs (Halkier, 2010, Warr, 2005). Conversation analysis may have have added valuable insights into groups dynamics (Grønkjær et al., 2011), however I chose to focus on the FGIs a tool for data collection. As the moderator of the FGIs, I was attentive and reflexive in regard to the interaction, which was an integrated in my sense of the 'whole'.
A limitation in using qualitative research interviews as method may be the central role of language, because suffering and discomfort may be difficult to verbalise. Few participants' may have lacked words about personal existential experiences, which may have favourised the experiences of the well-spoken participants. A limitation in the first interview round may be the dominating focus on body and physical function, which was representing my pre-understanding and physiotherapist knowledge from a health care context. However, the use of theory helped me to look beyond this pre-understanding and increased my sensitivity to more existential aspects in the following interviews. Moreover, paper 1 had only one research question added to the aim of the study, however this was chosen to provide an initial and open exploration of the participants' lifeworld experiences without emphasis on gendered nuances.

Discussion of sampling and participants
For the empirical studies, 16 participants were initially recruited, equally distributed between females and males. The participants were invited for three individual interviews and two FGIs. The actual number of individual interviews counted 36 in total and the four FGIs had four to seven participants. The sampling size was found to provide sufficient data to gain an understanding of the subject matter (Sandelowski, 1995). The equal distribution the females and the males should enable understanding of potential gendered experiences of well-being when being active in the process of lifestyle intervention and make the construction of gender segregated groups possible.
The participants were recruited from the same hospital department and were homogenous with regard to BMI status and gender (in the FGIs), but heterogeneous in regard to age, family status, education, housing and place of living. The participants were selected with the expectation that they could contribute with a wide range of data on experiences of being active (Krueger, Casey, 2009). The sampling plan was found suitable for providing well-articulated participants, who was willing and able to communicate their experiences. However, their heterogeneity may have influenced on their experiences, which was not taken into account in the gendered analysis.

Another limitation in the representation of participants may be that all the participants had enough resources to engage with the healthcare system. However, one female never attended intervention and another dropped out early and still stayed in the study.
For the FGI we invited eight participant for each group, i.e. enough to enable a discussion and allow each participant to share his/her experiences (Jayasekara, 2012). The sample size provided the possibility of each participant's participation (Morgan, 1996) by providing time to elaborate on the individual's experiences and still allow the participants to hear the experiences of the others and discuss the topics put forward (Krueger, Casey, 2009). The participants for the FGIs were categorised by being "female" or "male", due to their biological category, however not necessarily holding their experiences of being "feminine" or "masculine" (White et al., 2011).

As expected not all participants were able to stay in the study for time period of 18 months (Sandelowski, 1999), and the drop-outs may indicate that some of the more vulnerable participants were only represented in the first individual interview round. For example, one male dropped out for unknown reasons and may not have been ready to gain deep or painful insights into his own living (Gadamer, 2013). Overall, the recruitment and adherence of participants were challenged by cancellations and changed appointments, which I perceived as a way for the participants to protect themselves in their vulnerabilities (Sellman, 2005).
A minimum limit of four participants for each FGI was set (Jones, Brown & Holloway, 2013), and over-recruitment for the FGIs was made because cancellations by participants are commonly known (Morgan, 1997). We expected an increased drop-out rate among severely obese participants, as this has been found in relation to attending interventions (Moroshko, Brennan & O'Brien, 2011). Yet, the number of actual drop-outs required a second recruitment of participants to complete the FGIs. This may be considered a limitation as they newly recruited were unfamiliar with the other participants and the moderator of the FGI (Morgan, 1997), however the group dynamics seemed to persist in the groups.

Trustworthiness

In the following section, I present examples of how the trustworthiness of the qualitative research process was established based on the criteria of Lincoln and Guba (1985)(Lincoln, Guba, 1985). Trustworthiness was enhanced in term of credibility, to demonstrate that a true picture of the phenomenon of interest (Shenton, 2004) by presenting a plausible and extensive representation of

the participants' voices in the findings with accurate, broad and clear use of direct quotations from the transcripts. Moreover, the trustworthiness was increased by the repeated confirmation of the findings by contacting the participants several times for interviews (Fleming, Gaidys & Robb, 2003). The repeated interviews provided me with enough time and opportunities to ask participants to elaborate on topics addressed in previous interviews to deepen my understandings. When talking to the participants about their experiences, I aimed to track both their and my shifting horizons that developed over time (Gadamer, 2013). A member check (Lincoln, Guba, 1986) was made by testing two figures of preliminary analysis of the findings from the previous interview rounds. The figures served as a participant validation of my interpretation. They were used to expand my understanding of the phenomenon, because the participants recognised and elaborated on the figures (Fleming, Gaidys & Robb, 2003).

The combination of individual interviews and FGI at different times was used to confirm or cross check the findings as a kind of triangulation of methods (Lincoln, Guba, 1985). The combined methods were providing different contexts for the dialogues and were chosen as complementary methods to add breadth and depth to the findings (Crabtree, Miller, 1999) by providing different data and working across the limitations and strengths of the two methods (Morgan, 1997).

The FGIs were considered effective to provide insights into the sources of complex behaviours and motivations (Morgan, 1997) in a group perceived as marginalised in society and potentially vulnerable to stigma (Barbour, 2008). The homogeneity in regard to gender and BMI was a way of increasing the confidentiality in the groups and protect some of the participants' vulnerabilities (Morgan, 1997). Moreover, the FGI method was chosen to give direct access the participants' experiences of being active through their spoken language (Jayasekara, 2012). A variety of viewpoints was expected to be brought fort spontaneously through the interaction of the participants and provide data, which would not be accessible in an individual interview (Brinkmann, Kvale, 2014). The group setting was planned to be flexible in relation to each person's speaking time, demands of details in their explanations and intimacy in the interview situation (Morgan, 1997). The group approach helpful to challenge my present pre-understanding (Bradbury-Jones, Sambrook & Irvine, 2009) and it allowed the participants to verify their individual viewpoints and experiences as well as verify whether their experiences were in line with the rest of the participants (Pitney, Parker, 2009).

The process of the data analysis was continuously discussed with the supervisors of the research project and a specialist in lifeworld research. The discussions with the research team were utilized

to keep me think and struggle to better understand by making me aware of and reflect upon my pre-understanding (Fleming, Gaidys & Robb, 2003). In a hermeneutic process of reading, writing and talking with colleagues and lay persons, I continuously tried to track changes in my own pre-understanding that could influence on the research findings (Smythe et al., 2008).

The qualitative findings of this dissertation provided in-depth descriptions of the context, the setting and the participants and allowed the reader to judge whether the findings are transferable to different setting or patients (Pearson, Robertson-Malt & Rittenmeyer, 2011), e.g. less obese individuals or individuals living with chronic conditions.

To increase the trustworthiness of the papers, the Consolidated Criteria for Reporting Qualitative Research (COREQ) 32-item checklist was used as a framework to ensure the most important aspects when reporting the findings (Tong, Sainsbury & Craig, 2007).

Chapter 6
Conclusion and future perspectives

This dissertation is concerned with linking severe obesity and health to the existential experiences of being active when living within a large body before, during and after lifestyle intervention. This dissertation arose from a health care provider and was designed to provide evidence-based knowledge for a clinical practice of PA intervention. To the best of my knowledge this is the first study to empirically explore severely obese adults' gendered experiences of being active in the context of lifestyle intervention and everyday life interpreted from a philosophically perspective. This dissertation elaborates on severely obese patients' experiences in relation to suffering and well-being with regard to PA within six lifeworld domains over a time period of 18 months. Before intervention life was characterised as living within a downwards spiral of feeling powerlessness, loneliness and hopelessness in present situation. During intervention different experiences of well-being were foregrounded by females and males in the process of change, for example the development of their sense of self, own judgment, mood and hope that provided mobility in life. One year after intervention well-being in mood had provided energy to stay in a process of finding their way around PA and striving for a feeling of homecoming. The existential experiences provided novel insight into how hope, mood, identity and relations to others were influencing on patients' activity participation and how the experiences fluctuated and developed over time. The findings gave an initial insight into gendered experiences, as the females and the males addressed different topics and talked differently about being active with others. Based on the findings, it can be concluded that experiences regarding a feeling of well-being in regard to being active are underemphasised; in particular the experiences of dwelling may be overseen among the individuals living with severe obesity.

This dissertation contributes with a theoretically funded work regarding the way patients living with severe obesity experience being active. It provides some philosophical underpinnings toward ethical considerations and person-oriented dialogues in PA interventions in relation to meeting the severely obese patients' vulnerabilities and preserve dignity in language. Moreover, it gives a strong argument for ensuring that the experiences of severely obese patients are listened to when planning and conducting health care interventions. PTs are well positioned to apply the patients' perspectives in PA interventions, and the lifeworld approach was found appropriate to gain in-depth knowledge of the lifeworld domains and provided a person-centred language. This dissertation points to numerous of ways for PT and other HCP to address well-being and suffering in activity and rest,

and it provides evidence-based knowledge to guide a specialised approach to severely obese patients.

Implication for practice

The evidence has applications for HCPs at the Department of Lifestyle Rehabilitation and other health care settings, as it opens up for possibilities of rethinking PA intervention and the collaboration with the patients.

The study may have the following implications for practice:

- The six lifeworld domains can guide a nuanced approach to person-centred experiences of PA.
- Patients' lifeworld experiences can be activated through conversation and activities if sufficient time is provided and trustful relationships are established.
- Insights into downward spirals may be helpful in supporting patients in finding individualised strategies for increased well-being when being active.
- A variation of activities during intervention may provide new experiences of being active, which reveal possibilities of meaningful, enjoyable and realistic levels of PA in everyday life.
- Well-being in activity should be foregrounded as a legitimate goal of intervention and the patient's mood and hope should be supported.
- The awareness of potential gender-sensitive experiences of PA should be expanded to prevent stereotyped gendered norms to be enacted by patients or HCPs.
- A trustful relationship with the patient may allow a true dialogue about their experiences of well-being and suffering and help identify the need of long-term support.
- Use the individual's experiences of dwelling and mobility to make intervention most feasible, appropriate and meaningful even if PA is restricted or not wanted.
- Emphasis on the experiences in everyday life may provide long-term maintenance in the transition from intervention back to the home environment.
- Facilitation of positive group dynamics and voluntary participation without pressure may increase well-being during intervention.

The above-mentioned suggestions may also have applications to PTs' education to develop a comprehensive approach to health and PA among severely obese individuals.

Implication for further research

This dissertation provides insights into severely obese adults' experiences of being active. Yet, some aspects still deserve to be qualitatively explored to add or confirm the findings of this study.

Future research should be directed at the poor understanding of balancing well-being and suffering experiences in individuals currently living with severe obesity, as it may improve current treatment and prevent the development of obesity.

Understanding of the spatial and intersubjective experiences of PA in different setting and types of PA are lacking in research, and better understanding may provide evidence to facilitate prolonged engagement in PA after discharge from hospital.

This study also calls for further explorations of the experiences of severely obese adults that do not want to attend lifestyle intervention with regard to develop health care intervention towards their wishes and needs.

Clearly, further research is needed to explore gendered experiences. Particularly, qualitative exploration of severely obese males' experiences of PA may provide knowledge regarding how to intervene in relation to their existential challenges.

Finally, future research may pursue how lifeworld led intervention may complement existing rehabilitation, hence the descriptive findings of this study may inspire an intervention study focusing on severely obese patients' involvement in a lifestyle intervention programme, i.e. first a pilot test and second a randomised controlled trial focusing on user involvement in a lifestyle intervention programme.

List of appendices

English summary

Background: In Denmark 40,000 Danes are estimated to live with severe obesity. Severe obesity may entail inactive lifestyle due to complex barriers to physical activity (PA). The barriers to PA are poorly understood, and the underlying existential perspectives of being physically active when severely obese are lacking.
Aim: To explore and describe adults' lifeworld experiences and gender-specific aspects of being active, when living with a large body – before, during and after lifestyle intervention.
Design, methodology and methods: The dissertation has a qualitative inquiry and is founded in hermeneutic phenomenology and is guided by a theory of well-being. It consists of three empirical studies with a longitudinal design of repeated individual interviews and gendered focus group interviews. The studies were conducted and analysed through a hermeneutic interpretation.
Participants and context: Lifestyle intervention candidates: eight females (aged: 27-59y, median 38; BMI: 40-48 kg/m^2) and eight males (aged: 25-68y, median 47; BMI: 41-55 kg/m^2) were recruited by purposive sampling from a Danish public hospital.
Findings: A complex lattice of interacting existential experiences of well-being and suffering in relation to being active when living within a large body was found. The experiences had a temporal dimension and developed over time. Experiences of being active were related to the participants' sense of own self and relation to others, and some suffered when feeling exposed to PA. Possibilities for well-being increased mood and future hope were essential for long-term PA engagement. Gendered nuances seemed to exist in severely obese individuals' experiences of PA.
Conclusion: Qualitative evidence on severely obese individuals' experiences of well-being and suffering when being active in the context of lifestyle intervention and everyday life was interpreted from a philosophical perspective. Initial insights into general and gendered experiences were presented regarding six lifeworld domains. Existential experiences influenced the participants' being and doing in everyday life. The well-being of feeling 'at home' in PA was found a legitimate aim of lifestyle intervention. Experiences of well-being and suffering should be addressed in health interventions to promote an active and meaningful living.

Danish summary

Baggrund: Det estimeres at 40.000 danskere lever med svær overvægt. Svær overvægt kan medføre en inaktiv livsstil på grund af komplekse barrierer for fysisk aktivitet. Barrierene er dårligt kendte og der mangler eksistentielle perspektiver på hvordan det er at være fysisk aktiv, når man er svært overvægtig.

Formål: At undersøge og beskrive voksnes oplevelser af deres livsverden og de kønsbestemte oplevelser der er i forhold til at være aktiv når man lever i en stor krop – før, under og efter livsstilsintervention.

Design, metodologi og metode: Der anvendes en kvalitativ undersøgelse funderet i hermeneutisk fænomenologi og guidet af en teori om velvære. Undersøgelsen består af tre empiriske studier i et longitudinelt design af gentagne individuelle interviews og kønsopdelte fokusgruppeinterviews. Studier blev udført og analyseret ved hjælp af en hermeneutisk fortolkning.

Deltagere og kontekst: Livsstilspatienter: 8 kvinder (alder: 27-59 år, median 38; BMI: 40-48 kg/m^2) og 8 mænd (alder: 25-68 år, median 47; BMI: 41-55 kg/m^2) blev formålsfuldt rekrutteret fra et offentligt dansk hospital.

Fund: Der blev fundet et komplekst net af interagerende, eksistentielle oplevelser af velvære og lidelse i forbindelse med at være aktiv som svært overvægtig. Oplevelserne havde en tidsmæssig dimension og udvikledes over tid. Svært overvægtiges oplevelser af bevægelse var gensidig påvirket af deres selvopfattelse og relation til andre mennesker og steder. Humør og håb var afgørende for deres vedvarende deltagelse i fysiske aktiviteter. Der blev fundet kønsbestemte variationer i deltagernes oplevelser.

Konklusion: Kvalitativ evidens af svært overvægtige personers oplevelser af velvære og ubehag ved fysisk aktivitet i forbindelse med livsstilsintervention og i hverdagslivet blev fortolket fra et filosofisk perspektiv. Der blev præsenteret generelle og kønsspecifikke oplevelser af bevægelse inden for seks interagerede, eksistentielle domæner. De eksistentielle oplevelser havde indflydelse på deltagernes 'væren' og 'gøren' i hverdagen. At stræbe efter velvære og at kunne føle sig hjemme i bevægelse kan være et selvstændigt mål for livsstilsintervention. Oplevelser af velvære og lidelse bør adresseres i sundhedstilbud som ønsker at fremme en aktiv og meningsfuld livsstil.

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Dato 23. september 2015
Sagsbehandler Annette Sand
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Vedrørende projektet At være en stor krop i bevægelse: oplevelser af livsstilsforandringer gennem 2 år

Sagsnr. 1-16-02-425-15

Ovennævnte projekt er den 02-07-2015 anmeldt til Region Midtjylland. Der er samtidig søgt om tilladelse til projektet.

Det fremgår af anmeldelsen, at du er projektansvarlig for projektets oplysninger.

Behandlingen af oplysningerne ønskes påbegyndt den 01-11-2015. Data slettes, anonymiseres eller indsendes til Statens Arkiver senest ved projektets afslutning.

Oplysningerne vil blive behandlet på følgende adresse:

Regionshospitalet Horsens
Forskningsenheden
Sundvej 30
8700 Horsens

Oplysningerne vil blive behandlet i samarbejde med følgende myndigheder eller virksomheder:

Livsstilscentret i Brædstrup
Sygehusvej 20
8740 Brædstrup

Projektet omfatter ikke en biobank.

Tilladelse
Der meddeles herved tilladelse til projektets gennemførelse.

Der gives alene tilladelse til behandling af lovligt indsamlede oplysninger, og under forudsætning af, at alle øvrige nødvendige

tilladelser er indhentet, herunder eventuelle skriftlige patientsamtykker.

Region Midtjylland fastsætter i den forbindelse nedenstående vilkår.

Tilladelsen gælder indtil den 31-10-2025.

Projektanmeldelsen vil henhøre til Region Midtjyllands generelle anmeldelse til Datatilsynet, "Sundhedsvidenskabelig forskning i Region Midtjylland", jf. persondatalovens § 43 og godkendt af Datatilsynet under journalnummer 2007-58-0010.

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Samtykkeerklæring

Informeret samtykke til deltagelse i ph.d. projektet: "At være en stor krop i bevægelse: oplevelser af livsstilsforandringer gennem 1½ år". En interviewundersøgelse af mennesker med svær overvægt, der starter på en livsstilsændring.

Erklæring fra deltagere

Jeg kan hermed bekræfte, at jeg har modtaget både mundtlig og skriftlig information om forskningsprojektets formål, udførsel og anvendelse.

Jeg ved at:

- det er frivilligt at deltage
- jeg til enhver tid kan trække mit tilsagn om deltagelse tilbage
- alle oplysninger behandles anonymt og slettes, når projektet er endeligt offentliggjort.

Jeg giver hermed tilsagn om, at jeg ønsker at deltage i interviews i forbindelse med forskningsprojektet.

Deltagers navn: _____

_____

Dato Deltagers underskrift

Erklæring fra den der afgiver information

Jeg erklærer, at deltageren i forskningsprojektet har modtaget mundtlig og skriftlig information om forskningsprojektet. Efter min overbevisning er der givet tilstrækkelig information til, at der kan træffes beslutning om deltagelse i projektet

Navnet på den der har afgivet information: Bente Skovsby Toft, Ph.d. studerende og fysioterapeut

_____

Dato Underskrift

AARHUS UNIVERSITET

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Individuel interviewguide 1

Briefing

Tak: fordi jeg må komme hjem til dig og interviewe dig…
Formålet: er at få indsigt i hvordan du opleves at bevæge sig i forbindelse med en livsstilsændring…
Emne: Jeg vil belyse hvordan bevægelse opleves i forhold til nogle helt grundlæggende aspekter som; tid, sted, humør, selvopfattelse, relationen til andre og din egen krop…
Tidsramme: ca. 1 time
Optagelser: optages på diktafon og renskrives og analyseres til forskningsbrug og slettes…
Rettigheder: fortrolig og anonym behandling. Ret til at fortryde deltagelse…
Underskrift: af samtykkeerklæring...

Forskningsspørgsmål
1. Hvordan opleves det at bevæge sig, når man er svært overvægtig?
Interviewspørgsmål
Fortæl lidt om dig selv dit nuværende aktivitetsniveau i hverdagen? Beskriv din hverdag. Hvordan og hvor meget du bevæger dig i hverdagen? Hvornår er du tilfreds med dine bevægelser? Er der noget du gerne ville have var anderledes? Hvorfor? **Hvilke erfaringer har du med bevægelse?** Kan du fortælle om en særlig oplevelse af at være aktiv? Hvornår har du det godt med bevægelse? Hvornår føler du ubehag ved bevægelse? **Forandringer** Har du tidligere prøvet at ændre dit aktivitetsniveau? Hvordan? Hvad tror du, har indflydelse på, hvor meget du bevæger dig?
Spørgsmål rettet imod 6 livsverden domæner:
• **Tid** Hvordan ser du din egen udvikling i forhold til bevægelse og vægt? Hvordan kunne du ønske dig det skulle være i fremtiden? • **Sted** Er der steder, hvor du godt kan lide at bevæge dig? Er der steder, hvor du ikke ønsker at bevæge dig? • **Humør** Hvilke former for bevægelse kan du godt lide? Er der aktiviteter, der gør dig glad? Er der aktiviteter, du bliver nedtrygt eller i dårligt humør over? Hvordan vurderer du dit energiniveau?

- **Identitet/selvopfattelse**

Er der tidspunkter, hvor du føler dig specielt godt tilpas, og har det godt med dig selv? Forklar.
Hvilke oplevelser kan give dig en fornemmelse af succes og selvtillid?
Hvordan oplever du dit selvværd er, kan du give et eksempel, hvor du har følt godt selvværd under bevægelse?
Hvordan vil du gerne have at folk skal opfatte dig? Hvilke fordomme har du om dig selv? Tror du, andre har fordomme om dig? Hvorfor?

- **Relationen til andre**

Hvem befinder du dig bedst sammen med? Har du haft oplevelser af at være sammen med andre omkring bevægeaktiviteter? Vil du helst være aktiv med andre eller alene? Hvem vil du helst være aktiv sammen med?
Har du haft dårlige oplevelser med sammen med andre i forbindelse med bevægelse?
Hvem oplever du, som kan støtte dig i din livsstilsændring?

- **Kropslighed**

Hvordan mærker du din krop under bevægelse?
Hvilke bevægelser ønsker du at bevare eller at kunne gøre mere af? (mobility)
Hvornår slapper du af? Hvornår slapper du allermest af? (dwelling)
Hvordan betragter du din krop på nuværende tidspunkt? Har din kropsstørrelse indflydelse på det?
Vurderer du at din kropsstørrelse har betydning for dit hverdagsliv?

Afsluttende spørgsmål

Er der supplerende kommentarer eller er der emner, som du synes, vi mangler at snakke om?

Debriefing

Afrunding: Tak for din deltagelse.
Spørgsmål: er der noget du gerne vil spørge mig om?
Oplevelsen af interviewet: hvordan har det været at blive interviewet? Er der noget du synes, der skal være anderledes næste gang?
Næste interview: vil være et gruppeinterview på LIV næste torsdag (uge XX) direkte forlængelse af din indlæggelse (kl. 13.15-14.45). Der vil jeg bede dig om at fortælle om en oplevelse, som du har haft omkring fysisk aktivitet, som har været påvirket af andre.

Individuel interviewguide 2

Briefing

Forskningsspørgsmål
2. Hvordan opleves det at bevæge sig, når man er svært overvægtig?
Interviewspørgsmål
1) Siden sidst: Kan du fortælle hvad du har tænkt på siden sidst? Er der noget du synes du glemte at fortælle? Hvad har du fortalt andre om hvordan du har det? 2) Hvad er der sket siden sidst? Vil du prøve at beskrive de forandringer du har oplevet gennem det sidste halve år? Hvilke oplevelser vil du fremhæve som har været særlig gode? Hvilke oplevelser vil du fremhæve som har været dårlige? Hvilke udfordringer har du mødt? Hvad har du gjort i svære situationer? Hvad kunne du ønske dig skulle være anderledes? 3) Hvordan synes du det går? Hvad oplever du går godt? Hvad oplever du som problemer eller bekymringer? Hvilke forestillinger har du om hvad, der vil ske fremadrettet? Hvad ser du mest frem til? Hvad kunne du frygte? 4) Hvordan har andre reageret på at dig? Hvordan har dine omgivelser reageret på dig og dit forløb? Hvem har været en hjælp/støtte i processen med livsstilsændring? Hvordan? 5) Sidste gang sagde du/snakkede vi om....? (Specifikke individelle spørgsmål baseret på forrige interview) Vil du prøve at fortælle lidt mere om....? Jeg fik ikke hørt til....vil du prøve at sige lidt om det?
Afsluttende spørgsmål
Er der supplerende kommentarer eller er der emner, som du synes, vi mangler at snakke om?

Debriefing

Individuel interviewguide 3

Briefing

Afsluttende individuelt interview

Forskningsspørgsmål

3. Hvordan oplever mænd og kvinder med svær overvægt fysisk aktivitet på langsigt 18 mdr. efter livsstilsintervention?

Kan du beskrive hvordan du har det lige nu?
For et år siden fortalte du, at det var…hvordan er det nu?

Kan du fortælle om nye **aktiviteter** eller nye måder du bevæger sig på?
Hvordan har du det med at **bevæge** dig? Oplever du nye muligheder eller begrænsninger?
Hvad har været din bedste oplevelse med bevægelse? Hvad har været den dårligste oplevelse?
I de tidligere interview fortalte du…..hvordan er det nu?

Hvad er de største/**vigtigste forandringer** der er sket?
I de tidligere interview fortalte du…..hvordan er det nu?

Hvilken betydning har dit **ophold** på Livsstilscenteret haft?
Er der **vaner** du stadig arbejder for at ændre eller fastholde?
I de tidligere interview fortalte du…..hvordan er det nu?

Hvordan kunne du tænke dig det **næste år** skal være? Hvad skal der til for at det lykkedes?

Hvordan ser du din situation om **5 år**? Hvad betyder det for dig? Hvorfor?

Brug cirkel:
Ud fra det du og andre har fortalt, har jeg lavet en cirkel som viser nogle sammenhænge. Hvilke af dem kender du? Hvordan virker de for dig? Er der noget du mangler?
Kan sammenhængene gøre dig syg? På hvilken måde?

Afsluttende spørgsmål

Er der supplerende kommentarer eller er der emner, som du synes, vi mangler at snakke om?

Debriefing

Afrunding: Tak for din deltagelse, den har været uvurderlig.
Spørgsmål: er der noget du gerne vil spørge mig om?
Oplevelsen af interviewet: hvordan har det været at blive interviewet? Hvordan har det været at deltage i projektet?
Invitation: Har du lyst til at jeg sender en invitation til mit Ph.d.-forsvar om godt et år?
Nyt interview: må jeg kontakte dig igen om 1 år og høre hvordan det går?

Fokusgruppe interviewguide 1

Briefing

Projektets formål: få indsigt i hvordan mænd og kvinder oplever og taler om at være fysisk aktiv sammen med andre.
Emne: Jeres fortællinger om oplevelser af hvordan det er at være fysisk aktiv sammen med andre.
Tidsramme: 1½ time
Optagelser: optages på video og diktafon, analyseres til forskningsbrug og slettes efter brug.
Rettigheder: fortrolig og anonym behandling. Ret til at fortryde deltagelse.

Forskningsspørgsmål	
Hvordan beskriver, fortæller og refererer mænd/kvinder deres oplevelser af bevægelse i relation til andre?	
Indledning:	I er alle inviteret til at deltage, da I er netop startet på en livsstilsændring og alle er store mennesker. Jeg kunne godt tænke mig at få indsigt i jeres erfaringer med at bevæge jer sammen med andre mennesker.
1. **Åbningsspørgsmål** (alle i en runde)	Kan du kort fortælle hvem du er, hvor du bor og hvad du laver i din fritid?
2. **Nøglespørgsmål** (i runder, én ad gangen)	
• Kan I hver fortælle om en særlig oplevelse af at bevæge jer, som har været påvirket af andre? Hvilken betydning har det haft for lysten til at bevæge dig? • Er I kommet i tanke om andre oplevelser, som I har lyst til at supplere med? • Hvordan har det været at høre de andre fortælle?	
Slutspørgsmål	
Er der nogen, der har afsluttende kommentarer?	

Debriefing

Afrunding: Tak for jeres aktive deltagelse.
Spørgsmål: er der noget I gerne vil spørge mig om?
Oplevelsen af interviewet: er der kommentarer til hvordan interviewet er forløbet? Er der noget I synes jeg bør gøre anderledes næste gang?
Opsamling: Jeg har hørt om jeres oplevelser af fysisk aktivitet sammen med andre. Dem vil jeg arbejde videre med og følge op på med endnu et gruppeinterview om 6 mdr....
Næste interview: vil være et individuelt interview også om 6 mdr. Jeg ringer og laver aftaler med jer hver især om tid og sted. Gruppeinterviewet vil foregå på samme måde som i dag, og vil blive lagt i forbindelse med jeres 3. og sidste indlæggelse på Livsstilscentret.

Fokusgruppe interviewguide 2

Briefing

Forskningsspørgmål
Hvordan beskriver, fortæller og refererer mænd/kvinder til deres oplevelser af bevægelse i relation til andre?
Aktivititet – "vælg motiver"! (runde) **https://www.sdcc.dk/fagfolk/dialogvaerktoejer/need/Documents/Min_motion_WEB_2014_DK.pdf** **https://www.sdcc.dk/fagfolk/dialogvaerktoejer/need/Documents/HVEM_ER_JEG_WEB_2014_DK.pdf**
Vælg venligst 3-5 billeder, der kan inspirere dig til at fortælle om oplevelser, du har haft med bevægelse. Du bestemmer selv hvad du vil fortælle, og må fortælle om både gode og dårlige oplevelser. (Der vælges) Hvad viser de billeder, som du har valgt? Hvilke oplevelser minder billedet dig om? Hvordan repræsenterer de dine oplevelser? Hvad kan billedet ikke indfange eller vise?
Støttespørgsmål
Ubehag og velvære i bevægelse: Hvilke oplevelser kan I fremhæve som særlig betydningsfulde? Hvordan har I tænkt og forholdt jer til bevægelse gennem de sidste 6 måneder? Hvad tror I, har betydning for om oplevelserne er gode eller dårlige? Andre mennesker og fysisk aktivitet: Hvordan har I været aktive sammen med andre? Hvem har I været aktiv sammen med? Hvad lavede I sammen? Hvem tog initiativ til det? Hvordan var/oplevede I det? Hvilke aktiviteter har familie/venner/professionelle være involveret i? Hvordan kan I beskrive den støtte og/eller modstand, som I har oplevet fra omgivelserne ift. at være aktiv? Vurderer I at Livsstilscentret, jeres omgivelser, netværk eller lokaltilbud haft særlig betydning for jeres nuværende situation? Forandring over tid: Hvad er det væsentligst der er sket i jeres liv ift. bevægelse gennem de sidste 6 mdr.? Hvilke tanker gør I jer om fremtiden? Hvad drømmer I om?
Slutspørgsmål
Er der noget, vi skulle have talt om, som vi endnu ikke er kommet omkring? Er der nogen, der har supplerende kommentarer?

Debriefing

Personerne er de samme til begge interviews, og de vil være indlagt på det samme hold som dig.
3. gang du er indlagt afsluttes forløbet ved Livsstilscentret i Brædstrup med en samtale.

Hver samtale vil vare ca. 1 time og vil blive optaget på bånd.
Gruppe-interviews vil vare ca. 1½ time og vil blive optaget på video.
Alle optagelserne vil blive behandlet fortroligt og anonymt hele vejen og vil blive slettet, når projektet er afsluttet.

Din deltagelse i projektet er frivillig, og du skal ved vores første møde underskrive en samtykkeerklæring. Fortryder du undervejs, kan du til enhver tid trække dit tilsagn om deltagelse tilbage.

Med venlig hilsen

Bente Skovsby Toft
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midt
regionmidtjylland

AARHUS
UNIVERSITY

Krop, bevægelse og livsstil

- en undersøgelse af oplevelser

Appendix J

Hospitalsenheden Horsens
Livsstilscentret i Brædstrup
Sygehusvej 20
DK-8660 Brædstrup
Tel. +45 7842 9702

Deltagelse i undersøgelsen

Efter aftale med Livsstilscentret i Brædstrup, har jeg fået lov til at udlevere denne pjece med information om en interviewundersøgelse.

Mit navn er Bente Skovsby Toft og jeg er fysioterapeut og ansat ved Hospitalsenheden Horsens for at lave et forskningsprojekt, der skal give indsigt i svært overvægtiges oplevelser af at være aktiv og i bevægelse.

Med dette brev vil jeg give nogle informationer og invitere dig til at deltage i projektet "At være en stor krop i bevægelse: oplevelser af livsstilsforandringer gennem 1½ år".

Formålet med projektet er ved hjælp af gentagne samtaler, at høre dine oplevelser af at være aktiv i forbindelse med din livsstilsændring. Resultaterne af undersøgelsen vil blive offentliggjort i videnskabelige tidsskrifter og formidlet til relevante fagpersoner.
Der er ingen sundhedsmæssige risici forbundet med deltagelse i projektet.

I dette brev vil du kunne læse om projektet. Jeg vil snarest kontakte dig for at høre, om du har spørgsmål, inden du beslutter, om du kunne tænke dig at deltage.

Tak for din interesse.

Med venlig hilsen

Bente Skovsby Toft
Ph.d.-studerende fysioterapeut

Information om deltagelse i forskningsprojektet:

"At være en stor krop i bevægelse:
oplevelser af livsstilsforandringer gennem 1½ år".

Baggrunden for projektet er, at man ved meget lidt om hvordan det opleves at fysisk aktiv eller træne, når man er svært overvægtig.

Formålet er at få ny viden om, hvad der opleves som behageligt, støttende og motiverende eller ubehageligt, svært og problematisk i forbindelse med bevægelse. Derefter er målet, at vi som behandlere skal blive bedre til at støtte og vejlede til livsstilsændringer.

Deltagelse i projektet vil indebære 3 samtaler over en 1½ årig periode samt 2 interviews i en gruppe på 8 personer, med fokus på dine personlige oplevelser af at være fysisk aktiv. Planen er denne:

Før indlæggelse	1. indlæggelse	3. indlæggelse	Opfølgning 1½ år
Samtale		Samtale	Samtale
	Gruppe-interview	Gruppe-interview	

Den første samtale vil foregå umiddelbart før din indlæggelse på Livsstilscentret i Brædstrup, og den sidste samtale vil foregå 1½ år efter denne indlæggelse. Samtalerne kan foregå i dit eget hjem eller et sted vi aftaler.
I forbindelse med at du er indlagt 1. og 3. gang, er der planlagt et gruppe-interview med 7 andre personer af samme køn som dig selv. Personerne er de samme til begge interviews, og de vil være indlagt på det samme hold som dig.
3. gang du er indlagt afsluttes forløbet ved Livsstilscentret i Brædstrup med en samtale.

Appendix K

Hospitalsenheden Horsens
Forskningsenheden
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Til "projektdeltager"

midt
regionmidtjylland

Dato XX.XX.2016
Bente Skovsby Toft
Tel. +45 7842 6103
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Vedr.: Invitation til gruppeinterview

Kære _____
Mit navn er Bente Skovsby Toft. Jeg er fysioterapeut og ansat ved Hospitalsenheden Horsens for at lave et forskningsprojekt på Livsstilscentret om krop, bevægelse og livsstil.

Med dette brev vil jeg give nogle informationer og invitere dig til at deltage i et gruppeinterview. Interviewet vil foregå **torsdag d. XX/XX kl. 13-14.30.** Der vil være max. 8 kvinder til interviewet, som har fokus på dine personlige oplevelser af at være fysisk aktiv sammen med andre. Interviewet vil blive optaget for senere analyse. Optagelserne vil blive behandlet fortroligt og anonymt hele vejen og vil blive slettet, når projektet er afsluttet.
Resultaterne af undersøgelsen vil blive offentliggjort i videnskabelige tidsskrifter og formidlet til relevante fagpersoner.
Der er ingen sundhedsmæssige risici forbundet med deltagelse i projektet.
Gruppeinterviewet er en del af et større projekt, der har til formål at få ny viden om, hvad der opleves som behageligt, støttende og motiverende eller ubehageligt, svært og problematisk i forbindelse med bevægelse. Derefter er målet, at vi som behandlere skal blive bedre til at støtte og vejlede til livsstilsændringer.

Din deltagelse i projektet er frivillig, og fortryder du undervejs, kan du til enhver tid trække dit tilsagn om deltagelse tilbage.
Hvis du ønsker at høre mere og evt. deltage bedes du give sekretæren på Livsstilscentret besked.

Venlig hilsen

Bente Skovsby Toft
Ph.d.-studerende,
Livsstilscentret i Brædstrup
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