

The ups and downs of lifestyle modification: An existential journey among persons with severe obesity

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Abstract

Background: Maintaining a healthy living after the end of a lifestyle intervention is a challenge for persons with severe obesity. Measurable outcomes are often emphasised, but there is a need for understanding the process of lifestyle change and the long-term perspectives among persons with severe obesity.

Aim and objective: To describe and deepen the understanding of how persons with severe obesity experience making and maintaining lifestyle changes in everyday life three years after lifestyle intervention.

Methodology and methods: The study used a hermeneutic phenomenological approach. A purposive sample of seven adults with BMI ≥ 40 was recruited from a lifestyle intervention programme. Data were generated through individual follow-up interviews. The analysis was based on theoretical framework on dwelling and mobility. Ethical approvals were received from the Danish Data Protection Agency and the ethical principles of the Declaration of Helsinki were followed.

Results: One overarching theme emerged: 'The journey of ups and downs'. Three sub-themes were: 'Living with and tackling the demands of life's hassles', 'Deliberating the fight for weight loss' and 'Needing a trusted person to feel met as a human being'.

Conclusions: Everyday life among persons with severe obesity is experienced as a dynamic process of shifting experiences of dwelling and mobility. Sustained lifestyle changes require ongoing adjustments of action, which healthcare providers can influence in ways that either support or obstruct. Collaboration and a humanised approach across disciplines and sectors are suggested to promote sustained healthy living.

KEYWORDS

adult, health care, health personnel, hermeneutics, hope, lifestyle, severe obesity, qualitative study, weight loss

BACKGROUND

It is estimated that 1.5%–4% of the population live with the complex chronic condition of severe obesity (Body Mass

Index/BMI ≥ 40 kg/m²) [1]. The Western obesity-promoting environment characterised by easy access to food, reduced work-related activity and active transportation is unlikely to change in the near future. Accordingly, obesity-reducing

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behaviour in terms of healthy lifestyle is advocated [2] as it may prevent obesity-related diseases, for example, diabetes and cardiovascular diseases [3]. The severity of health problems increases with increasing weight, and persons with severe obesity have been found to be less adherent to general healthcare recommendations than persons with lower BMIs [4].

Lifestyle interventions for persons with severe obesity

Lifestyle is a way of living based on patterns of behaviour influencing a person's health. It is determined by the interplay between personal characteristics, social interactions and socioeconomic and environmental living conditions. A person's lifestyle is not fixed, but subject to change, however, there is no 'optimal' lifestyle to be prescribed for all people [1]. Along with lifestyle interventions aiming to support persons in avoiding disease and improving physical health, interventions also address the experience of well-being. Well-being is an integrated existential dimension connected to a person's lifestyle and health [3, 5], as well as a person's ability to partake certain everyday life activities [6]. Thus, lifestyle interventions are complex and entail numerous aspects of each person's life. Lifestyle interventions for persons with obesity are multidisciplinary and take motivation, barriers, facilitators, relationship with food, diet and exercise into account [7]. The goal is to promote behavioural changes that lead to weight loss. However, for nearly two decades the focus on weight loss has been criticised for lacking results and carrying the risk of harming the individual [8]. The result can be yo-yo dieting with relapses, which causes feelings of defeat, failure and shame. Based on these facts a different approach has been developed, which focuses on health and well-being, and allows weight loss to become a positive side effect of the maintenance of lifestyle change [9].

Persons with severe obesity may experience improved quality of life after lifestyle intervention with less binge eating and depression as well as improved physical and mental health in everyday life. This is known to contribute to their weight management [10]. Still, making lifestyle changes requires great personal efforts [11] and relapse is possible at any stage of the intervention [2]. It is challenging for healthcare providers (HCP) to support a person in maintaining healthy behavioural changes [12]. The HCPs may overlook the fact that facilitators and barriers to healthy living are numerous and have an underlying complex existential character [13]. Even after ending an intervention programme, persons with obesity continue to struggle with existential challenges in everyday life [14]. The experiences of well-being and suffering influence the capability of maintaining lifestyle changes [15] and those who have failed in maintaining weight loss may require continuous support of HCPs [16].

Well-being and lifeworld domains relate to everyday life and health

Everyday life can be described as 'being-in-the-world' in a seamless and familiar everydayness. The everydayness is temporary because our experiences may change our understanding over time [19]. Everydayness is holding the experience of possibility and of developing self-fulfilment, however, always within the limited freedom of being born in a pre-determined genetic, cultural and historical time [17]. We are always with others in our everydayness and the experience of well-being cannot be detached from them [18]. Well-being is defined as the experience of something positive and wanted in one's everyday life [20] and is opposed by the experiences of suffering. Together, they encompass all aspects of health across the physical, mental, social and spiritual dimensions [21]. Well-being and suffering exist in different nuances balanced between dwelling, mobility and dwelling-mobility. Dwelling is a capacity for settling into the present moment and to feel at peace with what is there. Mobility is a capacity for moving in ways that expand one's life (metaphorically or literally). Dwelling-mobility is a unified sense of peace and possibility [5].

A lifeworld-oriented health approach aims to understand a person's existential experiences of well-being and suffering within the domains of spatiality, temporality, identity, inter-subjectivity, mood, identity and embodiment [22]. There seems to be a tendency to overlook the everydayness nuances of dwelling and mobility in research and healthcare practice. Moreover, the significance of suffering can easily be obscured by over-emphasising well-being, hence, it is important to view and understand both in a continuum.

The approach of existential experiences in research

Little is known about how the existential challenges in everyday life influence choices and actions after lifestyle intervention among persons with severe obesity. Their needs and barriers deserve further attention in order to improve lifestyle interventions [23]. A deeper insight into the experiences of everyday life among persons with severe obesity after lifestyle intervention can support a lifeworld-oriented approach in healthcare practice.

The study presented in this paper is a continuation of the interviews in previous studies with the same group of participants. Previously, the participants' experiences of well-being were focused on physical activity within the existential dimensions: embodiment and identity (before and at the end of intervention six months later) [24]; inter-subjectivity and spatiality (during intervention) [25]; and mood and temporality (at 18 months) [15].

AIM AND OBJECTIVE

This study focuses on well-being and suffering in order to describe and deepen the understanding of how persons with severe obesity experience making and maintaining lifestyle changes in everyday life 3 years after lifestyle intervention.

METHOD

This study has a qualitative design and is grounded in hermeneutic phenomenology based on Heidegger's lifeworld perspectives, that is, the way human beings exist, act and are involved in the world [18]. It is the fourth interview round of individual interviews conducted by the first author and serves as a three-year follow-up.

The lifeworld was approached through interview about the participants' experiences, and the data from the interviews were interpreted through the hermeneutic circle of understanding. The interviewer's pre-understanding was part of the interpretation and included knowledge based on a theoretical framework of dwelling and mobility describing existential nuances of well-being and suffering. This pre-understanding was put at stake to expand previous understanding of the everyday life of the participants [26]. As the lifeworld is pre-reflectively experienced, it was interpreted and reflected upon in a continuous process of questioning and answering during the interviews and in the following data analysis [26].

Participants and context

Initially, participants were purposefully recruited by the criteria BMI ≥ 40 kg/m² from a group-based lifestyle intervention programme at a Danish public hospital in 2015, which they attended. The programme focused on health promotion and consisted of three in-hospital modules of four days over a six-month period. Eleven persons had participated in the 18-month follow-up study [24]. When contacted by telephone seven participants volunteered for this study (See Table 1). Reasons for non-participation were lack of interest and time, or unable to reach by phone or mail. The participants were aged 28–63 years, and they all had medical and/or psychosocial problems, which required support from HCPs.

Data collection

Seven qualitative in-depth individual interviews were conducted by using an interview guide consisting of open-ended questions (See Box 1). The questions held a temporal aspect as they were directed at the participant's present situation with openness towards their experiences since the last interview as well as their hopes for the future.

The interviews were conducted in June/July 2019 in the participants' home setting and lasted an average of 63 minutes. The interviews were audio-recorded, and field notes were written down after each interview. All interviews were transcribed verbatim.

TABLE 1 Self-reported characteristics of the included participants for this study (n = 7)

P	Woman/ Man	Age/y	Demography:	Socio-economic status: Occupation; education; income	Recent medical and psycho-social support
01	W	62	Divorced	Early retirement; medium-level education; low income	General practitioner (GP); general practice nurse; medical doctors; physiotherapist (PT); home carer; psychiatric aide; social workers; companion arrangement; pedicurist; dentist
06	W	33	Cohabiting, ≤ 2 children	Employment training course; low-level education; low income	GP; psychiatrist; trauma therapist; hypnotherapist; PT; career consultant; family counsellor
07	W	33	Married, ≥ 3 children	Full-time employed; medium-level education; low income	GP; bariatric doctor; clinical dietitian
09	M	56	Single	Early retirement; low-level education; low income	GP; medical doctor; psychiatrist; district nurse; PT; priest; psychiatric aide; social worker
11	M	63	Married	Full-time employment; medium-level education; high income	GP
15	M	48	Married, ≥ 3 children	Full-time employed; low-level education; medium income	GP; PT; social worker; bariatric doctor
16	M	28	Single	Full-time employed, low-level education; medium income	GP; psychologist

BOX 1 Examples of questions and follow-up questions from the interview guide

Questions:

"Please, tell how you are right now?"

"What changes have you experienced in our life for the last 18 months?"

"Please, describe a situation in everyday life, which carried with it a greater sense of well-being or suffering"

"What are your expectations and hopes for the future?"

Follow-up questions:

"Can you tell more about it?"

"Can you give an example of that?"

"What did that mean to you?"

How do you think/feel about that?

Last time you told me..., how is that now?

Analysis and interpretation

A phased analysis based on a hermeneutic approach took place as a movement across three overlapping steps: (1) What is addressed by the participant? (2) How does he/she talk about it? and (3) What experiences does he/she refer to and describe? (See Table 2). The development of themes was conducted through a circular interpretation across the

interviews going back and forth between previous and new understanding of the transcripts.

The analysis was conducted one interview at a time in relation to step 1 and merged in step 2 and 3.

By searching for meanings of well-being and suffering in everyday life, themes were developed. The analysis was conducted in a reflective way, placing the themes 'in the centre' (26:386), and testing whether they resonated with the co-authors' interpretations. The testing was a discussion, which generated deeper insights and understandings [26] and at step 3 the themes were sensitised by the theoretical framework of dwelling-mobility [5]; this involved a dialogue between the data gathered and the well-being theory (See Table 3).

Ethical considerations

The study was approved by the Danish Data Protection Agency (J. no. 1-16-02-425-15) and followed the ethical principles of the Declaration of Helsinki [27]. The participants, orally and in writing, were informed about the study and prior to the interview, they signed a written-consent form. The participants were guaranteed confidentiality and informed about their right to withdraw at any time without reprisal.

RESULTS

In everyday life, different kinds of well-being and suffering were experienced, which generally influenced the maintenance and development of a healthy living. The overarching

TABLE 2 The three analytical steps; address, talk and refer

Step	Content	Procedure
Address (step 1)	Topics addressed by the participants as subject matter What is talked about?	All interview audio recordings were listened and re-listened to and transcripts were read and re-read to find expressions that reflected the fundamental meaning of the text as a 'whole', that is, searching for the topics addressed. An overall identification of topics was made.
Talk (step 2)	Themes talked about How does the participant talk about it?	Each participant's talk was interpreted via dialogue with the first author's pre-understanding to identify common themes by moving back and forth between the topics addressed (the 'whole'), and the 'parts', that is, quotes from each participant. What was said, was not seen as an isolated matter, but an aspect of the larger topic.
Refer (step 3)	Existential experiences referred to (experience and knowledge-based analysis, i.e. through pre-understanding and theory)	The understanding of the subject matter was expanded to include the reflected meanings of the experiences expressed by relating the individual's experiences to the meaning of the 'whole' text including experiences or contexts that were referred to. Theory was used to gain a new and coherent understanding of the participants' existential experiences and an overarching theme were created.

TABLE 3 Example of the interrelatedness of address, talk and refer with data from the participants

Address (topics)		Refer (reflected meanings)	
Life change events	Weight and body size	Support from others	Existential experiences
Economical concerns	Weight loss and gain	Collaboration with HCPs	of well-being
Problematic housing	Bodily capabilities	Family relations	and suffering
Mental diseases and stress	Food and eating habits	Wanting help	in everyday life
Being suicidal	Physical activity	Feeling thwarted	among individuals
Capacity and effort made	Weight loss surgery	Healthcare system	with severe
Talk (themes)			obesity:
(1) Living with and tackling the demands of life's hassles	(2) Deliberating the fight for weight loss	(3) Needing a trusted person to feel met as a human being	'The journey of ups and downs'.
Quotes to illustrate themes			
That's what's makes it so shameful—that suddenly you forget it. That's what happens to me anyway...and not until you realise 'Wow, now I have lost it again', then you take action, right?! And so it goes on. And, that is how my life has been; up, down, up... and...(P11).	I thought, I could become normal with a snap, but I am normal... Earlier I thought I would never become happy if I did not lose weight, but I think I will (P16).	I have discovered that I, unfortunately, have fallen out, outside the system... The system is not trying to help me. I actually feel that they are pressurising me into a situation that makes me give up. That's what they are trying to do...(P09)-	
Sometimes, during the last week of the month, it can ail a little in relation to how much proper food you can get, because then it's what's in the freeze or the fridge...but there will be no meal plan like at the beginning of the month (P07).	I don't think that it will be any different...I think it is somewhere close to where I can maintain it [bike riding]...As I am doing now, with this weight, I feel fine...If I can keep it around 140, then I am quite well satisfied...but I really think other things matter more (P11).	What my doctor tells me is that I eat too much...and I answer: 'I eat nothing, for God's sake...do you want me to stop eating?'" (P15).	
I really want to exercise more, but I have to think about what I can endure...I have difficulty accepting how slowly it progresses, but earlier I just kept on fighting to get that one hour of exercise each day...now I am just going exercising 2–3 times a week (and) I have reduced it to half an hour instead (P06)	I must have gained weight during my education, as I was thinking about education instead of thinking about weight loss...If I had to choose again...between education and weight loss, then I would still have chosen the education) (P07).	It is kind of difficult to talk to someone new...well, it is kind of strange...This person wouldn't know what we talked about earlier...So it is kind of hard suddenly to start the talking all over again (P07).	

theme emerging was 'The journey of ups and downs'. Three sub-themes described the nuances of dwelling and mobility of well-being and suffering: 'Living with and tackling the demands of life's hassles', 'Deliberating the fight for weight loss' and 'Needing a trusted person to feel met as a human being' (See Table 3).

'The journey of ups and downs'

Ups and downs related to different aspects of life such as bodily changes and abilities; mood and mental distress; being

capable and having hope. The ups and downs challenged the balance between dwelling and mobility. The constant awareness towards lifestyle changes and adjustments made little room for dwelling, and with lack of dwelling it was difficult to experience mobility and continue fighting. Major life change events and hassles made a healthy lifestyle more difficult. Repeated relapses to earlier habits were inevitable parts of everyday life. These relapses contributed to lack of mobility in a sense of incapacity, and to a lack of dwelling, in a sense of shamefulness of being incapable. This was contrasted by a sense of well-being in mobility when new, meaningful and wanted changes were achieved.

'Living with and tackling the demands of life's hassles'

Apart from tackling and living with obesity, the participants were facing numerous hassles. Everyday life hassles were individual and numerous and included mental health problems; problematic parenting; relationships with others (including HCPs); challenging obligations and responsibilities; unemployment and limited economic freedom; messy and unsuitable homes; physical pain and limitations; and/or tiredness due to sleep disturbances.

Living with and tackling these hassles was exhausting and gave a reduced sense of mobility in life where doubts about whether it was possible to recover energy and vitality added to the fear of gaining weight and becoming inactive. A man found it difficult to maintain the energy to keep on making lifestyle modifications: 'I know it very well, I KNOW it, but I just can't do it any longer...I have lost the spark' (P09). Especially among the persons with an all-or-nothing approach to food and exercise, fear of failure and negative expectations of the future contributed to a spiral of suffering in dwelling-mobility, for example, leading to being less committed and having a sense of physical stasis and frustration.

Some experienced that their spatial surroundings blocked their dwelling possibilities. Living in messy and unsuitable homes and being unable to get them sorted due to a lack of physical and mental resources limited the opportunity for having a breathing space, where they could relax; for creating room for having guests and prevent feeling loneliness; carrying out cooking instead of eating random food; and moving around or training at home. Moreover, poor economy was a limitation for some participants. It reduced their possibilities of buying healthy food and doing certain types of exercise, for example, when they could not afford to join a health club or to go on family trips to a swimming pool, which reduced their physical activity level. All aspects, which hindered their mobility in everyday life and reduced well-being.

The hassles of everyday life imposed disturbing thoughts that can be viewed as an obstruction of dwelling and mobility. Being deeply concerned led to sleeplessness and tiredness, which reduced the initiative to be active during the daytime. Some would suffer from a sense of being alienated from themselves and at the same time being unable to live a meaningful life.

On the other hand, living a stable and regular life or being able to accept one's situation brought a sense of dwelling, that combined with a sense of being capable and seeing possibilities supported a sense of well-being in mobility, that is, elevated mood, energy, vitality and hope. Those who had achieved lifestyle changes such as regular circadian rhythms; healthier eating; increased physical activity; reduced stress or improved sleep patterns, seemed to enter a positive spiral of well-being in dwelling-mobility.

'Deliberating the fight for weight loss'

Obesity and weight loss were experienced as a daily concern that disturbed dwelling in one's view upon oneself and one's body and could make the fight for weight loss seem impossible. Without a sense of self-esteem, the failed weight-loss attempts led to disappointment, powerlessness and hopelessness. It was an experience of reduced mobility, as with this as this man, who was losing the energy to continue the fight: 'I have totally given up...somehow I feel I don't give a shit. Well, I am giving up. I hardly bother doing anything to lose weight anymore...because it's going up or stays the same...it doesn't help anyway' (P15). For the persons suffering the most, their present life with obesity was experienced to be intolerable and the future to be repellent or unliveable. They were suffering in dwelling-mobility stuck in life with no way out.

The participants' reflections upon obesity represented a tension between a nuanced and flexible attitude to health as a process and the achievement of a set weight loss goal or BMI. For a woman, weight loss became secondary as her point of departure was to tackle depression and anxiety:

One thing is that I went [to the Department of Lifestyle Rehabilitation] the first time. Actually, I also went the second and the third time. That mattered. I have overstepped some boundaries and had success by doing it. I might not have done it [started an education] if I had not been out [at the Department of Lifestyle Rehabilitation], because I did have anxiety, and it was the first time I went anywhere new by public transport. In itself, that was a great achievement - going away from home too (P07).

Being able to tackle anxiety and reducing depression became a turning point in her life. It provided mobility to succeed with other lifestyle changes and enabled her to start an education. Likewise, other participants were able to redirect the focus on weight loss to other aspects of life, for example, tackling lowered mood, managing a job, being able to take care of children and doing the housekeeping, which provided a balanced dwelling-mobility and increased well-being.

Dwelling as a sense of acceptance and settlement provided energy and engagement that gave mobility in making lifestyle modifications. However, this was difficult to achieve. Well-being was to a great extent influenced by the idea of an ideal weight and other's expectations and opinions on body size, appearance, and attractiveness. Accepting one's large body size was hard and body dissatisfaction raised the question whether lifestyle change was the 'right' way to go or whether undergoing weight loss surgery (WLS) could be a possible short cut to permanent weight loss. Considering WLS or deliberating the importance and priority of weight loss influenced the participants' attitude towards lifestyle change.

Needing a trusted person to feel met as a human being

Maintaining lifestyle changes was influenced by the social and healthcare systems. Health services had been used by the participants during the past three years in relation to physical and/or psycho-social health problems. HCPs had an important role in their everyday lives. The relationship with the HCPs influenced the participants' sense of dwelling-mobility, that is, how to find peace in what is given in life and be able to change what is possible. Having someone trusted to talk to and to meet in one's deepest concerns was considered of great importance for a person's possibility of dwelling, for example, when feeling understood and cared about – and not like a number. The HCPs showing genuine interest, empathy and sensitivity as well as remembering a person and his/her history added a sense of positive attitude and responsiveness to the help requested. Especially for the participants, who did not have anybody close, the dialogue and the collaboration with HCPs facilitated the mobility to tackle life's hassles and move on with healthy living. A man told, how HCPs could also impose suffering when pressuring him against his will: 'I don't want to hear "group exercise" one more time in my life, because then I will stop exercising. I feel like shit mentally, because I don't work with her [the physiotherapist]-but nobody wants to listen' (P09). The combination of a psychiatric diagnosis and physical diseases, which required professional care was experienced by a man as 'standing in a no man's land' of a 'fragmented healthcare system', which seemed to challenge his dwelling-mobility. Mobility was required in terms of energy and strength to stand up for oneself and get help, and at the same time lack of dwelling due to suffering from an existential crisis were adding to the complexities of health problems. The same man was about to give up and had suicidal thoughts during a hospital stay, but he felt rejected by the HCPs when wanting to talk about existential issues. Although he was not a religious person, he chose to talk to a priest:

The priest told me verbatim: 'you have so many good sides. You have done so much for yourself. You don't deserve to die. Death can be a relief for you, but there are many good things left in you' [cries]. So that actually meant that I put this awful idea away. But I cannot guarantee it won't come back, but it has been put aside for now (P09).

Talking to this (trusted) person helped the man experience hope and alleviated his suffering for a while. The possibility of talking to a trusted person about existential issues seems to increase well-being in dwelling as well as in mobility.

DISCUSSION

According to our findings, the journey of ups and downs can be understood and related to meanings of dwelling, mobility

and dwelling-mobility in relation to experiences of well-being and suffering. These complex and interacting dimensions made the process of making and maintaining the lifestyle changes a fluctuating and dynamic challenge, which most participants were unprepared for tackling. Well-being and suffering varied from time to time in our findings and made lifestyle changes a temporal and non-linear existential journey. In this way, our study adds empirical insights to existing research on how losing weight can be an enduring challenge [28] and how well-being can be a resource and provide mobility and human development [5]. Suffering can be both productive and unproductive for health [29], and we exemplify how it depends on a person's ability to dwell in or tackles life's hassles regardless if it is related to weight or not.

Failures reduce mood and hope and impose suffering

Tackling failed attempts of reaching one's goals seemed to be a common challenge among our participants as the sense of failure imposed suffering in dwelling-mobility in terms of reduced energy, lacking vitality and in the end extinguished hope. This stands in contrast to research claiming that trying over and over again can accumulate knowledge over time and may engender new hope through previous and current experiences [30]. Our participants found hope and hopelessness to be conditioned by past experiences, and failure could make some give up the hope of obtaining weight loss or an improved life. According to the literature, such specific hope influences the capacity of action, that is, to do something on the basis of hope and to work towards realising it [31].

In our participants suffering in mood was described as having depression as a personal follower, where disappointed expectations and reduced hope disturbed dwelling and blocked the mobility to move on in life. Previous research has claimed that suffering from depression makes a person incapable of carrying out everyday life and unable to imagine that their life situation will ever change [32]. Similarly, we found that unrealistic expectations towards oneself or one's goals could escalate into a present hopelessness and loss of the perspective of life to come. If specific hope is threatened, a more universal or deep hope might help the person to avoid giving up and prevent him/her from being caught in a vicious circle of suffering [31]. Hopelessness can be understood as severe suffering in dwelling-mobility and feeling the desperation of being stuck in an unwanted life with no desire to live on [33]. A severe kind of suffering was expressed by the participants with suicidal thoughts. They may have lacked deep hope, which is thought to involve the very meaning of human life, death and suffering [34]. Therefore, we argue that dwelling-mobility in mood and hope are essential aspects of lifestyle modification.

The development of well-being in identity influences lifestyle

Our findings showed how obesity and healthy living could impose a sense of being incapable and discontent at the same time. In an existential understanding, such experiences of a sense of self are related to suffering in dwelling-mobility in identity, which includes the person's insiderness, that is, who they are, how they feel and what they think (dwelling) as well as how they act (mobility) [35], thus leaving a person without respite [36]. According to our findings, the development of one's thinking is part of the development of one's sense of self. Our participants struggled with dichotomous thinking and unrealistic expectations, which according to previous research, are issues known to influence weight loss negatively as it commonly includes eating to regulate mood [2, 37, 38]. A more flexible and relaxed approach to weight loss may be beneficial as the sense of being a failure, a disappointment or a hopeless person may add to the participants' suffering in identity. According to Galvin and Todres (2011), a nuanced approach to health promotion requires a focus on identity that acknowledges 'a more' to one's identity than being obese or a failure, and at the same time support the mobility of thinking 'I can' make changes [6]. Previous research has identified identity to be the most complex and important lifeworld dimension in relation to lifestyle changes among people with obesity [39] and a review has suggested that identity may be a barrier to change [13]. Based on the findings that acceptance and settlement with body size, weight and physical capability added to the participants' embodied dwelling and mobility we argue that well-being in identity can develop and facilitate change. This study's emphasis on dwelling and mobility is a contribution to existing research suggesting that promotion of well-being among persons with obesity should replace the existing focus on body size and weight [40, 41].

The support from HCPs is essential for maintaining changes

We emphasise the importance of the relationship with other people including HCPs. We found that well-being in intersubjectivity was improved when having a trusted person to talk to and reflect with upon one's lifestyle process. This seemed to bring important insights into how the participants responded to themselves, their own obesity, illness, well-being and suffering. The HCPs held a central position in relation to supporting the engagement in lifestyle modification, and we agree with research arguing that it requires the ability to understand the lifeworld experiences of the patient to succeed [39]. Lack of understanding was experienced by our participants when HCPs tried to fit a person into group

exercise or into the diagnostic system of a hospital. This has previously been addressed as neglect of existential acknowledgement and a source of suffering [22]. By contrast, conversation and sharing of one's existential suffering have been addressed as a way to implement a humanised approach, which could add to well-being in dwelling and mobility [42]. Our empirical findings support earlier qualitative research documenting that a long-term alliance between persons with obesity and HCPs is beneficial [43]. Additionally, our findings point to the fact that in order to meet another person in a human manner the relationship and the collaboration with the HCPs needs to be trustful and with time to dwell in a conversation.

Methodological considerations

Hermeneutics go beyond the concepts of method [26], however, the stepwise analytical process of 'reading-writing-dialogue' provided structure [44] and the Heideggerian concepts 'Address, talk and refer' guided the analysis (18:§31–38) and made it possible to approach the interpretation in an empirical, practical and pragmatic manner [45].

In hermeneutic phenomenology, the researcher is an instrument for the research method and conducting repeated interviews may have increased the quality of the interviews as previous understanding could be expanded [46]. The same interviewer conducted all the interviews, which was considered an advantage as she was experienced in interviewing and working with persons with severe obesity as a physiotherapist within the context of the lifestyle intervention. She was familiar with the intervention, but not a part of the participants' intervention programme. She became familiar with the participants through the repeated interviews, which enhanced trust and confidentiality and allowed a dialogue about personal issues and provided thick descriptions of their lifeworld experiences [47]. To enhance trustworthiness, the first author's pre-understanding was continuously tested by reflecting with co-authors [48]. Finally, a checklist with criteria for reporting qualitative research was used [49].

A limitation of this study may be the transferability, however, we strived for in-depth descriptions of the participants, the context, the setting, and the research process to enable the reader to assess our findings and make them transferable to other lifestyle interventions [47]. Moreover, the small study sample of seven participants may be considered a limitation as it reduces the breadth, that is, variation of experiences represented in the study. However, with in-depth interviewing the quality of data is more essential than the sampling size in order to understand the phenomenon of interest more deeply [50,51].

Implication for practice

Lifestyle modification should be understood as a unique personal journey relying on dwelling in one's current situation and body and at the same time having a sense of mobility to move forward. These different kinds of well-being and suffering are constantly interacting and need attention from HCPs after lifestyle intervention has ended. A prolonged support can be provided by HCP in somatic or psychiatric care as well as by social workers from different sectors. It seems essential for HCPs to show genuine interest in a person and take the person's whole situation into account, especially by listening to the person's existential dimensions in order to understand their inner struggles. Moreover, it is necessary for HCPs to look beyond the effects of lifestyle changes, for example, weight loss, and emphasise the existential aspects of life in the dialogue about health. HCPs must be sensitive to the balance of a person's sense of dwelling and mobility and help the individual take small steps forward, dwell with the present and/or acknowledge the struggles of life as well as tackling the hassles along the way.

CONCLUSION

This study is the first to describe how persons with severe obesity are challenged in an existential way by the ups and downs in life, and how healthy living and weight loss are experienced three years after engaging in lifestyle intervention. The process of lifestyle change is an ongoing fluctuating process of well-being, which includes tackling different kinds of suffering in both dwelling and mobility. A reduction of the fluctuations seems to be a relevant aim for the process of lifestyle modification, and the alleviation of suffering is of great importance to support a person's capacity of action. HCPs in different sectors need to collaborate with each other and draw on the lifeworld experiences with an attentiveness and sensitivity towards existential concerns in order to increase well-being. This presupposes a humanised approach based on the understanding of the person's previous and current situation as well as their future hopes. Future research is needed to know more about how people deal with overweight and lifestyle changes and how they experience the co-operation on health and well-being with health care providers.

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CONFLICT OF INTEREST


The authors declare that there is no conflict of interest.

AUTHORS' CONTRIBUTION

BS Toft designed the study, conducted the interviews, drafted the manuscript and analysed all data. B Rasmussen has made substantial contribution in the analysis and interpretation of the data and with critical revisions during the process. U Hörberg has contributed to the data analysis and drafting the manuscript. All authors have approved the final version of the manuscript.

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