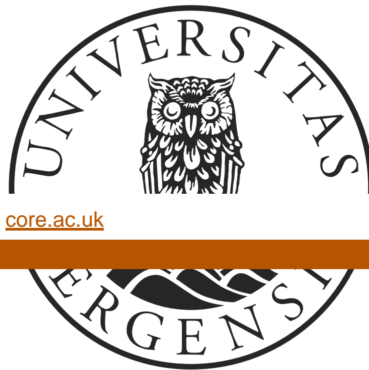
Carrying the weight of uncertainty: Patients' long-term experiences after bariatric surgery

Eli Natvik



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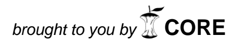

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Scientific environment

This PhD study is carried out as a joint venture between The Phenomenological Research Group in the Health Sciences and Physiotherapy Research Group, Department of Global Public Health and Primary Care, Faculty of Medicine and Dentistry, University of Bergen. My supervisors were Professor Målfrid Råheim and Eva Gjengedal, University of Bergen, and associate Professor Christian Moltu, Førde Hospital Trust and University of Bergen. I have attended to PhD courses at the Research School in Public Health and Primary Care at the University of Bergen and at Oslo and Akershus University College of Applied Sciences. I have participated in research seminars arranged by Sogn og Fjordane Centre for Health Research and the Regional Strategic Research Programme for Health and Social science in the Regional Western Health Authority.

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Eli Natvik, Juni 2015

Abstract

The prevalence of obesity and severe obesity has increased rapidly in Norway since the 1980's. Severe obesity is a medically introduced term for large body weight that is connected to health risk and impaired quality of life. The health care services can offer people with severe obesity an interdisciplinary assessment and possibly a weight loss intervention, although not necessarily bariatric surgery. Bariatric surgery is an option in severe obesity, and seems to be the most efficient intervention in terms of providing sustainable weight loss and reduction in comorbidities for the majority of patients. However, surgery involves risk and long-term outcomes, and complications beyond 1-2 years are currently scarcely reported in research.

The aim of this study is to explore patients' long-term experiences with bariatric surgery. The study has a qualitative design and is grounded in phenomenology. Data was produced by in-depth interviews more than five years after surgery. Seven women and 13 men with different backgrounds participated. The participants were aged 28-60 at the time of the interview. All of them had undergone a combined surgical procedure, called Duodenal Switch, which provides most substantial weight loss and carries a somewhat higher risk of complications when compared to other surgical procedures. The data consists of the patients' experiences after bariatric surgery processes, as recalled and described in the interviews. The analysis was inspired by Giorgi's phenomenological method. The process of reflexivity has been emphasised throughout the whole research process.

The findings are presented in three separate articles. The first article presents findings based on the first eight interviews. The article concentrates on the intertwining of change and altered social encounters and negotiation of embodied identity after surgery. In the second article, findings based on the first 14 interviews describe eating as an existential and situated practice which remained a sensitive issue after surgery. The third article reports the 13 male participants' experiences after bariatric surgery, and describes agency as pivotal for the men's self-understanding. Thus, bariatric surgery was experienced as a radical intervention, yet deeply

meaningful because it gave access to actively engage with the world and others. "Carrying the weight of uncertainty" constitutes a common and essential theme of the long-term experiences, across the presented findings. Despite sufficient weight loss and comorbidities in remission, the patients lived with health problems, illness, complications and worries about the future connected to body weight and health.

List of publications

Natvik, E., Gjengedal, E., & Råheim, M. (2013). Totally changed, yet still the same: Patients' lived experiences 5 years beyond bariatric surgery *Qualitative Health Research, 23*(9), 12. doi:10.1177/1049732313501888

Natvik, E., Gjengedal, E., Moltu, C., & Råheim, M. (2014). Re-embodying eating: patients' experiences 5 years after bariatric surgery. *Qualitative Health Research, 24*(12), 1700-1710. doi:10.1177/1049732314548687

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1. Introduction

Perhaps you have to experience the state from the inside, to know what fat is like (Mantel, 2003, p. 218).

In “Giving up the ghost”, Hilary Mantel described experiences with weight gain related to a chronic illness. She wrote this memoir primarily to take hold of her own story, but also to “locate myself, if not within a body, then in the narrow space between one letter and the next, between the lines where the ghosts of meaning are” (2003, p. 222). For Mantel, the large body was an unwanted yet inevitable situation, to which she eventually had concurred. Nonetheless, she described fatness as alien and a barrier to social interactions. Meanings attached to the long gone lean body seemed to lie just beneath the surface. In Mantel’s words:

> I was (and am) unsure about how I am related to my old self, or to myself from year to year. . . . For a few years, in my dreams I stayed thin. . . . It is said that, in dreams – in a lucid dream, where you are aware of your processes – you can’t turn on an electric light, or see yourself in a mirror. I set myself to test this; thinking that somehow, if I could see my fat self in a dream, I would have accepted it all through, and would accept the walking reality. But what happens when you face the mirror is that its surface melts, and the self walks into the glass. You step through it, and into a different dream (2003, pp. 221-224).

There seem to be some parallels in the nexus of weight gain and weight loss. A substantial and desired change in body weight in severe obesity or anorexia might not spontaneously provide a sense of well-being. Regardless of which direction substantial weight changes go in, the processes take place in the interface between the personal and the public self and between the experienced and the expressed. Changing body weight is highly perceptible; you can feel it physically and emotionally, it is visible and palpable for the self and for others.

As a clinical physiotherapist, I first came across severe obesity as a condition that could require treatment in the health care services in 2002, when modern bariatric surgery was in its infancy in Norway. [1, 2] As part of my job, I cooperated with bariatric patients to support them in avoiding complications related to the surgery, by preoperative guidance, practical exercises and postoperative physiotherapy. The bariatric patients immediately caught my attention, not just because they were very large, but because they were young adults who had substantial difficulties with functioning in daily life. Most of them expressed illness and pain, but they often tried to conceal it. Bariatric surgery seemed to involve high expectations of long-term weight loss and altered lives. Radical surgery was expected to provide weight loss and facilitate altered habits and practices for the long term, via a permanently altered digestive tract. As a member of the team involved at the very beginning of the patients' bariatric surgery processes, I had a lot of unanswered questions regarding their future lives. To gain health and better lives, the patients had to lose weight. I wondered what weight loss and change would imply, what it would be like to be in substantial change and sustain the changes in the long-term. Without explicitly being aware of it, I probably took for granted that weight loss could and would facilitate the powerful and permanent changes which the patients so desperately expressed that they needed.

Physiotherapy draws on the natural sciences, social sciences and the humanities, and acknowledges that a wide variety of cultural, social and individual factors are at play when health is sustained or challenged (Norsk Fysioterapeutforbund, 2012). Health is often understood as a resource for everyday life, and intimately connected to individuals' physical, social and psychological functioning in interaction with the environment. This conceptualization of health is parallel to the Discussion Document

[1] Bariatric surgery is surgery for weight loss. As this is a central term in the thesis, it is thoroughly defined and described (from page 26) in the section describing management of obesity and severe obesity, starting on page 23.

[2] Bariatric surgery had sporadically been offered in Norway from the late 70's but was stopped during the 90's because of complications with the surgical procedure. Before 2004, two hospitals in Norway had started offering modern bariatric procedures. From 2004, all health regions in Norway were expected to offer surgical treatment for severe obesity. The process might have been connected to an addition to The Patients' Rights Act concerning the patients' right to receive help from the specialist health care services in 2004.

on the Concept and Principles of Health Promotion from 1984, published by World Health Organization (2009, p. 29):

> The extent to which an individual or group is able, on the one hand, to realise aspirations and satisfy needs; and, on the other hand, to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living; it is a positive concept emphasising social and personal resources, as well as physical capacities.

Understanding health as a resource is part of a broad understanding of health, emphasising subjectivity and including phenomena that are not easily quantified, such as experiences and emotions (Svensson & Hallberg, 2011). The resource-perspective also involves some dilemmas. For example, health easily is individualized to a personal asset, whereas the societal and common responsibility might be less emphasised (World Health Organization, 2009). According to one study, lay people in Norway define health as a holistic, individual and relative phenomenon, and emphasise well-being, function, nature, a sense of humour, coping and energy as vital for health (Fugelli & Ingstad, 2001). Thus, the concept of health is positively laden and goes far beyond the own body and its functions. Rather, health seems to converge with the idea of “the good life”.

This thesis is about exploring and discussing lived experiences after bariatric surgery. Our experiences are rooted the interconnection and interaction between person and world. Therefore, the context of bariatric surgery is important to know, in order to understand the meanings attached to patients’ experiences. Accordingly, I introduce some contexts to provide a good point of departure for understanding and discussing bariatric surgery: Firstly, I show a slice of the cultural context, by describing a recent and ongoing debate on obesity and bariatric surgery in Norway. Secondly, I provide a theoretical context to display the underlying understandings of obesity that are relevant for the current study. Thirdly, I describe the theoretical and

empirical context for current management of obesity and severe obesity as offered by Norwegian health authorities, with emphasis on bariatric surgery studies.

1.1 Bariatric surgery in the Norwegian public debate

Bariatric surgery is a publicly debated topic in Norway, which has been inspiring and thought provoking during the research process. In my understanding, the connection and interaction between experience, knowledge and context are central to how we understand bariatric surgery. Therefore, I describe parts of the recent public discussion about bariatric surgery and my reflections along the way.

Should people who are obese receive help from Norwegian public health care, or is this a problem which "all of us" more or less struggle with? In Norway, health care is provided to those who are at risk, including people with a body weight so high that it is classified as severe obesity. However, the current public debate in Norway signals that the question remains controversial, especially with regard to bariatric surgery.

Strong opinions about severe obesity and bariatric surgery are mostly expressed by other people than those living with these conditions, and are typically expressed by lay people in social media during public obesity debates, or in media by professionals and researchers in medicine, health care- or sports sciences. [3] Often "good advice" based in personal experiences are shared, or insults, harassment or general verbal attacks are thrown out.

Powerful professional voices engage with bariatric surgery, and express opinions, sometimes grounded in experience and knowledge, yet often connected to the distribution of scarce health resources. How obesity should be encountered appears to be a contested topic and a complex matter for policy makers. Because they seek

[3] Severe obesity means heavy overweight, and how the term is understood and used in health contexts is defined and described on page 20.

information and listen to opinions and knowledge, it seems important to have an open debate, which we have had a good example of in Norway recently.

The National Council for Priority Setting in Health Care (The Council) put bariatric surgery on the agenda in 2011, and asked: “Which role should bariatric surgery have in treatment for obesity? What can be done to increase the knowledge about long-term effects after bariatric surgery?” [4] The Council works in line with the ideal of openness in priority debates in Norway, and ordered a systematic review and report about long-term effects of bariatric surgery (Kunnskapssenteret, 2014). Furthermore, they explored the process in Denmark, where access to bariatric surgery has been restricted and the public discussion involved a split between researchers and policy makers (Heissel, 2011). The Council’s secretary suggested restricted access to bariatric surgery in Norway, more lifestyle interventions for obesity and increased public health initiatives. This engaged public discussion prior to the Council’s first meeting in 2014, in which academic and professional environments connected to the field of bariatric surgery in Norway participated.[5] During the meeting, the discussion led to the following recommendation:

> The National Council emphasizes the importance of broad public health measures to combat obesity. It is important to develop good interventions for these patients, and the council recommends that non-surgical interventions have higher priority . . . The Council will return to this issue with concrete proposals on how the knowledge base, including registry data, can be strengthened for prevention, treatment and care for people with morbid obesity. The council wants to shed light on prevention of obesity. Structural measures and how to strengthen non-surgical interventions are particularly interesting (Nasjonalt råd for kvalitet og prioritering, 2014).

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[4] The secretary’s proposal is available in Norwegian under Vignette: http://www.kvalitetogprioritering.no/saker/kirurgisk-behandling-ved-overvekt.

[5] Severe obesity is a complex condition and connected to illness, quality of life and social stigma, and questioning the access to treatment increased the engagement in the debate. Several researchers, including a fellow PhD candidate and the author of this thesis, took part as audience in the Coucil’s meeting, wrote op-eds and participated in live debates on national TV/ radio. In our op-ed, we questioned the secretary’s line of argumentation, and the scientific foundation for their suggestions to the Council’s members. Our op-ed is available in Norwegian http://www.nrk.no/ytring/er-fedmekirurgi-problemet_-1.11511448.

The Council has continued working on the case. For example, some members presented an abstract (poster) in an international conference titled “Is the Normalization of Bariatric Surgery in the Interest of Public Health? Could the HTA inform the discussion?” (Wang & Høymork, 2014). Furthermore, powerful leaders in the Norwegian health sector who are strongly involved in The Council’s work have made a point of contrasting bariatric surgery with public health interventions for obesity in the public debate (Nylenna & Stoltenberg, 2014).[6] The case of long-term effects after bariatric surgery has generated a new discussion by the The Council, concerning “Prevention and non-surgical interventions for obesity and severe obesity” (Nasjonalt råd for kvalitet og prioritering, 2015).

Setting prevention/public health and treatment up against each other might be a rhetorical move to attract politicians’ and lay people’s attention to public health, and make the politicians skew their priorities “to the left”, or from treatment towards prevention. Very often, treatment strategies connected to life, death and technology have more publicity than public health initiatives. It is possible that the Council’s members aim to counteract the relatively one-sided and value laden information about bariatric surgery from private clinics on the internet, targeting potential customers for bariatric surgery (Groven & Hofmann, 2015). Changing the conversation about obesity seems like a good idea, but holding public health and prevention up against treatment initiatives for manifest and potentially life-threatening illness demonstrates a

[6] “Is surgery going to slim down the obese?” Magne Nylenna and Camilla Stoltenberg asked in an op-ed. Nylenna is the Director of the Norwegian Knowledge Centre for Health Services and the employer of The Council’s secretary and Stoltenberg is the Director of the Norwegian Institute of Public Health and Deputy Head of The Council. Underscoring that bariatric surgery is a risky procedure with uncertain long-term effects, and ethically a controversial intervention, the authors suggested that Norway could become one of the first nations to reverse the “obesity epidemic”. Accordingly, Nylenna and Stoltenberg called for stronger attention to the development and evaluation of non-surgical strategies for weight loss and powerful interventions for obesity prevention. These suggestions were expressed unilaterally as positive. Potential consequences, intended and unintended, of a sharper focus on obesity prevention and lifestyle strategies for weight loss to all (regardless of size/level of obesity), were not discussed or questioned. The effects of non-surgical strategies with respect to sustainable weight loss are poor when compared with surgery, and lifestyle interventions are not always adequate for people with severe obesity, but Nylenna and Stoltenberg did not take this knowledge into consideration. Bariatric surgery seemed not understood as a specialized intervention, but as part of a public health strategy for obesity (BMI 25-30 kg/m²), which is a misunderstanding. Norwegian health care services offer free weight loss interventions only to individuals with severe obesity (BMI ≥ 40, or 35 kg/m² with obesity-related comorbidities), who have tried to lose weight by other means without succeeding. Bariatric surgery is a treatment strategy, and an alternative to lifestyle interventions.

sharpened and dichotomous approach. This offers a possibility to engage new and interesting discussions in the Norwegian conversation about obesity.

The Council secretary's logic line of argumentation might be somewhat hard to follow: Primary prevention and public health initiatives on the structural level are needed to facilitate better public health and stop the increasing obesity rates, but are obviously insufficient and lack specific relevance to people with present severe obesity who seek bariatric surgery. Thus, public health initiatives cannot be expected to function as an alternative strategy to treatment and bariatric surgery cannot be expected to be beneficial for public health. It is unclear whether the Council's secretary's line of argumentation is considered acceptable because the issue at hand is severe obesity/bariatric surgery, which often seems understood as a threat to public health and a self-inflicted condition and lack the legitimacy of other diseases.[7] To underscore the threats connected to obesity, epidemiologists, medical researchers and public health authorities have introduced the term "obesity epidemic" (Lupton, 2013, p. 47; Ogden, Yanovski, Carroll & Flegal, 2007; Ulset, Undheim & Malterud, 2007). The term "epidemic" is imprecise because it is connected to infectious diseases and carries social and political overtones, but is claimed to be justified related to the surprising and unexpected increase in obesity that seem to be continuing (Flegal, 2006).

Contrasting weight loss interventions against public health initiatives appears to be rather unusual related to other complex non-communicable and life-style related diseases, such as diabetes, various forms of cancer and coronary disease. Unhealthy living, over-consumption, being out of control or taking risks are often disapproved of within health contexts, whereas expression of rationality, responsibility, control or vulnerability is accepted (Fry, 2012). These assumptions seem to be reflected in governmental reports on health, which often express an underlying understanding of the healthy body as a civilized body, which might have influence on the public debate concerning bariatric surgery.

[7] The relationship between obesity, severe obesity, health and illness is described from page 20-22.

The Council has not suggested the end of bariatric surgery, but has demonstrated scepticism and disinterest in bariatric surgery compared to other interventions and public health initiatives. The lack of documentation for such initiatives' efficacy and effectiveness in severe obesity seemed not taken into consideration.[8] As such, the Council's point of departure seemed to converge with critical perspectives, as expressed by the founder of the Health at Every Size movement: "Bariatric surgery is better described as a high-risk, disease-indulging, cosmetic surgery – not a health-enhancing procedure" (Bacon, 2010, p. 291).

The public debate about bariatric surgery centres on very different and complex issues, involving competing medical perspectives and priority. Bariatric surgery concerns usage of new developments in medical technology, and resources are scarce when compared to the prevalence of severe obesity. Furthermore, bariatric surgery is an initiative to help individuals striving with illness and pain, whereas obesity also is a public health issue, to which surgery has no relevance. Should the access to bariatric surgery be restricted and resources be used on less invasive (and less effective) treatment strategies and public health initiatives, in line with the Council's initial view? And if so, who should receive the most and least effective treatments, in terms of sustainable weight loss? Should patients recovering from bariatric surgery have easier access to support and follow-up to handle the difficulties they encounter? What kinds of situations require extra care, and what types of care are needed? Most of these questions are related to policy, and might become easier to discuss when new guidelines on priority settings in the Norwegian health care services are agreed upon (Helse og Omsorgsdepartementet, 2014). Simplifications, dichotomies and tensions between various perspectives are counterproductive and might be harmful to people with obesity (Kleinert & Horton, 2015). Rethinking obesity might be a good point of departure for continuing the conversations and discussions about bariatric surgery.

More basic questions connected to obesity are not that often raised and discussed. Possibly, an unclear or simplified understanding of obesity can make

[8] Weight loss strategies are described from page 23.

bariatric surgery even harder to discuss. Some questions to think about are: Is health, healthily eating and physical activity something society can demand from people, or should it be something offered? What if the good life is about something else, beyond or contradictory to health/living healthily? Do we know enough about what is self-inflicted, and what is bad luck, with regard to illness and health? How might society's demand for a healthy population or a population constantly hunting for health improvements affect our attitudes towards illness? Which attitudes and assumptions are at play, with regard to illness connected to abuse/control and normative structures, for example obesity, smoking, alcohol and drug abuse and psychiatric illness? How might the current emphasis on individual responsibility affect our values with regard to community and fellowship in our societies? In the debate I have described, bariatric surgery was approached form a traditional and normative public health perspective. There are interesting studies exploring and discussing public health perspectives from other approaches than biomedical ones that will not be explored here, because the public health discourse is not within the scope of this thesis. [9]

1.2 The problems of obesity: A prevalent and diverse condition

The prevalence of obesity has increased in developed and developing countries for three decades. Worldwide, more women than men are obese (BMI $\geq$ 30). In developed countries, men seem to have higher rates of overweight and obesity, whereas this relationship is reversed in developing countries, in which 62% of people who are classified as obese individuals currently live (Ng et al., 2014). In Norway, obesity rates have been on the rise between 1984 and 2008, from 8-22% in men and from 14-23% in women (Midthjell et al., 2013). It is estimated that about 2, 5 % of the Norwegian population aged 20 or above has a body weight that can be classified as severe obesity (BMI $\geq$40/35 with comorbidity) (K. Midthjell, personal communication, April 23,

[9] For example, the understanding of health and a good life has been explored through switching from a traditional medical perspective rooted in epidemiology to an experience-based popular perspective (contemporary lay understanding) anchored in a cultural tradition in a rural area of Norway (Solheim, 2013). From this work it was suggested that: "Public health workers should listen to what people say, because the individual's experiences and values mean a great deal in reality, perhaps more than recommendations on a national level for how life should in fact be lived" (Solheim, 2013, p. 186).

2015). The majority of those having severe obesity are women (Midthjell et al., 2013). There are differences in the prevalence of obesity in Norway, related to geography and education. For example, the prevalence of obesity is higher in rural compared to urban areas, especially among women and children (Folkehelseinstituttet, 2014).

From the perspective of medicine and health care, obesity is understood as detrimental to health. The World Health Organization (WHO) has framed the populations' increasing body weight as a *health risk,* and described overweight and obesity (BMI ≥ 30) as "abnormal or excessive fat accumulation that may impair health" (2015b). WHO uses the Body Mass Index (BMI) to classify weight related to health risk; having a BMI ≥ 25 is overweight, whereas a BMI ≥ 30 is obesity. In overweight and obesity, the health risk increases progressively with weight, and having a BMI ≥ 40 or 35 with obesity related illness is defined as severe obesity (World Health Organization, 2015a). [10] That is, when a person who is 1.68 meters tall weighs 113 kilograms, her weight is classified as severe obesity because she has a BMI of 40.

The relationship between obesity and related diseases is not yet fully understood. The American Medical Association declared obesity to be a disease in 2013, but this was controversial (Katz, 2014). Overall obesity is understood as a condition connected to health risk, as expressed by WHO and the Norwegian Institute of Public Health (Folkehelseinstituttet, 2014). It is documented that obesity in adults is associated with several conditions, such as coronary heart disease, type 2 diabetes, hypertension, dyslipidaemia, sleep apnoea, gastro-oesophageal reflux disease, some types of cancers, musculoskeletal disorders, psychological and psychiatric morbidities and increased risk of disability (National Institute for Health and Care Excellence,

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[10] The BMI is a number expressing an individual's bodyweight (in kilograms) divided on height (in meters, squared), kg/m^2. The Belgian mathematician, astronomer and statistician Adolphe Quetelet (1796-1874) was a pioneer in developing and validating mathematical measures for body weight, and initiated the concepts "normal man" and BMI (previously called Quetelet Index). He is also referred to as one of the founders of the current International Classification of Diseases (Eknoyan, 2008). The BMI is considered a reasonably good measure for the level of obesity (the amount of body fat) in order to predict severe illness and premature death (Prospective Studies Collaboration, 2009). The BMI is widely used to monitor the prevalence of obesity and overweight, but WHO underscores that BMI does not account for body shape and composition (which seem to have impact on health), gender or different ethnicities (World Health Organization, 2015a).

2006; National Institutes of Health, 2012). Obesity and severe obesity can limit life expectancy with two to four and eight to ten years, respectively (Prospective Studies Collaboration, 2009). Accordingly, obesity challenges public health and expresses individual health risk or burden.

Obesity is increasingly acknowledged as a complex issue, arising from the interaction between individuals (genetics, lifestyles) and their environments (Roberto et al., 2015). Although obesity is connected to an imbalance between dietary intake and physical activity levels, research has pointed to increased energy intake as the predominant driver of the rising prevalence of obesity (Gortmaker et al., 2011; Simpson, 2014). This is connected to changes in the global food supply, which for example provide high access of energy dense foods at low prices (Gortmaker et al., 2011; Swinburn et al., 2011). Thus, obesity should be approached at the community level through joint efforts from governments, industries and civil society, and not trough interventions directed either towards individuals or their environments (Roberto et al., 2015). It has recently been argued that obesity is a “social disease” because very large bodies seem to challenge aesthetics, morality or other social norms (Hofmann, 2015). According to Hofmann, understanding obesity as a social disease might make it easier to strengthen public health and address the social determinants of obesity, whereas medicalization enhance stigmatization and discrimination connected to size or behaviours.

1.3 What if large body size is not necessarily a problem?

Critical studies questions what is taken for granted, and some reject the dominant view on fatness as unhealthy and damaging to public health/national economics, and claim that the obesity discourse and moral (fat) panic are intertwined (Monaghan, Colls & Evans, 2013). From a sociological perspective, initiatives to halt the rise in obesity or promoting weight loss strategies can be understood as means of social control, through the framing of deviant bodies as pathological (Conrad & Schneider, 1992, p. 28). Such

critical studies emphasise how gender, society, politics and culture impact on the conceptualization of obesity, and thus view obesity as a socially constructed and multi-layered phenomenon.

Fat studies for example are rooted in critical (or queer) theory and often have a feministic perspective. The main criticism is that in obesity medical/health care sciences are solely problem oriented and obsessed with weight loss (Harjunen, 2009). Studies inspired of feminism acknowledge that women historically have lacked social and political status, partly connected to their bodies; vulnerable, difficult to control and less engaged with the cultural world (Moore, 2010). The interdisciplinary Health at Every Size movement challenges the current promotion of weight loss and behaviour change in obesity, and advocates health promoting habits and practices regardless of body size (Bacon & Aphramor, 2011). Advocates argue that long-term weight loss not necessarily imply slender and healthy bodies exclusively, but can involve harmful weight cycling, diminished interest in general health, low self-esteem, problematic eating practices, stigmatization and discrimination (Bacon & Aphramor, 2011).

Recently Norwegian researchers representing medical- and health care sciences have written op-eds questioning whether body weight really is related to illness (Samdal & Meland, 2014).[11] The researchers claim that the public pressure to lose weight when obese and the inevitable weight cycling, add to shame and stigma connected to obesity, and are more harmful than obesity *per se*. It is not clear whether the researchers think that any level of obesity might be threatening to health and well-being.

According to an anthropologist, social scientists tend to draw on the discursive construction of fatness rather than the bodily matter, and thus contribute to maintaining the split between social construction and biology inherited form Cartesian

[11] Such "countering the war on obesity" voices are few in Norway, and seem inspired of the Health at Every Size movement http://www.haescommunity.org/. The authors are researchers with background in medicine and nursing, and use the same line of argumentation as researchers with similar points of view in the US, UK and Australia (Dickins, Thomas, King, Lewis & Holland, 2011; Cooper, 2008; Murray, 2008). The Norwegian physiotherapists and researchers Gunn Engelsrud, Gro Rugseth and Karen Synne Groven have expressed critical approaches publicly since 2010, including a more explicit criticism towards bariatric surgery. Critical perspectives on obesity seem to add nuances and variation to the public debate in Norway.

thinking (Warin, 2014). Accordingly, the tendency to reduce obesity into either a biological/material reality or a social construction seems common across different perspectives. Unlike the Health at Every Size movement, stakeholders in the medical/health care community view obesity as harmful, and believe that the rise in obesity can be reversed. In a recent editorial in The Lancet, Kleinert and Horton highlight the urgency of reframing and rethinking obesity (2015). They suggest approaching obesity as a complex issue, because dichotomies and simplifications in the obesity discourse might hinder progress and policy action. The dichotomies they point to are:

> Individual blame versus an obesogenic society; obesity as a disease versus sequelae of unrestrained gluttony; obesity as a disability versus the new normal; lack of physical activity as a cause versus overconsumption of unhealthy foods and beverages; prevention versus treatment; overnutrition versus undernutrition (Kleinert & Horton, 2015, p. 2326).

Acknowledging the diversity of obesity (or obesities), the underlying assumption in this thesis is that obesity seems to be problematic for health, requiring knowledge, discussion and actions on individual and societal levels.

1.4 Managing obesity and severe obesity: An introduction

From the perspective of *public health*, broad health promotion initiatives targeting large populations are appropriate approaches to obesity. When the issue at hand is obesity, health promotion usually means facilitating healthy habits and practices, often expressed as “making healthy choices the easy choices” (Helse- og omsorgsdepartementet, 2013). [12]Aiming for a health promoting community, the

[12] The *Action plan on physical activity (2005-2009)* suggests information campaigns, implementation of the Ministry of the Environment’s outdoor activities strategy, continuing effort towards daily physical activity in schools and environmentally and health-friendly transport, Furthermore, implementation of National transport plan 2014-2023, *National walking strategy*

Norwegian government integrated public health in national policy; the responsibility for public health was recently moved from the health care services to the local authorities (municipalities), and is based in The Public Health Act from 2012 (Helse- og omsorgsdepartementet, 2013; Helse og omsorgsdepartementet, 2012; Helsedirektoratet, 2014).

In governmental documents, this move is expressed through the imperative sentence “health in everything we do”. The integration of health promotion in national politics is connected to the Norwegian democratic welfare state’s emphasis on equality and universality (Raphael, 2013). Obesity fluctuates in the nexus between public health and health care – a relationship which seems to involve both ruptures and coherence. Environmental perspectives and policy are not sufficient to help people with severe obesity who seek sufficient and sustainable weight loss, whereas obesity management still seems dominated by individual approaches (Dietz et al., 2015; Jepsen, 2015).

To be classified as severely obese according to BMI gives the right to an interdisciplinary assessment and possibly access to weight-loss interventions in the Norwegian health care services (De regionale helseforetakene, 2007; Helsedirektoratet, 2015). This means that the related expenses can be fully covered by the welfare state. Weight loss strategies for severe obesity are lifestyle interventions, pharmacotherapy and bariatric surgery (De regionale helseforetakene, 2007; Dietz et al., 2015). Lifestyle interventions focus on diet, physical activity and behaviour change, which are central components in all three approaches to severe obesity. Losing 5-10% of the body weight and maintaining the weight loss for at least a year is considered sufficient to benefit health and reduce obesity related risks (Goodpaster et al., 2010; Tsigos et al., 2008; Wing & Hill, 2001).

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and *National cycling strategy* is suggested. Promoting healthy diet is based in the *Norwegian action plan on nutrition (2007-2011)* and includes campaigns, continuing work on the Keyhole label, implementation of the salt strategy and facilitating healthy meals in schools and kindergartens. Furthermore initiatives that support free fruit and vegetables scheme in schools and monitoring marketing of unhealthy food and drinks targeting children and adolescents is emphasized, and the need for a strategy targeting nutritional competence in the municipalities is discussed.

In a variety of programs, from clinical counselling to multi-modal interventions lasting for several years, lifestyle changes primarily are patient driven with professional guidance and support (De regionale helseforetakene, 2007; Dietz et al., 2015; Jepsen, 2015; Rössner, Hammarstrand, Hemmingsson, Neovius & Johansson, 2008). Lifestyle interventions can induce significant weight loss and improve obesity related risk factors, but to a lesser extent than bariatric surgery (Colquitt, Pickett, Loveman & Frampton, 2014; Goodpaster et al., 2010; Karlsson, Taft, Ryden, Sjöstrom & Sullivan, 2007; Look AHEAD Research Group, 2014; Ryan et al., 2010; Wadden, Webb, Moran & Bailer, 2012; Wadden et al., 2009). Studies have shown that most people with severe obesity who participated in lifestyle interventions regained weight afterwards, and several quit the programs before they ended (Christiansen, Bruun, Madsen & Richelsen, 2007; Ryan et al., 2010; Shaw, O'Rourke, Del Mar & Kenardy, 2005).

Lifestyle interventions for severe obesity require lot of effort and long-lasting commitment to be successful, but do not involve risks for complications and adverse effects (Hjelmesæth, Hofsø, Handeland, Johnson & Sandbu, 2007). It is speculated that in severe obesity, a 5-10% weight loss might not be experienced as sufficient, despite documentation for health benefits. Before seeking bariatric surgery, people with severe obesity are advised to try alternative weight-loss strategies, and it has been reported that participants in lifestyle programs tend to seek surgery later on. One study reported that six years after a lifestyle intervention, 80% of the participants were operated or on the waiting list for bariatric surgery (Andersen, Hage Stokke, Bye Tøsdal, Robertson & Våge, 2013).

Pharmacotherapy is an option for adults having a BMI ≥ 27 with obesity related diseases or BMI ≥ 30, and can be expected to provide 5-10% weight loss (Dietz et al., 2015; Statens Legemiddelverk, 2015; Witkamp, 2011). The last years, Orlistat has been the only approved generic drug for weight loss in Norway, despite its discussed benefit-risk profile (RELIS Produsentuavhengig Legemiddelinformasjon, 2014; Statens Legemiddelverk, 2012). This might change, as the European Medicines Agency recently approved of two new drugs (Statens Legemiddelverk, 2015). Obesity

drugs remain a challenge for industry and academia and are connected to strong financial interests. Documentation for the efficacy and effect of pharmacotherapy for severe obesity is limited (Dietz et al., 2015). Several drugs have been introduced and then withdrawn because of damaging side effects. In 2010 all obesity drugs containing sibutramine were removed from the European market, because the benefits did not outweigh the increased risk for heart attack and stroke (European Medicines Agency, 2010; Williams, 2010).

1.5 Bariatric surgery explained: Quantitative research

The term *bariatric surgery* points to a variety of procedures aiming to induce weight loss via an anatomically and physiologically altered digestive tract. Restrictive procedures limit nutritional intake, whereas combined procedures (restrictive and malabsorptive) limit nutritional intake and absorption (Blackburn et al., 2009; Buchwald, Ikramuddin, Dorman, Schone & Dixon, 2011; Moshiri et al., 2013). Bariatric surgery affects metabolism, and the mechanisms of action go beyond weight loss (Hussain & Pomp, 2011; Mala, Søvik & Kristinsson, 2015). It is suggested that complex neural/hormonal/cerebral mechanisms as well as inflammatory and gut microbial factors are involved (Buchwald et al., 2011; Hughes, 2014; Madura & DiBaise, 2012). Accordingly, several aspects of how bariatric surgery works on the body are not yet known.

Bariatric surgery is an intervention for severe obesity when other approaches have not provided sufficient and sustainable weight loss, and can be the first choice at a BMI above 50. Furthermore, surgery can be an option in patients with obesity (BMI $\leq$ 35) when obesity related illness seriously harm patients' health, for example if medical treatment of diabetes type 2 or hypertension has not worked out (De regionale helseforetakene, 2007; Helsedirektoratet, 2015; National Institute for Health and Care Excellence, 2014). An interdisciplinary team should assess and inform bariatric candidates, who must express motivation to change lifestyle. Substance abuse and

severe psychopathological conditions require extra assessment and interdisciplinary collaboration, to evaluate whether surgery is indicated or not, or should be postponed (Helsedirektoratet, 2015; National Institute for Health and Care Excellence, 2014).

Surgical interventions have increased progressively with the obesity rates worldwide and in Norway (Buchwald & Oien, 2009; Buchwald & Oien, 2013; Hofsø et al., 2011; Kunnskapssenteret, 2014).[13] Surgery is more effective than other weight-loss interventions, and provides sufficient and sustained weight loss in the majority of patients, with positive effects on obesity related illnesses and quality of life (Adams et al., 2012; Colquitt et al., 2014; Karlsson et al., 2007; Kolotkin, Davidson, Crosby, Hunt & Adams, 2012; O'Brien, MacDonald, Anderson, Brennan & Brown, 2013; Puzziferri et al., 2014; Sjöström et al., 2007).[14] Research indicates that bariatric surgery is associated with improvements in mental health and psychosocial function for most patients, and except for patients with severe psychiatric illness, it seems not to reinforce mental health symptoms (Aasprang, Andersen, Våge, Kolotkin & Natvig, 2013; Herpertz et al., 2003; Müller, Mitchell, Sondag & de Zwaan, 2013; Nickel, Loew & Bachler, 2007; Økland Lier, 2012). Furthermore, bariatric surgery seems to be associated with reduced overall mortality, and therefore is considered safe and beneficial in severe obesity (Adams et al., 2007; Piché, Auclair, Harvey, Marceau & Poirier, 2015; Pontiroli & Morabito, 2011; Sjöstrom et al., 2004; Sjöström et al., 2007).

The long-term effects of surgery are not clear, because the majority of studies have short follow-up or low levels of patient follow-up, and inconsistent reporting of complications (Colquitt et al., 2014; Kunnskapssenteret, 2014; Puzziferri et al., 2014). Bariatric surgery carries risk of mortality and complications – early complications may occur within the first 30 days, and include for example gastric anastomosis leak,

[13] Worldwide, the number of performed bariatric surgeries increased from 300,000 to 341,000 between 2008 and 2011. In Norway it was estimated that about 2000 and 3000 bariatric surgeries were performed in 2010 and 2012, respectively, in the public and private health sector. It is known that Norwegians undergo bariatric surgery abroad, but information regarding these patients is unavailable.

[14] Depending on procedure, mean ten-year weight-loss is between 10 and 25%, and it is reported that patients are able to maintain weight loss of > 50% and a reduced mortality risk (Adams et al., 2007; Kunnskapssenteret, 2014; Neff, Olbers & le Roux, 2013; Sjöstrom et al., 2004; Sjöström et al., 2007; Sjöström, Peltonen, Jacobson & et al., 2012).

bleeding, pulmonary and venous embolism (Flum et al., 2009; Neff et al., 2013; Piché et al., 2015). Late complications depend on procedure, and include nutritional deficiencies, diarrhoea and gastrointestinal symptoms (reflux, vomiting and dumping syndrome) (Bult, van Dalen & Muller, 2008; Maggard et al., 2005; Neff et al., 2013; Piché et al., 2015).

A certain variability in patients' outcomes after bariatric surgery is reported, with regard to weight loss and health improvements (Courcoulas, Christian, Belle & et al., 2013). A significant group of patients seems not to achieve sufficient weight loss or regain weight, which negatively affects quality of life and psychosocial situation in the long-term (Karlsson et al., 2007; Kubik, Gill, Laffin & Karmali, 2013; van Hout & van Heck, 2009; van Hout, Boekestein, Fortuin, Pelle & van Heck, 2006). It is estimated that unfavourable outcomes occur in more than 20% of bariatric patients (Greenberg, Sogg & Perna, 2009).

When surgery somehow fails, the recommendations are a thorough evaluation and offering multidisciplinary support regarding lifestyle changes or psychological needs, before introducing pharmacological treatment and/or surgical revision (Mechanick et al., 2013). According Neff and colleagues, assuming that failed surgery is a consequence of patients' non-compliance with lifestyle changes is a fallacy, as failure most often relates to biology (2013). Choice of procedure then seems essential, as they change human biology, physiology and hormonal responses through different mechanisms of action.

It seems difficult to know beforehand who will be able to achieve and maintain weight loss, because predictors of surgery outcomes remain unclear. Studies have suggested that high preoperative BMI, age above 50, iron deficiency, liver fibrosis, using medication for diabetes type 2 and personality disorders might affect weight loss negatively (Livhits et al., 2012; Neff et al., 2013; Still et al., 2014). Nutritional deficiencies regard minerals, vitamins and protein, and might involve negative health consequences if not successfully treated with dietary advice and supplements. Vitamin D deficiency is associated with obesity, and can persist despite nutritional

supplementation, possibly involving hyperparathyroidism, metabolic bone disease and fractures (Buchwald et al., 2011; Neff et al., 2013). Accordingly, life-long care is recommended when patients have undergone combined procedures, such as Roux-en-Y gastric bypass (RYGP) and Biliopancreatic diversion with duodenal switch (DS) (Buchwald et al., 2011; Mechanick et al., 2013; Neff et al., 2013).

RYGP is the most popular procedure worldwide, whereas DS is rarely performed (Colquitt et al., 2014; Kunnskapssenteret, 2014). This is a topic of debate, because DS is reported to be the most efficient procedure regarding weight loss and remission of type 2 diabetes, although associated with more complications and being a technically demanding procedure which requires advanced skills on behalf of the surgical team and follow-up services (Gagner, 2015; Hedberg, Sundström & Sundbom, 2014; Helsingen, 2015; Marceau et al., 2007; Risstad et al., 2015; Shah, Simha & Garg, 2006).

This review of quantitative studies indicates that bariatric surgery is the only intervention that provides sustainable weight loss in severe obesity, despite that the mechanisms of action are not fully understood. A significant group of patients does not benefit from surgery, but it is not clear what might have led to this or what it means. Furthermore, current knowledge about unfavourable outcomes, long-term results and complications is insufficient.

1.6 Bariatric surgery experienced: Qualitative research

Qualitative studies describing patients' experiences with *waiting for surgery* have indicated that surgery is considered a potential solution for most problems and thus is expected to improve physical, mental and social well-being (Da Silva & Da Costa Maia, 2012; Temple Newhook, Gregory & Twells, 2015). Prior to surgery, bariatric patients have expressed how deeply they depend on the intervention, the need of control over eating habits and bodyweight, and fear of illness and premature death (Engström & Forsberg, 2011; Engström, Wiklund, Olsén, Lönroth & Forsberg, 2011).

In these studies, loss of control involved social encounters, meaning that patients had been subjected to stigma and ignorance.

One phenomenological study deepened the meanings of waiting for weight loss, and suggested that longing for a body that fits in among others might be more important than the weight as such (Glenn, 2013). That is, when the body fits in, it can be accepted, enjoyed, embraced and loved. There seems to be an underlying assumption that in severe obesity, most problems are connected to the excess bodyweight, and thus that weight loss implies problems solved.

Some early qualitative studies exploring patients' *experiences with bariatric surgery* described positive changes in health and well-being, and indicated a dichotomy between life before and after surgery, despite variation among participants (Bocchieri, Meana & Fisher, 2002; LePage, 2010; Ogden, Clementi & Aylwin, 2006; Wysoker, 2005). Studies exploring women's experiences during the first postoperative year have described *ambivalence* connected to weight loss after surgery, and how unmet psychological needs during follow-up accompany the life- changing experience (Earvolino-Ramirez, 2008; Sutton, Murphy & Raines, 2009; Warholm, Øien & Råheim, 2014). Ogden, Clementi and Aylwin explored eating behaviours after bariatric surgery and identified a new and different relationship between choice and control which they termed *the paradox of control*; surgical restriction might remove choice and can help in re-establishing a sense of self-control (2006). However, a prospective study with two years follow-up suggests that perceived control after bariatric surgery might wane over time (Engström & Forsberg, 2011).

One study explored experiences with body image, based on interviews with young female participants in the first year after surgery, and reported that body image was related to the feeling of being on the edge of control (Jensen et al., 2014). This study suggested that perception of control is an essential aspect of body image and connected to empowerment and quality of life. Another study reported that body image changed both positively and negatively after surgery, and was heavily impacted by feedback from the outside world (Lyons, Meisner, Sockalingam & Cassin, 2014).

One study explored patients' descriptions of quality of life and meanings attached two years beyond bariatric surgery, using a focus group design (Stolzenberger, Meaney, Marteka, Korpak & Morello, 2013). In this study, patients reported improved quality of life related to weight loss despite variation in postoperative health status, occurrence of complications and negative psychosocial perceptions, and despite that psychological adjustments were demanding and seemed to affect health and quality of life more than expected.

Some qualitative studies have explored negative consequences following bariatric surgery, including weight regain, self-blame, living with fatigue, shame and pain (Groven, Råheim & Engelsrud, 2010; Ogden, Avenell & Ellis, 2011). One study investigated patients' explanations for unsuccessful outcomes, and found that patients expressed insufficient awareness and effort regarding self-control connected to health behaviour (Zijlstra, Boeije, Larsen, van Ramshorst & Geenen, 2009). One ethnographic study has argued that the surgical weight management which is currently provided might obscure the uncertainties, moral judgements and values attached to bariatric surgery (Throsby, 2012).

Since the current PhD project started, three Norwegian dissertations thematising bariatric surgery through a qualitative research design have been accomplished. The first dissertation explored empowerment in the context of an intervention for severe obesity, and was theoretically inspired of Foucault's work on discourse, power and governmentality (Knutsen, 2012). An observational study exploring a mandatory lifestyle course for severe obesity ahead of bariatric surgery/other interventions showed that contrasting discourses were at play; both autonomy and compliance were promoted (Knutsen & Foss, 2011). The participants were presented as morally acceptable individuals who were capable of lifestyle change *and* as members of a group dependent upon weight loss treatment. The participants tried to be good and compliant, because they wanted to achieve "normal" size (Knutsen, Terragni & Foss, 2011). Interviews with participants during the process of lifestyle course, bariatric surgery and aftercare (9 months after surgery), displayed their identity work as a negotiation between credibility and control. Despite the program's intention to

empower the participants, their identities were fragile, according to the study (Knutsen, Terragni & Foss, 2013).

Drawing on a sociological perspective, the next dissertation explored how large bodies were negotiated after bariatric surgery by interviewing men and women three times during the first postoperative year (Berg, 2013). Undergoing bariatric surgery was described as seeking normality (relations and practices) through a dysfunctional body (manipulated anatomy and physiology). The surgical restrictions were described as a challenge that had to be managed *and* an opportunity to practice the body in ways consistent with normal weight. Accordingly, the post-surgical body was understood as a “liberating restriction”, and surgery was described as a paradoxical treatment (Berg, 2013, p. 215).

A recent dissertation described women’s experiences after bariatric surgery (gastric bypass) from the outlook of phenomenology and bodily change (Groven, 2014). Some participants were observed and interviewed as they took part in a rehabilitations programme, whereas others were interviewed once or twice after surgery, varying between seven months and four years after surgery. The study showed that the process of change was complex and ongoing. Despite that some health problems and worries became less prominent or disappeared after surgery, new challenges emerged, such as trying to become physically active while living with side effects or feelings of being ill (Groven, Engelsrud & Råheim, 2012; Groven et al., 2010; Groven, Råheim & Engelsrud, 2013a, 2013b).

Qualitative studies have described patients’ desire for weight loss and a desperate need of having bariatric surgery. Beneficial changes following surgery, such as weight loss and improved well-being are emphasised, however most studies describe ambivalence and unfavourable outcomes following surgery too. It has been reported that some patients have ended up in a worsened situation after surgery. Accordingly, bariatric surgery seems to involve paradoxes and tensions related to weight loss and change.

1.7 Why this study? Research Gap

An increasing amount of research indicates that bariatric surgery seems by far the most effective weight-loss strategy for people with severe obesity, when outcomes are bodyweight and quality of life. However, as long-term outcomes and complications beyond the first two years are scarcely reported in research, the lack of rigorous knowledge about sustainability of results and safety of surgical procedures constitutes a gap. Furthermore, surgery does not work for everybody; some patients do not achieve the intended weight loss and/or improvements in health and well-being. Some studies indicate that patients' ability to adjust and be compliant with the required lifestyle changes after surgery is pivotal for the results, whereas others point to the lacking knowledge about predictors for weight loss after surgery and warn against making patients responsible for unfavourable outcomes.

Studies exploring bariatric surgery from the first-person perspective are few when compared to quantitative studies, despite an increase during the last decade. Qualitative studies have shown that weight loss and positive health outcomes are connected to ambivalence, and do not necessarily mean that the required adjustments and negative consequences following surgery are managed and coped with. The qualitative studies we found were conducted within the first two years after surgery, and include few men or no men at all. Thus, studies about women and men's long-term experiences (five years or more) after surgery seem to be lacking.

When choosing a qualitative design, we search knowledge from the ones who have acquired and can tell about lived experiences, and might gain a less fragmented and more nuanced understanding of life after bariatric surgery. Individual in-depth interviews might provide new insights in the nexus between bariatric surgery, weight loss and changes attached, and weight loss maintenance. Through meeting and having conversations with people who have had bariatric surgery five years previously, we can deepen the understanding of how bariatric surgery, health, emotions, habits and practices intertwine and connect to the individuals' subjective situations and the sociocultural context.

1.8 The aim of the study and research questions

The overall aim was to describe patients' long-term experiences with bariatric surgery and meanings attached. Knowledge based in the first-person perspective might support health care professionals in guiding, treating and following-up persons with severe obesity considering/ undergoing bariatric surgery. As such, we aim to contribute to the body of knowledge, and thus contribute to improved health, well-being and participation in society. The current thesis consists of three articles, based in the following research questions:

- How do patients experience bariatric surgery, change and meanings attached, at least five years postoperatively? What do they think about the future?
- How do patients experience their own bodies (including thoughts and emotions), changes of habits and practices and social interactions, at least five years after bariatric surgery?
- How do patients experience eating and a change of eating practices in the long term after bariatric surgery? How do they describe the body in relation to eating?
- How are men's experiences with health and well-being, more than five years after bariatric surgery?

2. Theoretical approach

Phenomenology is often defined as the science of phenomena. The term phenomenon originated in Greek language, and means what shows itself in itself or what is possible to see or uncover (Heidegger, 1927/2007, p. 57). This study is founded in phenomenology, and phenomenological insights have permeated the research process through and through. The phenomenological outlook is most easily identified in the methodological approach, analysis and discussion of findings and writing style. There is diversity in how phenomenology is understood and practiced across disciplines, and below I outline what a phenomenological foundation means in this study.

2.1 The phenomenological outlook: A unique approach to science

Edmund Husserl (1859-1938) established phenomenology as a science of "concrete" issues (Moran, 1900/2001, p. xxii). Here, the terms concrete and facticity points to the same meaning (Landes, 2013a, p. 80), for example an embodied experience in itself, rather the essential structure of it as a described phenomenon. Concrete issues are to be found in everyday experiences in their way of being connected to something specific, embedded in a certain context with a particular direction towards something. From a phenomenological perspective, everyday experiences are valuable sources for philosophical exploration and a sound basis for science, as expressed by Husserl's famous phenomenological imperative: "we must go back to the things themselves" (1900/2001, p. 168). Here, doing phenomenology means to explore how various phenomena show themselves to us through concrete experiences, and to investigate what the structures of experiences are like. Phenomenological investigations search for *essential structures* or essences, such as the essence of perception.

A description of a phenomenon's meaningful structures aims to provide new insight and understanding (Husserl, 1900/2001, pp. 169-170; 1931/2012, p. 144).

Merleau-Ponty stated: “To seek the essence of perception is not to declare that perception is presumed to be true, but rather that perception is defined as our access to the truth” (1945/2012, p. Ixxx). With reference to Merleau-Ponty, I understand a description of a phenomenon, its essential structure and the meanings attached as non-exhaustive (1945/2012, p. 228). In Dahlberg and colleagues’ words: “Meaning is infinite, always contextual, and recognized as expandable and expanding” (2008, p. 53).

Phenomenology is a philosophy that “places essences back within existence and thinks that the only way to understand man and the world is by beginning from their facticity” (Merleau-Ponty, 1945/2012, p. Ixxi). Understanding person and world must begin from *lived experience*. Lived experience gives access to concrete and embodied being in the world. Human beings are *intentional*, meaning that they are embodied, active, and always reaching towards objects and projects in everyday life. Because human beings are actively engaged in our lives and the objects in our surroundings, spontaneous concrete experience is not necessarily easy to access. To possibly reach a genuine level of experience, Husserl suggested *“bracketing”* one’s previous knowledge, theoretical standpoints and thoughts on human existence (1931/2012, pp. 56-60). In other words, bracketing was intended to draw the attention away from the natural attitude to the world and things and towards *how* phenomena appear to someone. Bracketing, *epoché* and phenomenological reduction point to the same goal: to describe the phenomena as they are given and appear to us in experience when the natural attitude and theoretical assumptions are attempted bracketed, or looked away from.

Phenomenology emphasises the subjective dimension, *the first person’s perspective,* as from where any understanding of human experience begins. The first person’s perspective is decisive, but that does not mean that the subject takes precedence over world, or that a certain truth resides inside the person (Merleau-Ponty, 1945/2012, p. Ixxiv). According to phenomenology, person and world are inseparable, and the person gets to know herself only through encounters with others. *Intersubjectivity* means that the person is always connected to others and the world.

When born, human beings are already connected to others, and not isolated (Merleau-Ponty, 1945/2012, p. 368). To live alone and withdraw from others is a possible way of living, but some human encounter and interaction is inevitable throughout life. Accordingly, I approach and explore lived experience as an open interconnection between person and world, and not something buried inside the person for the researcher to unearth (Zahavi, 2003, p. 36). This phenomenological study depends on persons who have lived through and experienced weight loss after bariatric surgery and their encounters with others, including the researcher.

2.2 The lifeworld approach

The *lifeworld* approach was initiated by Husserl, who in his late analyses presented it as the fundamental theme of phenomenology (1954/1970). According to him, the distance between human life as it is lived and science had become too wide apart. Therefore, Husserl argued for the lifeworld as a point of departure in philosophy and science, and the lifeworld approach was discussed and further developed by for example Heidegger (1927/2007), Merleau-Ponty (1945/2012) and Gadamer (1960/2010). The lifeworld is the world of experience into which all persons are born, and can never escape from. It contains everyday activities, encounters with others, the environments human beings are embedded in and the accessible things to possess and use. The lifeworld is primarily understood as pre-scientific, but since it is spontaneous and related to time, it somehow must be influenced by current knowledge, science and beliefs. However, such knowledge is known from the perspective of the first person, and rooted in the lifeworld.

The lifeworld is a familiar world which is all I know of, but at the same time impossible to fully grasp. There are aspects of our lives, so close to us that we nearly can touch them, but of which we lack full awareness or insight, and they belong to the lifeworld. I know my lifeworld better than anyone else, but it is not fully uncovered to me, and it is impossible to grasp exactly what I do not know. The simultaneous

presence of the unvoiced and the explicit dimensions of the lifeworld express the ambiguity connected to our being in the world. This ambiguity shapes a unique approach for understanding human experience. Merleau-Ponty suggested that phenomenology is a special kind of science, which might not be exhaustively understood:

> . . . although phenomenology is a transcendental philosophy that suspends the affirmations of the natural attitude in order to understand them, it is also a philosophy for the world which is always already there prior to reflection . . . It is the goal of a philosophy that aspires to be an exact science, but it is also an account of "lived" space, "lived" time and the "lived" world (Merleau-Ponty, 1945/2012, p. Ixxi).

Phenomenology means different things to different disciplines and can be understood in different and new ways in the future. I have outlined this study's general theoretical basis, to establish a common ground for understanding. I will now turn to the phenomenological concepts which have played a vital role to my description of long-term experiences after bariatric surgery.

2.2.1 The lived body: The pivot of the world

"My body is an object that is always with me. But then, is it still an object?" (Merleau-Ponty, 1945/2012, p. 92). In his central text, Phenomenology of Perception, Merleau-Ponty established the body at the heart of lived experience. He provided a thorough philosophical analysis of the body experienced as unified, and deepened our existence as simultaneous natural and subjective beings and active agents in the world. Accordingly, he managed to bridge the chasm between subject and object, mind/emotions and body, and launched the ambiguous *lived body* (1945/2012). The ambiguity of the body points to certain paradoxes of being in the world; I can see and be seen, touch and be touched and so forth. Moreover, when losing function related to

illness, disability is known to me, and at the same time I can be ignorant of it (Merleau-Ponty, 1945/2012, p. 84).

Merleau-Ponty rejected that consciousness was mere physiology; an organic lump of neurons which can be explained trough causal laws. Furthermore, he rejected that the world exists separately from consciousness, as comparable to any object in the world. He emphasised that subjective existence primarily is *embodied*, which means that processes which have been understood as mental/emotional here are understood to begin in the body (Romdenh-Romluc, 2011). Accordingly, the terms body, embodiment, lived body and the own body carries meanings that reach beyond the traditional word *body*, which often is understood as mere object, with emotions and thoughts attached. The body is understood as from where consciousness *begins*, rather than a kind of container for consciousness/thoughts/emotions (Merleau-Ponty, 1945/2012, pp. 99, 431).

The lived body and social world are *intertwined*. As bodily beings we cannot perceive the world unless from our embodied being; I do not exist if I do not have a world. Accordingly, personhood is not only embodied, but also enworlded (Carel, 2008, p. 13). We know our embodied self through the always present and ongoing interaction with the world and others. I know the world through my embodied being (Merleau-Ponty, 1945/2012, p. 311). As such, lived body, consciousness and world constitute a unity and are seamlessly connected. Because mental/emotional processes begin from the embodied encounters with the world, consciousness seems to be embedded in the world, rather than being separated from it as a mere thing among other things.

The body is a unity, but in his philosophical reflections about the paradox of embodied being in the world, Merleau-Ponty wrote: “it is as though our body comprises two distinct layers, that of the habitual body and that of the actual body” (1945/2012, p. 84). In my understanding, *habitual* here points to incorporated, meaningful habits, including the social and cultural aspects attached which we have taken up in our encounters with the world. According to Landes’ reading of the

habitual versus the actual body, the habitual body may continue to refer to a world that is no longer possible, because of changes to the actual body (2013a, p. 91).[15] In light of a patient's experience of a phantom limb (a leg that no longer was there) Merleau-Ponty explored how the habitual body possibly could vouch for the actual body, and connected his thinking about the habitual/actual body with the ambiguity of lived body, lived time and experience (1945/2012, p. 84). "The ambiguity of being in the world is expressed by the ambiguity of our body, and the latter is understood through the ambiguity of time" (Merleau-Ponty, 1945/2012, p. 87). As such, the notion of the habitual body versus the actual body does not point to a split body, but rather an ambiguous and lived body.

The lived body is our actual expression in the world, showing physical characteristics, emotions, knowledge, meaning and experience (Merleau-Ponty, 1945/2012, pp. 147, 224). Lived experiences are embodied and include perceptions, actions and modes of expression, and therefore are saturated with meaning. Although human beings can shift between perspectives, the departure point for having a perspective always is the lived body. Over the course of time new experiences replace the former, but cannot erase or preserve significant or possibly traumatic past experiences. Merleau-Ponty explained it like this:

> New perceptions replace previous ones, and even new emotions replace those that came before, but this renewal only has to do with the content of our experience and not with its structure (1945/2012, p. 85).

In other words, we might incorporate the structure of experiences in our style of being. I understand the structure experiences as an integration of the corporeal and emotional dimensions connected to our encounters with the social and cultural world. Past experiences do not merely exist in our memories and thoughts, but in our embodied being. Merleau-Ponty did not speak for any kind of determinism. Rather, he

[15] The term habit is important in this study, and is defined and deepened in 2.2.2, from page 42.

emphasised freedom in our encounters with the world; I develop and can take different perspectives. We do not stick with previous experiences and let them define us and our lives – neither can we shake them entirely off and live as if we did not have them (Landes, 2013b, p. 102). We cannot leave the paradoxical lived body behind, but we can process, forget or oppress our past experiences, while simultaneously carrying them. In Merleau-Ponty's words: "There is never determinism and never absolute choice" (1945/2012, p. 480).

How to embody and live out the paradoxical situation of being here and now, and between presence and past, is a question belonging to the lifeworld, or one's concrete situation. This paradox signals the complexity and intensity involved, when substantial weight loss after surgery appears as being changed beyond recognition.

2.2.2 The lived body in action: Getting hold on the world

Within phenomenology, being in the world is characterised by practical action and interaction with the environment and connected to time. Heidegger set our practical handling and using of things first, before being able to taking a theoretical approach to our active ways of being in the world (Heidegger, 1927/2007, pp. 91-95). In active encounters with the world, perception and movement are intimately related, and hard to distinguish. *Perception* is situated and contextual, and seems to take place between a passive structure of sensations (stimuli and responses) and active thought about experience, or between determinism and freedom (Gallagher & Zahavi, 2012; Landes, 2013a; Landes, 2013b, p. 11). We perceive through embodied engagement with the environment, connected through intentional threads, according to Merleau-Ponty:

> . . . the body, by withdrawing from the objective world, will carry with it the intentional threads that unite it to its surroundings and that, in the end, will reveal to us the perceiving subject as well as the perceiving world (1945/2012, p. 74).

The moving body is essential for apprehension and perception of the world and simultaneously our *expression* to the world (Landes, 2013b). That is, the lived body is impression and expression; our access to the world and the world's access to us. Moving around and living our lives, we express experience which might not otherwise be voiced, as well as the more physical characteristics such as size, height, age, ethnicity, gender and so forth. Accordingly, our moving bodies carry meaning and are shaped in the tension between spontaneity and sedimentation (Landes, 2013b, p. 86; Merleau-Ponty, 1945/2012).

Tension between spontaneity and sedimentation can be understood as tensional fields between the unpredictable and the habitual, the momentarily and the continuous, the present and the past, the abstract and the incorporated. This is at the core of Merleau-Ponty's philosophical reflections about the ambiguity of the lived body, and the central issue of "How it is that humans are subject and object, first person and third person, spontaneous and yet wholly determined?" (Landes, 2013, p. 4).

With reference to Heidegger, Gallagher and Zahavi emphasised that the world is "a network of meaning . . . a world saturated by practical references of use" (2012, p. 171; 1927/2007). We perceive the environment and objects from the value attached for us, concerning our capacity for action (Romdenh-Romluc, 2013, p. 10).[16] The values embedded in the environment express themselves as something standing out and attracting the person's attention, and thus perception and action are connected. This value points to a quality the person perceives in a specific environment that then demands, or invites her/him to perform certain actions, or supports the person in taking specific actions, rather than others. To me, a football on the living room floor demands to be removed and stored in its place, whereas for our son, the football invites to kicking, juggling and playing, regardless of place and space (1927/2007, p. 93).

Habits are deeply incorporated practices and always related to meaning, and therefore go far beyond patterns of frequently repeated actions. We express ourselves

[16] Such "values" that are interconnected with action have been called *affordances* – concept was introduced by James J. Gibson (1977), and is still used in ecological psychology.

through habits, interaction and coexistence with the world and others, without necessarily being aware of it. We seem to more easily perceive possibilities for action that are related to our habitual and meaningful practices. Habits help us to recognise situations as typical, and relieves us from first having to concentrate on interpretive processes and details related to our daily living, and second having to put it into practice (Merleau-Ponty, 1945/2012, p. 153; Romdenh-Romluc, 2013, p. 13). Habit is acquiring "knowledge in the hands", including incorporating new instruments, and is only accomplished through bodily effort (Merleau-Ponty, 1945/2012, p. 145).

Habit and body schema are interconnected. The term *body schema* points to the tacit knowledge about how to be a body in the world, and thus the organisation and structure of how to perceive the body's position, posture and capabilities (Merleau-Ponty, 1945/2012, pp. 101, 103, 142). The experience of being a body in the world involves perceiving the capability and capacity for movement and action within the environment, including an ongoing and continuous adjustment to the same environment. Merleau-Ponty understood acquiring a habit as a reworking and renewal of the body schema, mastered by the own body, rather than the consciousness (Merleau-Ponty, 1945/2012, p. 143).

Gallagher and Zahavi distinguished body schema from body image; Body image is a perceptual experience, conceptual understanding and emotional attitude toward the own body as a phenomenon for me. Body schema is close to an automatic system of processes and a pre-reflective and non-objectifying body awareness (2012, pp. 164-165). Accordingly, the body schema attunes the own body to the physical-, social- and cultural environment.

Agency means the capacity, condition or state of acting or exerting power, according to the dictionary.[17] I use agency for embodied action depending on the subject's consciousness, in line with Gallagher and Zahavi and Merleau-Ponty (2012, p. 117; 1945/2012). This means that agency points to a complex web of what we do

[17] According to Merriam & Webster, agency means the capacity, condition, or state of acting or of exerting power, see online http://www.merriam-webster.com/dictionary/agency. Also, Merleau-Ponty refers to the body as a power for action, intentionality and signification (Merleau-Ponty, 1945/2012).

and how we do it. With respect to consciousness, agency concerns at which level we can explain our actions, the interrelated intentional aspect and awareness involved, the reflective and pre-reflective levels, and what makes our actions intentional (Gallagher & Zahavi, 2012, p. 179). The experiential sense of agency can be separated from the attribution of agency (Gallagher & Zahavi, 2012, p. 179). The experiential level concerns my sense of moving, for example when lawn mowing, without being aware of every move I make. The second depends on the first, and means that I confirm something I have done ("I have mowed the lawn today").

The sense of agency and ownership felt for the own body are pre-reflective experiences, and not easy to distinguish (Gallagher & Zahavi, 2012, p. 44). For example, my experience of the walking I do as *mine* is usually inseparable from the sense that this body is mine, and I am the one who is walking. This is referred to as self-agency, and it should be noted that the experience would be different in situations involving involuntary movements (Gallagher & Zahavi, 2012, p. 182). From the phenomenological literature on illness experiences, we also know that pain, fatigue, lack of function or deteriorating health often have impact on the experience of self-agency.

There are different ways of having hold on the body; it is possible to think about a movement and sense an experience of that movement, without actually performing it. That is, we are in power to turn away from the world and change the perspective and can concentrate on sensation, feelings and thoughts, or "more generally, be situated in the virtual" (Merleau-Ponty, 1945/2012, p. 111). However, agency remains essential for being in the world. Gallageher and Zahavi expressed it like this: "To be human is already to be action-situated in the world in a way that defines the organized usefulness of the things we find around us, and then lets us think about them" (2012, p. 189).

2.2.3 The lived body: A fundamental kind of situated freedom

There is an ongoing, dynamic and dialectic relation between the embodied subject and a multitude of situations related to the lifeworld. Our situation is related to nationality, language, social class, body, acquired habits and personal history (Sartre, 1943/2003, p. 503). Human beings are meaningfully embodied and situated within the relationships between the past and future, the culture and the immediate surroundings, their ideological and moral situation (Merleau-Ponty, 1945/2012, p. 137). We are *thrown* into the world which is always already there; uncovered to us together with everything else which being in the world encompasses, according to Heidegger (1927/2007, pp. 107, 157).

Merleau-Ponty emphasised that the perspective of the lived body is our point of departure, but situated and related to others from the day we are born till we no longer are alive. He expressed it like this: “If we are situated, then we are surrounded and cannot be transparent to ourselves, and thus our contact with ourselves must only be accomplished in ambiguity” (1945/2012, p. 401). That is, the lived body is a fundamental situation. That is because the own body is the foundation for my lived experience, and from where I understand myself and the world (Moi, 2005, p. 63). Toril Moi expressed this in her famous essay ‘What is a Woman?’ – a text which made the profound meaning of Simone de Beauvoir’s perspective on *the body as a situation* possible for me to grasp. That essay together with ‘I Am a Woman’ appeared like new windows for me to see through and open, when reading Beauvoir.

Women’s situation was the subject of Beauvoir’s analyses. She showed that women were not existentially free subjects, but rather oppressed by structural hindrances present in society, culture and time. She argued that women were reduced to *the other,* or “the second sex” when compared to men (1949/2000; Moi, 2000, p. xxv). Beauvoir argued for women’s existential subjectivity and freedom as beneficial for both women and men. She called for a societal structure which facilitated women and men’s acknowledgement of each other; an ideal she termed *reciprocity* (Moi, 2000, p. xxv). Beauvoir’s vision of the future was a society in which women and men

were considered equal, rather than the usual practice of comparing women to men, as if men were the standard or norm (Moi, 2000, p. xviii).

Accordingly, I understand Beauvoir's approach to emphasise gender equality, and not only women's situation. Feminism challenges the traditional hierarchy between women and men, in which men historically have been superior and benefitted more than women. At present both men and women define themselves as feminists and anti-feminists. The differences between men and women and the meanings attached have been widely debated within and outside feminism since Plato[18], and have raised profound philosophical question which are not yet fully answered.

Introducing Beauvoir's philosophy particularly in order to understand *men's* experiences after bariatric surgery may seem an original approach, because of its renowned position within feminism. However, Beauvoir drew on the perspectives of lived experience and lived body, and developed the understanding of the body as a *situation*, which I found to be an interesting and relevant approach. Beauvoir drew on Merleau-Ponty, Heidegger and Sartre's works, and wrote: ". . . the body is not a thing, it is a *situation*: it is our grasp on the world and a sketch of our projects" (1949/2000, p. 46). The body *as* a situation embeds the body *in* a multitude of situations. This approach points to the profound and fundamental meaning involved with the lived body (Moi, 2005, p. 65).

Understanding the body as a situation makes it possible to avoid the splitting of lived experience along the subject/object dichotomy (Moi, 2005), which is central in this study. That is, understanding the body as a situation provides a possibility, a passable road, to overcoming the dichotomies of object/subject, biology/experience and sex/gender, and not the least avoiding the body as what primarily defines us – as our line of destiny (Moi, 2005, p. 76). Beauvoir captured this in the famous quote: "One is not born, but rather becomes, a woman" (1949/2000, p. 279).

[18] In his ideas about society and the republic, Plato can be understood having expressed that women and men have equal opportunities to achieve the highest education and qualify as leaders of the ideal republic (Brown, 2011).

Sartre described *freedom* as facticity, which means that we can only be free in relation to something or despite something (1943/2003, pp. 506-507). In my understanding, this something is the situation. “For Beauvoir, our freedom is not absolute, but situated”, according to Moi (2005, pp. 65-66). Thus, the situation is a fusion between freedom and the circumstances we are in. According to Moi, Beauvoir drew a line between transcendental freedom (existential for all human beings) and concrete freedom (the specific situations each of us are in) (Moi, 2005, p. 229). Sartre and Beauvoir’s understanding of transcendental freedom is a different point of departure than Heidegger’s emphasis on being in the world as being *thrown* into the world which is already there, offering limitations and possibilities. Inspired by Beauvoir’s notion of the body as situation, I understand the meanings attached to a (woman’s or man’s) body as inseparable from her/his projects. Thus, women or men’s individual embodied situations, agencies and freedom can be lived differently, and involve a multitude of actions and choices.

It is tempting to speculate what Beauvoir would think and say about the present situation in terms of gender equality, but speculations do not bring me further than doing some creative and hypothetical thinking. When reading about bariatric surgery, weight loss strategies, lifestyle, eating and emotions, men’s perspectives and voices are rare to come about, whereas feminist approaches do exist and represent an opposition against the common medical/biological/psychological approaches. This does not mean that men’s perspectives are totally neglected in the literature on long-term weight loss processes, but they clearly are less voiced when compared to women’s stories and experiences.

Men’s health practices are often talked about as behaviours and are frequently problematized as stereotypical and not entirely responsible, especially when it comes to taking care of own health (Gough & Robertson, 2010). The phenomenological approach in this study implies openness and (gender) sensitivity, meaning that I understand health practices as contextual and social. Accordingly, I do not think of health practices as possible to reduce merely to individual behaviours or lifestyles, and

do not understand variation in health experiences as necessarily connected to gender (Gough & Robertson, 2010; Moore, 2010).

3. Method

Aiming for insight into the meanings attached to bariatric surgery I designed a qualitative study anchored in phenomenology. I was wondering what *bariatric surgery experiences* were like in the long-term, which I define as at least five years after surgery. Accordingly, lived experience connected to bariatric surgery is the phenomenon explored in this study. What understandings we might accomplish through research depend both on the phenomenon itself and how it is explored. As such, we aim to describe the methods we have chosen to answer the research question(s) broadly enough to show what we did and detailed enough to understand how we did it.

With respect to *study design*, this study developed as a stepwise process, meaning that we asked a research question, included the participant we anticipated that we needed, interviewed them, transcribed and analysed the transcripts, and started writing (Figure 1). We acknowledge variation, and have been interested both in women's and men's descriptions of undergoing bariatric surgery. In the first sub-study, we saw that there was an interesting variation in habits and practices after bariatric surgery, and to explore this, we needed to interview more participants. When we had interviewed seven women and seven men, we had a sense that there was something in the men's descriptions that we had not been able to grasp. Because of interesting nuances and unanswered questions connected to the men's descriptions in the two first studies, we searched the literature and discovered that men's experiences with undergoing bariatric surgery had not yet been described. We decided to follow this track. Therefore, we redefined the third sub-study, and continued interviewing men.

Article 1	Article 2	Article 3
8 participants 4 women, 4 men	14 participants 7 women, 7 men	13 participants 13 men
Data gathering: 8 interviews	Data gathering: + 6 interviews	Data gathering: + 6 interviews
Results published 2013	Results published 2014	Results published 2015

Figure 1: Stepwise research process

In the literature, the term *methodology* seems understood more broadly than *method*, because it points to the method's theoretical and philosophical underpinnings (Carter & Little, 2007; Dahlberg et al., 2008). In this study, the terms method and methodology cover the same meanings, and are used interchangeably. Phenomenology primarily points to a method for philosophical investigation, questioning *how* a phenomenon is, including its meanings (Heidegger, 1927/2007). As such, phenomenological method is more like "a way toward human understanding" than a set of controlled procedures (van Manen, 2002, p. 249). Several qualitative research methods have been developed on the basis of phenomenology, and are used in the human sciences, including psychology, pedagogy and health care. As a method, phenomenology seems to be practiced quite differently in health research. Because it is not necessarily obvious what a phenomenological study is, clarity and transparency is decisive when describing the theoretical and methodological underpinnings in empirical phenomenological studies (Nordlyk & Harder, 2010).

This study is inspired of Reflective Lifeworld Research, which is a methodological approach developed by Karin Dahlberg with colleagues for nursing

sciences (2008). Reflective Lifeworld Research (RLR) is suitable for exploring lifeworld phenomena, such as well-being, illness and meaning. Dahlberg with co-workers are inspired of Husserl, Heidegger, Merleau-Ponty and Gadamer, and thus are open to descriptive and hermeneutic phenomenology. Insights from phenomenological philosophy have driven RLR as a human science research approach in fields where the natural sciences remain the dominating research paradigm.

RLR was inspired of Amedeo Giorgi's development of a phenomenological method for empirical studies in psychology. Giorgi has worked with creating and implementing a rigorous phenomenological research method in psychology since the 1970's (1975, 1985, 1997; 2009; 2003). Inspired by Husserl, Giorgi concentrated on descriptive phenomenology. Giorgi's phenomenological method has inspired several empirical studies within psychology and health care sciences over the last decades, including the process of analysis in the current study.

3.1 Aspiring for openness

In phenomenology, an open attitude towards the world and phenomena is at the core. Openness concerns how making oneself available to how the world and phenomena appear, and is put into practice through choices made when designing and undertaking empirical lifeworld studies (Dahlberg et al., 2008, p. 97). Availability here points to being sensitive and attentive to the other's experiences, perspectives, ideas and arguments. Openness involves balancing the immediate presence and engagement with the phenomenon and one's sense of being receptive and reflective (Dahlberg et al., 2008). Accordingly, an attitude of openness can imply *actively waiting* and not mere listening. This is not necessarily easily achieved, and demands the researcher's awareness throughout the process (Dahlberg et al., 2008).

Openness also points to the fact that the phenomenon is open to interpretation and to be questioned. Accordingly, the researcher must be prepared for a degree of uncertainty as an inevitable aspect of the phenomenological research process. As

Dahlberg points out, phenomenology is not about making definite what is indefinite, but rather letting the infiniteness last for as long as possible (2008, p. 241).

Research methods claiming to be based in Husserl's phenomenology seems sometimes to raise debate and possibly lead to misunderstandings. Giorgi has underscored the difference between philosophy and science, and thus between philosophical analysis and analysis of empirical data (2003, p. 247). This is a fine line, and possibly not always that easy to see. Giorgi applied the lifeworld perspective from phenomenology, and tried to adapt it to empirical studies directed towards others' experiences. Phenomenological reduction is one of the concepts he used concerning the intention to hold back one's own pre-understandings, point of views and theories, in order to let the phenomenon and the meanings attached unfold during the research process. This process is called *bracketing*, and is meant to open up for the phenomenon's meaning, including what is taken for granted or concealed connected to the lifeworld, and make the phenomenon's essential meanings available for description (Giorgi & Giorgi, 2003, p. 249). Thus, according to Giorgi, bracketing is equivalent to phenomenological reduction in research (2003, p. 247).[19]

In RLR, bracketing is called *bridling* to emphasise the researcher's ongoing active and sensitive attitude in the research situation which makes it possible for her to open up for *and* hold back her own thoughts, contributions and involvements. According to RLR, the researcher can learn to be aware of her own natural attitude and thus to question it, which is supposed to be essential for adopting an open attitude (Dahlberg et al., 2008, p. 130). [20]As such, bridling involves loosening the intentional threads between the researcher and her lifeworld, and give space for what that might bring about. Obviously, these threads are impossible to cut and thus, researchers

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[19] Phenomenological reduction seems to converge with *eidetic* reduction, which is defined as "shifting focus from the facticity of experience to the essential or necessary structure of that experience" (Landes, 2013a, p. 68). According to Giorgi, the eidetic approach in phenomenology is a strength in terms of generalisation, because aiming for essential structures provides qualitative analyses with strong intersubjective findings (2009, p. 55).

[20] The natural attitude of experience and thought points to our existence and living in the world as immediate and intuitive (Husserl, 1931/2012, p. 3). A natural attitude means that we are not critical or reflective; we just are or act (Dahlberg et al., 2008, p. 33). When exploring a phenomenon, we cannot accept the taken for granted assumptions that are embedded in our natural attitude to direct our investigations, according to Husserl (Zahavi, 2011, p. 71).

cannot separate from their pre-understanding. Rather it needs to be bridled in order to let the other's descriptions come about (Dahlberg et al., 2008).

In hermeneutics, pre-understanding is described as a presupposition for new understanding, by bringing the researcher into the situation as an active participant drawing on who she is and what she knows. According to Gadamer, pre-understanding is prerequisite for understanding at all, and therefore positive (1960/2010, p. 273). However, as it is possible that the researcher's pre-understandings might limit the exploration of a phenomenon, there are some potential negative aspects as well. An open attitude can stop us from being led astray by own pre-understandings as long as we manage to connect the other's thoughts and meanings to ours (Gadamer, 1960/2010, p. 274). It seems like the researcher's awareness of own pre-understanding in an intersubjective situation, for example a conversation, is connected to creativity and new ideas. This presupposes that we are able to look away from ourselves and let the other's situation become visible and simultaneously being present in the situation.

In my understanding, the attitude of being open and actively waiting in RLR does not rule out spontaneity, immediacy and active participation in the process. RLR acknowledges that pre-understanding always is there, but because lifeworld research is directed towards the participant's lived experiences, bridling is a useful approach. In this study, bridling means that I tried to be sensitive and aware about when and how I used my own knowledge and experiences in the dialogue with the participants and the data material. The intention was to give enough space for the participants' descriptions to unfold, and to gain new insights and deeper understanding.

3.2 Research interviews: Aiming for closeness to lived experience

The aim of this study is to understand lifeworld phenomena connected to bariatric surgery. Therefore, I encountered people who had experienced long-term weight loss processes after surgery, and invited them to an interview. Inspired by phenomenology

and empirical health research, I sought for meaning attached to other peoples' lived experiences. Aiming for in-depth understanding, I sought rich descriptions and concrete examples from the participants' lifeworlds (Dahlberg et al., 2008, p. 35). Therefore, I planned open interviews.

I thought people who had lived through the bariatric surgery process themselves might know something which the professional environment did not or possibly have not paid sufficiently attention to. I was curious about the meanings attached to lived experiences and the patients' point of view. I wondered how the participants understood themselves as embodied beings in the world after bariatric surgery, including their actions and interactions with others, and what it was like, how it unfolded or changed in the participants' concrete situations. To find out more, I needed to be in dialogue with people who had undergone bariatric surgery.

An interview is when at least two persons meet to have a conversation in order to create or deepen their understanding of a topic which both parts are interested in. It is a social and intersubjective situation, and thus knowledge from interviews is created by those who take part in the process and their interactions (Kvale & Brinkmann, 2009). Interviewing is widely applied, for example in therapeutic interviews, job interviews or journalistic interviews (Roulston, 2010, p. 10). The research interview is founded in the conversation as it occurs in everyday life (Kvale & Brinkmann, 2009, p. 2; Van Manen, 1997a, p. 66). For example, establishing a common ground and a common "language" early on in the conversation is central for developing new and shared understanding, as well as keeping the phenomenon of interest in the foreground (Gadamer, 1960/2010). [21]

The research interview usually is both spontaneous and reflective, and is characterised by circular movements expressed as an ongoing and mutual process of formulating and re-formulating, clarifying and elaborating. Gadamer described the meaningful conversation through the dialectic relationships between questions and

[21] Gadamer wrote about the conversation and not the research interview. In my understanding, the research interview has much in common with the conversation as described by Gadamer. Therefore, I draw on his insights when I write about the research interview.

answers, giving and taking, talking past each other and getting along with each other. He described asking good questions as an art, based on the ongoing dialectics and thinking involved in the conversation (1960/2010, pp. 330-332). Accordingly, interviewing is described as a craft, a production of knowledge and a social practice (Kvale & Brinkmann, 2009, p. 20). High quality research interviews depend on knowledge about how to do interviews and the topic of interest.

The questions I wonder about and ask are connected to my experience and thus involve meaning (Gadamer, 1960/2010, p. 326). Questions often signal a certain openness (Gadamer, 1960/2010, p. 333). Open questions often start with "what was it like...", "how...", "can you describe...", and require answers beyond short responses. Open questions are not meant to be vague or abstract. In phenomenological studies, we rather ask for concrete examples, specific situations or events to make it easier for people tell about their lived experiences. Asking for the concrete is necessary to be able to grasp core meanings and nuances of the phenomenon investigated. We aim for presence and immediacy in the situation, ask follow-up questions and use pauses to get closer to lived experience (Dahlberg et al., 2008; van Manen, 2014).

In phenomenological research the interview is a way to make another person share detailed and concrete experiences connected to specific situations. This is not an easy task: We tend to tell *about* experiences, rather than telling an experience as lived through (van Manen, 2014, p. 315). Lived experiences are arranged according to time; present, past and future (Merleau-Ponty, 1945/2012, p. 432). Retrospection has some implications; although previous experiences are accessible, there might be a slight difference between the reported and actual experience and meanings attached (Giorgi, 2009, p. 117). As researchers, we encourage interview participants to tell about experiences from their past and present situation, which means that we need to be careful when interpreting the findings (Giorgi, 2009, p. 117). As such, interviewing is not a rule-governed method but rather depend on the researcher's ability to develop her personal skills and experience through preparations and practice (Kvale & Brinkmann, 2009). That is, the researcher needs to facilitate a climate of safety and trust in the interview situation. An interview largely depends on the contact between

the interviewer and the participant (Fog, 2004). The researcher *must* genuinely engage in dialogue with the participants and respond to them, which is a central dimension of openness and understanding (Dahlberg et al., 2008, p. 102; Fog, 2004, p. 72).

3.3 Preparing for interview research

In a phenomenological study, the researcher aims for an as complete as possible description of a lived through experience (Giorgi, 2009, p. 122). A good interview is an intersubjective encounter with a spontaneous quality that cannot be prescribed. I prepared for the interview setting in various ways. I read about interviewing, discussed interviews with others, and as part of the project planning, I developed a thematic *interview guide* (appendix 1, 2). The interview guide included the main topics of interest, broad opening questions and suggestions for follow-up questions (Kvale & Brinkmann, 2009, p. 134). The term semi-structured interview is often used for an interview guide with open ended questions and a rather flexible interview situation, whereas *unstructured* interviews are spontaneous and do not follow a pre-planned schedule (Roulston, 2010, p. 15).

Aiming for good research interviews, I needed to prepare some structure, especially to start the interviews, but not at the cost of openness and spontaneity. As such, I primarily used the interview guide for preparation, and not as a tool for streamlining the interviews or following ready-made questions.[22]

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[22] In a few interviews, I tried to let the interview guide help me. One was an interview yielding very much information in bits and pieces that were hard to follow and the other was an interview with a less talkative participant. The interview guide was something to hold on to, but could not help me handle those situations. In the first example, I just had to try to hang on to the participant's story, listen, try to understand, and maybe get the opportunity to ask some clarifying questions. In the opposite situation, I had to try to have a different kind of conversation. Questions and answers were not working, so I tried to find out what the participant was interested in, and we talked about that (which had little to do with the research topic), before I tried moving back to the topic. In the situation, I was uncertain of what this interview could bring in. Later, I discovered that this participant had described unique experiences. The participant said little, but her/his story was very special and added important nuances to the data.

I had prepared myself for the interviews, but aimed for openness and in-depth descriptions, rather than structure. As such, I chose to call them in-depth interviews, and not semi-structured interviews. Thinking through one's own perspectives, motivations and feelings connected to the phenomenon and the interview situation can have impact on empirical data, according to Fog (2004). Looking into the interview guide before each interview was helpful, and made me aware of the phenomenon I was interested in. I recaptured previous experiences from interviewing, and tuned in to the situation ahead. In my opinion, this preparation made me relaxed in the interviews, which I think was a good starting point. Usually, I used the interview guide when rounding off the interview. A few times, I used it to take a time-out, and sum up what we had talked about so far. This is an example of how preparation was helpful in creating safety for the participant and me in the interview situation.

3.4 Ethics: Procedures and considerations

Before starting the study, I sent an application to the Regional Committee for Medical and Research Ethics (REK) and the Norwegian Social Science Data Service (NSD) who approved of the protocol (appendix 3-5). Accordingly, I follow the ethical principles for research involving human beings and information about their personal health, stated in the Helsinki Declaration and The Health Research Act (Helse og Omsorgsdepartementet, 2008; World Medical Association, 1964/2013). I developed a letter of invitation and consent form (appendix 6-8). I asked permission to invite an experienced nurse to participate in identifying and recruiting study participants from a hospital offering bariatric surgery. A formal leader and medical doctor in the institution approved. As the study-design developed along the process, we informed REK about changes several times, and sent new applications. For example, we applied for including more participants. Because of the time passed, we sent a new letter of information to the 8 first participants, in line with REK's instructions (appendix 9).

The information participants shared in interviews is sensitive and can easily be identifiable if it is coupled to detailed information about them. Therefore, the data has been handled confidentially; information coupling the data to the participants' identity has been erased from the transcripts (stored at secure server at University of Bergen), and the list of participants has been locked in and stored separately from the transcripts. Confidentiality remain an ethical concern when communicating research findings, because being very large and then becoming rather thin after bariatric surgery is a process which makes the individual highly visible and exposed in social contexts. In research, persons might be recognized if details about their life circumstances, health and weight loss process are coupled to age, gender and so forth. Accordingly, to protect the participants' confidentiality, I only provide rather broad information (table 1, page 62) and have not coupled quotes from interviews with the participant number or pseudonym in the articles.

The imbalance of the relationship between the researcher and the participant in interviews demands an ongoing ethical awareness and reflection (Dahlberg et al., 2008; Kvale & Brinkmann, 2009). Ethical reflections have been central throughout the whole research process, and I have aimed for this to shine through in the published articles and the current thesis. Further ethical considerations are included in researcher's reflexivity, starting on page 91.

3.5 Recruitment and participants

To identify and get in touch with participants, I had assistance from a nurse employed at an obesity clinic offering bariatric surgery in a Norwegian hospital. For ethical reasons, a third person (the nurse) identified and contacted eligible participants, and sent the letter of information and consent form to those who were interested. The patients who volunteered returned a signed consent to me, and I invited them to an interview. The exact number of participants cannot easily be determined beforehand in qualitative studies, but rather depend on the quality of the data material. Based on

experience and methodological literature, I anticipated that we needed between eight and 15 interviews in this study. Because new research questions came up along the process, we designed a study including male participants only, and thus needed some more interviews with men. All in all, I interviewed 20 participants, seven women and 13 men.

Often, the final *sample size* is explained by “inclusion until saturation was obtained” (Morse, 1995). Saturation points to the stage in the research process when interviews provide little new information, or when the researcher has enough data (Kvale & Brinkmann, 2009; Morse, 1995). However, a situation with “no gaps left to fill” is not what phenomenology is about or aims to achieve (Dahlberg et al., 2008; Kvale & Brinkmann, 2009; Morse, 1995). According to Dahlberg and colleagues, it is the process of analysis which shows us whether we have enough data or not, in order to describe the phenomenon (2008, p. 176). Describing a complex phenomenon, such as long-term experiences with bariatric surgery, might require a larger sample than a less complex phenomenon. This relates to the imperative in phenomenological studies; meanings are infinite and cannot be fully completed (Dahlberg et al., 2008; Giorgi, 2009; van Manen, 2002). Accordingly, the phenomenon and its meanings cannot once and for all be exhaustively and completely described across a variety of situations, times and contexts. Based on these insights, I tried to balance the idea that describing a complex phenomenon requires rich and varied data with the idea that large amounts of data might challenge the process of analysis (Dahlberg et al., 2008; Kvale & Brinkmann, 2009).

The participants were recruited among patients who had had bariatric surgery and follow-up at a Norwegian hospital [23] and according to some *criteria for inclusion*. To highlight the research question, we needed participants who were able to do so, and thus our sample can be described as a purposive sample (Polit & Beck, 2008, p. 355).

[23] Broad description of the follow-up services which the participants have been offered: During the first 18 months after bariatric surgery, the participants were expected to attend five postoperative visits at the outpatient clinic/family physician, and then annual visits. At regular times every week, the participants could contact the dietician or an experienced nurse at the hospital by telephone. During follow-up, the main focuses are monitoring body weight, nutritional status (blood samples) and side effects/complications. Furthermore, diet and physical activity are topics of conversation, along with the patient’s sense of well-being. Group-meetings focusing on diet and physical activity were offered at the outpatient clinic one and two years postoperatively if enough patients signed up for participation.

Variation is a very important data quality in lifeworld studies, and therefore we included both genders and participants with different educational background, working experience and family situation (Dahlberg et al., 2008). We included men and women aged 18-60, who had undergone the bariatric procedure Duodenal Switch (DS) at least five years before the research interview. Although bariatric surgery is offered to people aged 18-60 in Norway, we included participants aged 30-50 in the first round. I was aware that peoples' lives vary a lot beyond age, but I had an idea that interviews with people in this age span/phase of life would include a good variety of experiences from balancing the bariatric surgery process with everyday life, including employment and family life. As the study progressed, I learned that age seemed less important, and possibly could limit my understanding of the phenomenon, as well as the access to participants. Therefore, I changed the criteria to include participants aged 18-60.

I included patients who had had one specific bariatric procedure (DS) for two reasons; DS was the most frequent procedure offered at the hospital from which we recruited participants at that time. The procedure is still in use in Norway and worldwide because of its effectiveness with respect to weight loss. DS is a major combined procedure, and is expected to provide the largest weight loss but also involves somewhat higher risk of complications and side effects. Because DS seems to be the most radical of combined procedures currently performed, we assumed that descriptions of long-term experiences after DS would be useful.

I asked people about their experiences with a comprehensive variant of bariatric surgery at least 5 years afterwards. As such, *time* is a meaningful aspect in this study. Based on working experience from the bariatric field and conversations with health care professionals who met patients during follow-up, we knew that the weight loss process after DS might last one to two years. I anticipated that the process of weight loss and change would be most intense and peak within the first two years. Therefore, I wanted to await the interviews until the participants' situation had returned from a more or less extreme situation to a more ordinary daily life. From the literature, we knew that research on long-term experiences was lacking. I assumed that a long-term perspective could open up for a larger variety of lived experiences than interviews

during/near the weight loss process. I was interested in how the relationship to oneself and others had developed over time and connected to the bariatric process. I sought insight in issues related to weight maintenance, weight gain or late side effects, which might arise later in the process. Therefore, I decided on a long-term perspective, which means at least five years after surgery. In hindsight, I think that as the process of change after surgery apparently is abrupt and rapid but also long lasting, allowing for time was important for the results. Thus, the depth and variation in the participants' descriptions may be connected to the time passed as they lived through the experiences.

I invited participants with Norwegian ethnicity, because the understanding of the body, bodily expressions like weight and meanings attached vary among cultures. Furthermore, cultural belonging might have implications for which conversations we can have about the own body, body size, emotions, eating and so forth. This is an interesting topic in itself, but I found that cultural difference as these dimensions might concern different phenomena than the one I planned to investigate. People with intellectual disabilities and severe psychiatric illness have undergone DS. Because we thought these points of departure might raise other questions than we have asked in this study, we chose not to invite them to participate in this study.

For ethical reasons, patients whom I knew from my work as a physiotherapist were not invited to participate in the study. Before the interviews, I did not know anything about the participants apart from their names. The background information provided is collected from the interviews. The 20 participants were aged 28-60 at the time of the interview. 18 were married or cohabiting, two lived alone and 13 participants had children. The participants' educational level varied from below upper secondary education to tertiary education. Most participants were employed, some had disability pension, some were job seekers and one was a student. They lived in cities, smaller towns or rural areas spread over four counties in eastern and western parts of Norway. The participants' background information is presented in table 1, page 62.

Table 1: The participants' background information

Participant	*Gender*	*Age*	*Years after surgery*	*Civil status*	*Work participation*	*Education*
1	M	43	6	Married, parent	Employed, full time	Upper secondary education
2	F	48	7	Married, parent	Employed, full time	Upper secondary education
3	M	53	6	Single	Employed/disability leave	Below upper secondary education
4	M	47	6	Married, parent	Employed, full time	Upper secondary education
5	M	40	5	Married, parent	Disability leave	Upper secondary education
6	F	49	7	Married, parent	Employed/disability leave	Tertiary education
7	F	42	6	Cohabiting, parent	Disability leave	Below upper secondary education
8	F	47	5	Cohabiting, parent	Disability leave	Below upper secondary education
9	F	53	6	Married	Job seeker	Tertiary education
10	F	53	6	Cohabiting	Disability leave	Tertiary education
11	M	40	6	Married, parent	Employment, full time	Tertiary education
12	M	28	6	Cohabiting	Student	Tertiary education
13	F	42	5	Married, parent	Employment, full time	Upper secondary education
14	M	51	5	In a relationship	Employment, full time	Upper secondary education
15	M	60	5	Married, parent	Employment, full time	Tertiary education
16	M	54	5	Cohabiting	Job seeker	Below upper secondary education
17	M	45	5	Married	Employment, full time	Below upper secondary education
18	M	49	7	Married, parent	Employment, full time	Upper secondary education
19	M	44	7	Married, parent	Employment, full time	Upper secondary education
20	M	54	5	Married, parent	Job seeker	Below upper secondary education

I thought body weight might be a sensitive topic for the participants, but in this setting it seemed not to be; body weight/size was a natural subject of our conversation.[24] On average, the participants had lost 86 kilograms after surgery (median). Most participants described their current weight situation as stable (+/- 5 kilograms), which for some meant weighing 10-15 kilograms more than their lowest weight after surgery. These participants expressed that they had not felt comfortable at their lowest weight. A few participants were either constantly weight cycling or currently regaining weight, although they desired a stable and low weight. The largest weight gain reported was 30 kilograms. Brief information about the participants' weight loss after surgery is presented in table 2.

Table 2: Weight loss after surgery

Weight loss in kilograms	*Number of participants*
Weight loss < 50 kg	4 participants
Weight loss 50-90 kg	6 participants
Weight loss 90-100 kg	4 participants
Weight loss ≥ 100 kg	5 participants
Weight loss not reported	1 participant

[24] One of the participants did not talk about his weight loss. Unlike the other interviews, this participant started straight away to tell about his process and shared profound experiences. I did not want to interrupt him, and the background information came where it fitted into his story, and not as a result of me asking these questions as an introduction to the interview. Later, I discovered that he had talked about weight cycling 30 kilograms, but not his total weight loss. I had his permission to call him and ask for further information or clarifications after the interview, but I did not, because the interview had been so good, and he had shared so much. To call him and ask how many kilograms he had lost seemed misplaced and not appropriate, I thought. This piece of information about weight loss meant so little when compared to what he had said in the interview.

3.6 Conducting interviews

I interviewed each participant once, and the interviews lasted on average approximately 90 minutes. The shortest lasted about 60 minutes, and the longest about 120 minutes[25]. I used a recorder, and transcribed the files verbatim. Whether to invite participants to one or multiple interviews was a question which I thought through and discussed within the research team, with other researchers and the nurse at the hospital. Because of the time passed after surgery, I anticipated that one in-depth interview would be sufficient and give good opportunity for the participants to share their experiences. Furthermore, I assumed that participants might more easily volunteer for one interview than two. On the practical side, two interviews with each participant would imply a lot of time and resources for travelling, meaning that I would have to consider interviewing participants within a limited geographical area, or include fewer participants.

I aimed to contribute to a safe interview situation in which the participant could feel comfortable enough to provide rich descriptions of lived experiences, which is a supportive and non-therapeutic environment, according to Roulston (2010, p. 18). I suggested having the interviews in a place with some privacy and minimal interruptions, and the participants could choose the location. Most participants preferred to be interviewed close to where they lived or worked, and I booked a suitable meeting-room in a library, a hotel or a restaurant, and travelled to where they lived. Some invited me to their home or workplace for the interview. Other participants preferred coming to where I was located, and were interviewed in a quiet meeting room at the University.

After some informal talk and finding out what the participants wanted to drink or might need to feel comfortable, I started with a short introduction to the topic, which was a repetition from the main points in the letter of information. I asked for background information on age, education, employment and family situation, in which

[25] I conducted and transcribed the interviews, and started the process of analysis. The supervisors and co-author took part in the analysis by reading the interview transcripts and discussing the analysis and findings along the process. Christian Moltu joined the research team after the first article was drafted, and took part in the research process and writing of article 2 and 3.

year they had surgery, whether they had undergone other surgical procedures related to bariatric surgery (plastic surgery, reoperations and so forth), pre-operative weight, total (maximum) weight loss, current weight/weight situation (stable, weight cycling and so forth). Then, I asked how the current situation was. I had planned gathering contextual information early on in the interview to make contact with the participants, to make them familiar with the interview situation and to encourage them to talk from the start (Kvale & Brinkmann, 2009, p. 128). Also, it was helpful for me to have an idea about their current situation from the start.

For example, one participant had recently been diagnosed with a serious disease. The participant had prepared for an interview about the bariatric surgery process, which she was interested in, and wanted to proceed. From a lifeworld perspective, I understood that the new situation would have meaning for how the interview turned out. We solved it by opening up for including the new situation in the interview, if and when the participant felt like it. After the participant had told about the most recent illness experience, he/she went into the bariatric surgery experiences, which remained the core topic of the interview.

Most of the interviewees started talking about their bariatric surgery processes without me asking that many questions. They typically started by talking about their reasons for having surgery, how they went about to have it and what it was like afterwards. Some began with the current situation, and moved back and forth with respect to a timeline. I listened, asked follow-up questions and tried to make them deepen their experiences and use concrete examples from lived situations. One example was a participant who told that his/her body still was a topic of conversation in social life, years after surgery, and he/she seemed tired of this. I asked: Can you try to tell as concretely as you possibly can about one such time when someone wanted to talk about your body? Dependent on how rich the participant's description was, I asked how the participant experienced that specific situation, and what they thought about it today. When the participants talked about the experience of own body and bodily change, they often paused, sort of listened to themselves and searched for words to describe what they were talking about. In hindsight, I think this was an

experiential aspect which they found difficult to grasp and were not used to talk about. I waited until the participants had described an experience in as concrete details as possible, and then asked: How was this before? How is it now?

Before summing up and closing the interview, I asked the participants what they thought about the future. This question made the participants stop and think, and the answers I got were insightful and intimately connected to their descriptions of different bariatric surgery processes. In the interviews I was concentrated on lived experiences rather than opinions about bariatric surgery. However, before rounding off the interviews, I asked the participants if there was anything else they would like to add. Some participants used this opportunity to share opinions and comments on the problem of obesity, how badly very large people are treated by others, how negatively severe obesity is talked about in media, the need for improvement of the health care services/ follow-up after bariatric surgery and so on. Others chose to sum up their own experiences, and basically rounded off the interview themselves. I wrote a note of reflection after each interview. This was helpful in order to remember contextual information, my own immediate impression of the interview situation and what I initially grasped as the core of the participant's contribution (Kvale & Brinkmann, 2009, p. 130).

3.7 Analysis

The analysis of empirical data is intersubjective and dynamic, and not detached from the rest of the research process (Dahlberg et al., 2008; Giorgi, 2009). Data consisted of 20 interviews and reflective notes. The stepwise research process (Figure 1, page 50) made the large amounts of data possible to handle: We asked a research question, conducted interviews, analysed and started writing, before moving to the next research question, new rounds of interviewing and so forth. I wrote reflection notes after the interview, and transcribed the interviews as soon as possible, which often meant the next following days. Although I concentrated on being attentively present and actively

listening to the interviewees, I simultaneously started reflecting about what I heard and saw during the interview. This process continued as I wrote reflection notes, transcribed the interviews, analysed the descriptions, discussed and wrote the articles together with others.

In analysis, the researcher looks for meaningful patterns which can be identified and described. Across different strategies for analysing qualitative data there are some common features. Usually one needs to read the whole text, code the meaning units, condensate and describe/interpret the meanings (Giorgi, 2009, p. 128). When analysing a text for meaning, each part must be understood related to the whole, and the whole must be understood in terms of the parts (Dahlberg et al., 2008, p. 236). The empirical material was substantial and contained variation, and understanding the lifeworld as a central point of departure for describing a phenomenon, I assumed that moving too quickly from each interview to the whole material might conceal the variation and context which I needed to understand the meanings. Therefore, I intended to do a thorough analysis of each interview before seeking meanings across the whole material. Accordingly, the analysis in this study is inspired of Giorgi's phenomenological method with respect to *how* I did it (1975, 1985; 2009; 2003).

Rooted in Husserl's philosophy, Giorgi developed a descriptive phenomenological method, meaning that the researcher aims to stay close to the participant's description. The point is to understand that the meanings of the phenomenon are given in the presented data, and carefully describe them at a higher level of abstraction (Giorgi, 2009, p. 127). [26] The underlying assumption is that essential meanings already exist from the intentionality between the phenomenon (long-term experience) and the subject, and thus are not merely added as a result of the researcher's interpretation. Meanings arise from the intentional field between the participant's descriptions, the researcher and the phenomenon. Therefore, it becomes possible to describe implicit and explicit, visible and invisible meanings that are already there. Because interviews are mutual dialogues between the interviewer and

[26] Central topics related to phenomenological analysis, such as the tension between interpretation and description, bridling/bracketing is described in the theory section.

the interviewee about a predefined topic of shared interest, I understand interview data as not merely "gathered" but also as coproduced (Kvale & Brinkmann, 2009). Both Dahlberg with colleagues and van Manen have described that phenomenology always is descriptive and interpretive, hermeneutic and linguistic (2008; 2014). Furthermore, it is a method of questioning, rather than answering, according to van Manen: "Phenomenological research begins with wonder at what gives itself and how something gives itself. It can only be pursued while surrendering to a state of wonder" (2014, p. 27).

I did not know beforehand how to best handle the large amounts of data, but other's ways of encountering this challenge pointed me in a direction; I started with the interviews containing most variation and moved on from there (Råheim, 2001b). I started by reading the transcription to get an impression of the whole.[27] Then, I re-read the interview from the beginning, and spontaneously marked each shift in meaning. I have described how I practically worked with the analyses in further detail in the methodology sections of the included articles.

When the interview was divided into meaning-units, I moved to what Giorgi has called "the heart of the method", which is about transforming the participants' meaningful descriptions into the researcher's voice, but still stay close to the original description. Here, I used my experience and knowledge to extract, understand and deepen the participants' meaningful and unique expressions. I wondered about the text's meanings, asked different questions from my understanding of the participant's description, the context and my experience. I tried to see and clarify the phenomenon and the limits of the phenomenon. In my understanding, this approach is what Giorgi (inspired by Husserl) calls imaginative variation (2009; 2003).

Sometimes it was hard to understand the meanings and I went in circles. For example in the process with the second article, I first analysed habits and practices concerning both eating and physical activity. Eventually, after a long process and good

[27] Three out of four in the research team have read all interviews, whereas one researcher read a selection of interviews; the descriptions I thought provided most variation in the material.

discussions, we realized that meanings of eating and physical activity were described very differently. Eating was described as existentially meaningful, infused with ambiguity and difficult to comprehend after surgery, whereas physical activity was described as important and for some meaningful, but with less depth. At other times, "something" showed up, or I gained insight through the ongoing process of questioning, thinking, writing and rethinking. For example, the general structure "translating weight loss into embodied agency" developed through an ongoing dialogue among the researchers about the men's common emphasis on activity, action and employment across their varied experiences with bariatric surgery, backgrounds and current life circumstances.

Driven by this process, I wrote condensed descriptions of the meaning units at a higher level of abstraction. Descriptions at a higher level of abstraction made integrating data from all participants possible, and thus I became able to describe essential meanings of the phenomenon, rather than ideographical findings (Giorgi, 2009, p. 136). When one interview was transformed into multiple condensed descriptions, I moved to the next, until I had been through the data, and was ready to write a phenomenological description. A phenomenological description aims at elucidating those structural features of the phenomenon that helped to make the phenomenon's essential meanings (as they were) visible to us (van Manen, 1997a, p. 121). As such, a phenomenological description can be understood as "an example composed of examples" (van Manen,1997a, p. 122).

Aiming to describe a phenomenon's essential meanings (a general structure), means to reach for a level of generality, but not at the cost of variation and particularity. [28] In lifeworld studies, the whole structure is described, including the essential meanings of the phenomenon and its constituents, also called essential themes, which contain particularity and variation (Dahlberg et al., 2008). Accordingly, a phenomenological description includes the phenomenon's essential meanings and its constituents, and these are intertwined. In this study, the essential meanings developed

[28] With respect to universality, Giorgi makes clear that unlike philosophy, phenomenological analyses in empirical studies do not push towards universality (2009, p. 132; 2003, p. 250). This is discussed related to transferability, on page 90.

along the process of writing the essential themes, and did not emerge until quite late in the writing process.

However, it is not always possible to achieve an essential meaning structure, possibly because of superficial or poor data, the researcher's reluctance to interpret the findings, lack of experience or advice (Dahlberg et al., 2008, p. 255). We experienced this in one of the sub-studies, in which we explored eating and meanings attached after bariatric surgery. I wrote a phenomenological description containing two essential themes including richness, variation and depth, but did not provide a general structure. This was because eating after bariatric surgery did not appear as a phenomenon with a clear structure, firm or easy to distinguish; rather, its boundaries appeared as somewhat fluid. Inspired by Giorgi, we did not push towards an essential meaning structure:

> To force clarity on a phenomenon that does not have that attribute does not necessarily result in clarity. Rather, the relationship to the nature of the phenomenon being investigated also has to be taken into account. Thus, an ambiguous description of a phenomenon that is intrinsically ambiguous communicates a type of clarity (2005, p. 81).

The *variation* in the participants' experiences was striking. All participants described a wide span of different emotions, thoughts and embodied experiences after surgery. Some participants' descriptions stood out from the others, connected to extremely difficult situations and unusual trajectories after surgery, involving alarming experiences and ongoing high levels of psychosocial stress. I had a data material containing variation and depth, which made the analysis both interesting and demanding. For example, when a participant's description was very different from several others, I sometimes needed to ask new and different analytical questions to the material. Furthermore, this inspired me to read different kinds of literature and allow enough time for analysis, writing and rewriting. The variation was important for developing sound descriptions of the phenomena's essential meanings, and is displayed and deepened in the essential themes.

As a continuation of the analysis, I started writing *phenomenological descriptions*. A good phenomenological description displays the deeper significance of lived experiences, and can be compelling and insightful, according to van Manen (1997a; 1997b). In phenomenology, language is based in our existential being, intimately connected to thinking and a tool for dialogue and understanding (Dahlberg et al., 2008, pp. 83-85; Gadamer, 1960/2010, p. 340). Understanding another person's experiential world depends upon expressiveness, and language entails opportunities and limitations (Giorgi, 2009, p. 108).

When I described the participants' experiences, I noticed that something was going on beyond writing *about* the findings. I sensed a kind of quivering link between the lived experiences I tried to describe and the writing (apart from the obvious), which was pivotal for how I expressed myself in the text. I thought of this as a parallel to "reading between the lines", or being in the nexus between *what* a text says and *how* a text speaks, as described by van Manen (1997b). Both these forms of meaning are embedded in the structure of phenomenological texts (van Manen, 2014, p. 47). Doing phenomenology implies developing one's interest for vivid and insightful texts, reflecting and writing in a phenomenological manner about lived experiences, phenomena and events (van Manen, 2014, p. 23). To work on my writing, I expanded my reading to a larger variety of texts.

Analysis and writing were time-consuming and laborious phases, including rather long periods without particularly visible or tangible progress. As such, going in and out of slower and intensively productive phases was part of this research process. However, Giorgi's phenomenological method was helpful and inspiring; I got started and came through comprehensive processes of analysis. Across phenomenological approaches, *wondering* is central. Wondering is a state of openness, rather than an intellectual activity, and goes deeper than asking questions or being curious (van Manen, 2014, p. 37). Phenomenological analysis and insight cannot easily be forced, and "an active passive attitude of patience" is an approach suggested by van Manen (2014, p. 345). As such, the phases when not that much seem to happen might be valuable and pivotal for phenomenological analysis and writing. Having the patience

and willingness to wait might not be the easiest part of the process, according to my experience.

4. Summary of Results

The overall aim of this study was to gain and develop knowledge about how undergoing bariatric surgery might be perceived and experienced form the first person perspective, and insight into what life turns out to be like in the long-term.

4.1 Article 1

Natvik, E., Gjengedal, E., & Råheim, M. (2013). Totally changed, yet still the same: Patients' lived experiences 5 years beyond bariatric surgery *Qualitative Health Research, 23*(9). doi:10.1177/1049732313501888

The first article explores experiences of the body, changes of habits and practices, social interactions, and how patients lived and understood the changes in the long term. The article displays our analysis of the first eight interviews, and the essential meaning of our findings as "totally changed, yet still the same", which consists of two core dimensions (a) the altered body and bodily functions: between emancipation and control, and (b) a body among other bodies: rediscovering oneself.

Long-term experiences involved tension and ambivalence related to the altering body and relations to the social world. In parallel with the desired weight loss, meanings and consequences attached, the major changes challenged the participants' sense of stability and coping. In social encounters, the participants were met with increased interest and as new persons. To be met with openness was something they had longed for, but others' responses to them after weight loss entailed some uncertainty; they experienced themselves as the same persons as before, although they had lost a lot of weight and lived changed lives. More than 5 years after surgery, it was pivotal not to lose control over habits, practices and the own body again, in order to avoid weight gain. Weight regain was related to emotional stress, shame and self-contempt. We describe the findings across participants and in-depth in the dimensions,

and discuss the meanings with literature on the phenomenology of the body and previous research.

4.2 Article 2

Natvik, E., Gjengedal, E., Moltu, C., & Raheim, M. (2014). Re-embodying eating: patients' experiences 5 years after bariatric surgery. *Qualitative Health Research, 24*(12), 1700-1710. doi:10.1177/1049732314548687

The second article explores eating practices after bariatric surgery, and presents an analysis of the 14 first interviews. We present the findings as two essential themes (a) inhabiting healthy eating: negotiating flexibility within a forced structure and (b) beyond healthy eating: at the mercy of the altering body.

Eating was negotiated from the perspective of health, but at the same time health was an inadequate framework for eating. Eating was restricted (physiologically) after surgery, which implied eating less, and thus a change connected to eating. The freedom to eat without being attentive and reflective about food and eating practices seemed to be lost. The new sense of fullness or satiety carried meanings beyond the physiological/anatomical aspects. As time went by, the physical restriction seemed to have vanished, which implied that response to hunger, enjoyment of food, and neglect of dietary advice and side effects again was possible. The participants described varied responses to this opportunity, but for all of them, eating had remained a complex challenge. For some, difficulties with eating impaired their sense of health and well-being. We describe eating practices in-depth and across participants in the two themes, and discuss the meanings in relation to phenomenological literature on the body/illness, one essay about eating and previous research.

4.3 Article 3

Natvik, E., Gjengedal, E., Moltu, C., & Råheim, M. (2015). Translating weight loss into agency: Men’s experiences 5 years after bariatric surgery. *International Journal of Qualitative Studies on Health and Well-Being, 10.* doi: 10.3402/qhw.v10.27729

The third article presents an analysis of interviews with 13 men, and describes experiences with health and well-being more than five years after surgery. We present a general structure which we have coined “translating weight loss into agency” including four constituents (a) becoming a bariatric patient: from large to ill, (b) being weight lost: ungraspable transitions, (c) revisiting the large body: between social life and embodied shame, and (d) the urge for employment: new opportunities, new uncertainties.

Action and capability to act was pivotal, and the men described that agency and self-understanding converged. To qualify for surgery, they had to shift from viewing themselves as being large to being seriously ill. Weight-loss had not translated spontaneously into agency, but rather involved an unexpected collapse which had forced them into an intense and exhausting process of thoughts and emotions. Incorporating and maintaining weight loss and changes in daily life was hard and ongoing work, of which navigating tension was an essential part. Weight loss was followed by growing self-acceptance and less bodily shame, but weight-related illness and disability was still expressed as shameful conditions. Employment was deeply meaningful for the men, and ill health interfering with the capacity to act freely, despite successful weight loss, carried a profound uncertainty about their future. We describe the constituents in-depth and discuss the meanings related to phenomenological literature on the body, illness and gender and previous research, especially studies regarding women’s experiences after surgery.

5. Discussion of results and methods

In this chapter, I discuss the findings and the methods.

5.1 Discussion of results: Carrying the weight of uncertainty

Results from the current study describe bariatric surgery as a dramatic life event followed by a profound and complex process of change (Natvik, Gjengedal & Råheim, 2013). The analyses display how bariatric surgery and its consequences were made sense of at the experiential level. The lived body (past and present) was a prominent premise for how life after bariatric surgery was experienced. Altered anatomy and physiology was followed by substantial and sustained weight loss, side effects and complications (Natvik, Gjengedal, Moltu & Råheim, 2014). This was expected, but the intensity of living with and living through the long lasting process of change that affected their entire life was unexpected and involved emotional reactions, altered interaction with others and emergence of new and alienating illness-like experiences (Natvik, Gjengedal, Moltu & Råheim, 2015).

The ambivalence following weight loss was not foreseen, and created an unclear situation in which the participants did not understand what happened and were uncertain of what to do. The enigmatic impression that the previous large and heavy body was still somehow present when they moved around in the world was ungraspable. After all, the severe obesity was gone. As such, the findings show that experiences of consequences after surgery might differ from the consequences as they are framed by the so-called objective sciences; experiences involve variation, nuances and uncertainty.[29] The participants expressed life after bariatric surgery as negotiating various layers of uncertainty. As such, the meanings attached to long-term experiences with bariatric surgery go far beyond improved health and well-being, and despite desired and intended weight loss, uncertainty connected to health and the future

[29] Here, the term uncertainty points to "the quality or state of being uncertain and something that is doubtful or unknown", as defined in the dictionary by Merriam-Webster (2015). That is, uncertainty as it is lived and experienced after bariatric surgery.

persists. Although five years or more had passed, bariatric surgery remained an open and unfinished chapter of the participants' lives.

"Carrying the weight of uncertainty" expresses an essential theme across the core findings and the relationship between the articles. Accordingly, I discuss the study's core findings in light of this essential theme.

5.1.1 Totally changed, yet still the same

The essential meaning structure "totally changed, yet still the same" indicates that bariatric surgery carried identity work involving an internal contradiction, or a sense of ambiguity (Natvik et al., 2013). The *experiential* self has a structure which remains stable throughout life despite changing experiences, whereas the *narrative* self develops across the lifetime (Gallagher & Zahavi, 2012, p. 227). Here, experiential points to embodiment and action, whereas narrative points to sociality, memory and language. In phenomenology, the experiential self is understood as a premise for narrative practices, because embodied experience and action come prior to language and necessarily must be perceived from the first-person perspective before they can unfold a story or be part of a personal history (Gallagher & Zahavi, 2012, p. 228). Distinguishing between the experiential self and narrative self is meaningful in a study based on first-person experience, but does not necessarily mean that these two notions of self are contradictory (Gallagher & Zahavi, 2012, p. 227). In fact, self-understanding is usually highlighted with a self-narrative, meaning that a given experience's structure often is possible to articulate (Gallagher & Zahavi, 2012, p. 229). If we accept that the experiential- and narrative dimension can coexist, this means that being a person undergoing bariatric surgery can involve a stable structure despite profoundly changing experiences (yet still the same) and development across time and related to change (totally changed). When "totally changed" is put first, this points to the expected and overwhelming impression of dramatic change.

Major weight loss and change had forced the recognition of meanings attached to the body as an essential dimension of the self, and inextricably linked to thoughts, emotions, skills, size, shape, gender and so forth. To open up for the body as deeply meaningful was a sensitive and sometimes painful process; for some, self-loathing had involved neglecting the body, rejecting others and not allowing anyone, including themselves, to care for them (Natvik et al., 2014, 2015; Natvik et al., 2013).

Human beings are embodied subjects in a shared cultural world (Merleau-Ponty, 1945/2012), and come into being through interacting with others, action and expression, well stated by Gallagher and Zahavi: “I become a person through my life with others in our communal world” (2012, p. 228). Human beings are connected to each other from the beginning until the end of life. The body is expressive and actively engaged in a mutual relationship with others (Landes, 2013b; Merleau-Ponty, 1945/2012). Thus, the body is not just the subject’s access to experience, but also constitutes others’ access to the subject. This indicates the intertwining of embodied subjectivity and intersubjectivity. Human beings reach towards the world and others, and thus seem to long for community. It is possible to withdraw into isolation, but one can hardly escape the social world entirely. Other people’s responses to the altering body after surgery appeared as meaningful for the participants’ self-understanding. They were often encountered as “totally changed”, which often was understood by the participants as not only slimmer, but also more interesting, important and likable. This objectification reinforced ambivalence related to weight loss and the public aspects of the body, including the body as a topic of conversation and social evaluation. “Still the same” emerged as part of their self-understanding, despite the life changing process (Natvik et al., 2013).

The participants related severe obesity to exclusion or at least a previous split between themselves and others. This can be understood in light of the stigma associated with large bodies in our culture (Goffman, 1963; Lupton, 2012). Others’ disapproval of deviant bodies, and certainly when connected to lack of will power and excess, make a damaging split between the self and other (Goffman, 1963). The cultural stigma related to severe obesity is often expressed as fear of fatness and strong

emphasis on each individual's responsibility for body size and weight (Malterud & Ulriksen, 2010; Penney & Kirk, 2015; Puhl & Heuer, 2009). The stigma of obesity is enacted in health care settings and it has been shown that health care providers fail to provide the support which people living with obesity need, namely long-term support built on respect and non-judgemental attitudes (Kirk et al., 2014; Malterud & Ulriksen, 2011). In case bariatric surgery does not involve sustained weight loss, patients might risk to be held responsible, and to be blamed for lack of self-discipline, being non-compliant and so forth and being subjected to feelings of shame (Throsby, 2009). Internalized stigma and shame might make them vulnerable for negative attribution and guilt (Malterud & Ulriksen, 2011). According to the participants, the altering and slimmer body entailed new openings in social life, but because of the major change, they were still subject to the gaze of others (Natvik et al., 2013).

The other's gaze expresses intersubjectivity. The body has a public side, and is visible, possible to engage with, judge or reject. According to Merleau-Ponty, it is not the gaze *per se* that makes the other an object (1945/2012, p. 378). Objectifying might occur when one falls back into stereotypical modes of thinking, has an inhumane gaze, or does not understand how one's actions are perceived and made sense of (Merleau-Ponty, 1945/2012, p. 378). Thus, the intersubjective field does not have to involve offensive gazes, and could be a safe and shared space for coexistence. Merleau-Ponty reflected about the fact that seeing, perceiving and being with others provide knowledge about them and insight into their project, however not access to their existence (1945/2012, p. 368). He argued that when standing together with his friend Paul and gazing across a landscape, they are not locked into two private and separate perspectives, but rather share an intersubjective experience (Merleau-Ponty, 1945/2012, pp. 427-428). It is a mutual relationship; Paul points to a deer for Maurice to see, and Maurice's response reaches towards Paul and into his experience. That is, they know each other, are friends and live in the same cultural world in the same era of time.

The example above exemplifies intersubjectivity and coexistence in a safe and familiar world, which was not something the participants could take for granted. They

had gone from being very large, via bariatric surgery to an altering and for some unrecognisable body and appearance, and repeatedly experienced splitting between self and world (Natvik et al., 2013). These splits somehow still seemed to reside in them. Our findings displayed that the participants' bodies were on the move from severe obesity towards a future habitual postsurgical body that had not yet been established; they were still in the trajectory of change. As such, bariatric surgery means a shift from a concrete embodied situation to being in transition for years ahead (Natvik et al., 2013).

According to the findings, social encounters were connected to uncertainty after surgery. To be included in the community which the participants had felt excluded from, based on body size and appearance, was not an entirely comfortable situation, and they remained slightly sceptical about others. This was related to experiences with objectification and the stigma of obesity.

5.1.2 Re-embodying eating

Our findings show a variation and negotiation of eating, hunger and satiety after surgery. The description "re-embodying eating" points to eating as a continuing challenge, and a deeply embodied practice. Meanings attached to eating emerged from two different points of departure: "inhabiting healthy eating" and "beyond healthy eating" (Natvik et al., 2014). Embodying a specific type of body involves certain meanings and relate to our activities and projects within the current social, cultural and political context (Beauvoir, 1949/2000; Merleau-Ponty, 1945/2012; Moi, 2005). Therefore, eating is often understood related to the embodied subject who eats and the context. Based in norms embedded in western culture, a very large person might not be supposed to eat according to her own preferences, but rather to lose weight for the sake of health. Bariatric surgery is meant to help out this situation. According to our findings, the physiological and anatomical restriction of food intake and nutritional uptake implied a new sense of fullness which was followed by sustained weight loss. However, it also restricted the freedom to enjoy food and eat well, which is

meaningful for health and well-being, in terms of living a good life. Most participants in our study did not talk about the enjoyment of food, the good life, happiness and well-being – they wanted to live and enjoy an ordinary life (Natvik et al., 2014). One might wonder, is being very large and enjoying food incommensurable, or at least culturally unacceptable? If so, then enjoyment of food might be a taboo, or be judged as an ungrateful or offensive practice after surgery. More restrictions than the biological ones might be in play, and because the underlying norms connected to bodies and eating are profoundly embedded in culture and people, they might be sustainable.

Levinas used eating as an example to address ethical questions about our responsibility for other human beings. He argued that hunger is not merely a physical phenomenon and a basic need, and that eating is not just a practical activity of everyday life (Goldstein, 2010; Moran, 2000). Levinas emphasised enjoyment when he described the relationship to eating, which he viewed as vital to our sense of self in the world. Accordingly, *enjoyment* of eating is existential (Goldstein, 2010). This highlights our findings, showing that health and nutrition make an important, yet insufficient framework for eating practices after bariatric surgery.

To live up, a child needs to be fed, and to stay alive the person must continue to eat, or else be fed through modern technology (meal replacements, enteral tube, intravenous feeding and so forth). However, what it means to eat well varies across situations, cultures and historical time. Habits are developed through a dynamic and mutual relationship between person and world, and within the possibilities and limits of the lifeworld. How the person eats or drinks is connected to habit and availability of food, but can also relate to politics, beliefs, convictions, life difficulties and illness. Examples are global food supply systems, religious rituals, vegetarianism/ecology, overeating, anorexia and so forth. This indicates that meanings connected to food and eating reach far beyond need and enjoyment of food, and shed light on our findings: Although the participants had their anatomy and physiology changed and desperately needed a sustainable weight loss, changing their eating practices remained a difficult task.

In bariatric surgery studies, eating is usually framed as behaviour connected to body weight, health and ill-health, such as severe obesity, binge eating disorder or overeating. A recent qualitative study on patients' long-term experiences following bariatric surgery centred on eating behaviours (Wood & Ogden, 2015). The study reported variation and changes in weight and eating behaviours, relationship with food and quality of life. Eating for practical reasons (need), avoiding emotional eating and replacing food thoughts with physical activity were behaviours connected to weight loss maintenance after surgery. Furthermore, a shift in identity into a "thin" or "healthier" self was regarded as important. It is suggested that the connection between a new identity and successful weight loss might limit further weight gain, because a potential weight gain could be experienced as loss of self. Because this study explores eating after surgery, its findings are relevant to discuss related to findings reported in the current study, despite different theoretical perspectives (phenomenology and health psychology).

According to Wood and Ogden' findings (2015), emotions attached to eating and food preoccupation were replaced with rational practices and strategies for moderation among those who reported successful weight loss maintenance. Their findings somewhat overlap ours in this sense, because several participants in our study reported similar strategies, which are "by the book", and in line with dietary advise after surgery and literature on how to maintain weight loss (Natvik et al., 2014). However, across all participants, we found that eating practices involved ambivalence related to enjoyment of food versus restriction and uncertainty connected to weight loss maintenance (Natvik et al., 2014). The participants framed food choices within *or* beyond the perspective of health and nutrition. Uncertainty or normative cultural aspects connected to eating were not described by Wood and Ogden (2015). We described eating as an embodied practice of existential importance related to weight maintenance, whereas sustained changes remained a challenge. Both studies report that bariatric surgery and weight loss seem to entail identity work, but Wood and Ogden describe a positive reinvention and a new identity that can reinforce future healthy eating behaviours, whereas we described identity as an ambiguous matter, involving both change and stability, and that the process seemed unfinished; they were still in

transition (Natvik et al., 2014, 2015; Natvik et al., 2013; Wood & Ogden, 2015). The differences I have highlighted between these studies are possibly connected to some core differences in the interviews and data materials, and to different understandings of eating and identity within health psychology and phenomenology.

In light of the findings discussed, eating involved uncertainty in the long-term connected to the fear of weight regain or relapse into problematic eating practices. How flexible or restrictive eating practices the participants could dare to engage with remained an open question. There were tensions between enjoyment versus need of food, and optimism or carelessness versus guilt and shame.

5.1.3 Translating weight loss into agency

The general structure "translating weight loss into agency" indicates the profound meanings connected to being capable to act, having the capacity to act, taking action and being an active agent in the world, expressed by the men in this study (Natvik et al., 2015) . They held on to bariatric surgery as something they *did* to stay independent and capable, rather than a being subjected to treatment, or having something done to fix their bodies. Accordingly, weight loss after surgery had implied a far more intense and draining experience than they had imagined. The physical changes, such as weight loss, illness going in remission, side effects and new responses to food, were part of it. However, what the men stressed, was that being thrown into a chaotic and unforeseen process of emotions and thoughts had felt like a misery, involving confusion and uncertainty about the future (Natvik et al., 2015). They had not expected that weight loss would affect them negatively in that sense, and possibly could involve *losing* capacity and capability for a while. The men knew about the risks connected to surgery before they went through the procedure, but had not imagined how late complications, acute or chronic, might act upon their lives in the long run. This bariatric procedure relieved the men of many problems, as they had hoped for, but they seemed not to have fully comprehended that its effect inevitably represents a new condition associated with health risk and uncertainty.

One of the mechanisms of action following DS is malnutrition, which carries health risk and requires lifelong monitoring and care, despite nutritional supplements. Some call this a side effect, but it is an intended effect which partly produce the weight loss. Although it is documented that bariatric surgery is a relatively safe procedure, the mechanisms of action are discussed and not yet fully understood (Colquitt et al., 2014; Hughes, 2014). For example, researchers work to establish why the patients' metabolism changes so quickly after the surgery, and discuss which mechanisms in the gut are changed and how this seems to affect the entire body, for example through hormonal or inflammatory processes (Buchwald, 2014). The uncertainties associated with bariatric surgery in the long term gives meaning to the patients' uncertainty; after all, they live and breathe it.

The men in the current study had lost a lot of weight, which was expected according to the type of procedure, although there seems to be no guarantees (Natvik et al., 2015). Not everyone has a good outcome of bariatric surgery, and clinicians and researchers are constantly trying to find predictors for weight loss. One aim is to improve the selection of patients and the individualization of bariatric surgery, for example the decision on which procedure to choose (Gagner, 2015; Neff et al., 2013). These questions are reflected in the current debates about prioritization related to bariatric surgery in Norway (Helsedirektoratet, 2015; Mala et al., 2015). How the patient makes sense of the changes after surgery (body, mind and emotions) and how it affects his life beyond metabolism appear as questions that are largely neglected in this field of research.

In the current study, the men had not identified themselves as ill or disabled prior to surgery. Most of them had experienced obesity related illness, such as stroke, heart attack, hypertension, diabetes type 2 and so forth, but had not focused on the body size in these matters. The obstacles they faced relating to daily life, future plans, projects and interests had increased progressively with weight, but they did not identify obesity related problems as disability (Natvik et al., 2015). According to our findings, it had been crucial for the men to be respectfully approached by their physician and to be offered some relevant and viable options to improve their

situation. Discussing what kind of phenomenon obesity *is* might be relevant for theory or policy. However, will drawing the distinction between obesity as a medical or a social disease possibly do good to large people and society?

In a recent philosophical analysis it is argued that if obesity is a disease (in line with WHO) it is better understood as a *social* disease. This means that obesity is a disease in line with social phenomena, such as aesthetics, morality and behaviour (Hofmann, 2015). From the perspective of social disease, medical weight loss interventions are medicalization of behaviour, which benefits commercial and professional interests, and interferes with sustainable and structural approaches to obesity. Furthermore, weight loss interventions might reinforce stigma and discrimination of large persons, rather than improve their health and well-being, according to Hofmann. Therefore, both individuals and society can benefit on defining obesity as a social disease, he argues. However, it is difficult to understand how categorizing people according to body weight might do any good or reduce the stigma of obesity, just because the definition is social, and not a medical one. Is it possible that dichotomous and theoretically driven definitions might do more harm than good? One consequence might be that people, for example men who are ill and large, will not seek help from health care services, or might seek help very late. Having to identify as socially (or medically) diseased seems not very tempting, and should not be necessary to get the help one needs. Philosophy can deepen our understanding of diagnosis and new ideas, but good conversations and better policies are needed to enforce political action on the structural level regarding obesity. However, it is hard to see how redefining obesity from a medical to a social disease could involve any change for the better.

Phenomenology is a philosophical tradition that unifies the subjective and objective dimension to an integrated understanding of person and world (Merleau-Ponty, 1945/2012). There seems to be a growing agreement that obesity is a complex issue, which means that reducing the phenomenon to individual/society, disease/behaviour, biology/emotion and so forth cannot be the point of departure. Rather, broad perspectives, in-depth understandings and science seem required to

capture the nuances and variations on so many levels. Public policy issues with high levels of complexity, uncertainty and divergence are often called “wicked problems” (Head, 2008; Rittel & Webber, 1973). [30] Accordingly, the increasing rate of obesity worldwide has been described as a classical “wicked problem” (Gortmaker et al., 2011; Groves, 2008; Head, 2008). In the field of obesity and bariatric surgery, it seems necessary to acknowledge and live with contradictions, uncertainties and differences. Siri Hustvedt, an author who lives with chronic symptoms that are not yet fully understood, once wrote: “Although some empathy in one’s doctor is certainly desirable, an ethical position requires respect, above all, the simple recognition that the patient in front of you has an inner life as full and complex as your own” (2013, p. 173). As we strive to understand and help each other, I think this is a meaningful approach.

Our findings have parallels to some findings in a recent qualitative study that highlighted gendered meanings among women and men waiting for bariatric surgery (Temple Newhook et al., 2015). The study reveals gendered meanings expressed prior to bariatric surgery, and the findings related to men are relevant to the current study. The men in the study (six out of 27 participants) identified as big guys and did not identify with *fat*. Rather, the men drew on an understanding of the male body as tough and strong, expressed some concern about future dietary changes towards smaller, healthier meals (which was understood as feminine). The men seemed reluctant to express emotions or concern related to the body. These findings are in line with the current study, showing that men identified as large men and were reluctant to identify as bariatric patients. Temple Newhook et al. indicated that the men express a personal responsibility to control own health, and wish to lose weight to “be able to do things”, which highlight our findings. One of their quotes clarifies the parallel between the essential structure we have presented and their findings:

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[30] According to Rittel and Webber (1973) planning problems and societal problems are “wicked”, which means that they are not clear and easy to define. Rittel and Webber claimed that nearly all public policy issues are “wicked problems”, and that societal problems are at best repeatedly resolved, but never fully *solved*. Treating a “wicked problem” as a different kind of problem, such as a “tame problem” might be morally questionable, according to Rittel and Webber (1973). Accordingly, understanding and aiming to solve the problem of obesity within the perspective of natural sciences or medicine might not only be futile, but also harmful. In research, a growing acceptance for obesity as a complex problem has been expressed. However, some disagree. For example Hawkes (2008) has argued against framing obesity as a complex problem.

> To be able to do more. Obviously, you got the weight on of two people. You get tired easily. You don't have the energy you used to have . . . After 5 hours [working] now I'm ready for a nap. I'm only [in my thirties], so it's time to do something now before it gets too late (Temple Newhook et al., 2015, p. 10).

It is interesting that aspects related to agency were so clearly expressed by the men who were "waiting for surgery" and in a different context. According to our findings, agency was essential throughout the whole bariatric surgery process, and connected to the uncertainty about the future expressed by men more than five years after surgery (Natvik et al., 2015). After surgery, they could no longer distance themselves from emotions, doubts or other ambiguities connected to the lived body. However, bariatric surgery had provided possibilities to live and engage actively with the world. Accordingly, surgery was an extreme, yet deeply meaningful life event.

The findings in this study indicate that surgery solved several problems related to agency for the men, but also entailed new health concerns which involved new uncertainties about the future.

5.1.4 Bariatric surgery and phenomenology

The body has been understood differently across historical time and different contexts (Råheim, 2001a, 2001b). What a human being/body is and can be put through are questions residing in the tension between medicine, religion, technology and morality (Stueland, 2009). Bariatric surgery is an example of modern medicine/technology, anchored in the natural sciences and still embedded in a normative field. Thus, obesity, severe obesity and bariatric surgery are value laden and contested topics in society and research. Phenomenology inspires different ways to explore lived experiences in-depth, emphasises concrete and nuanced descriptions of complex phenomena, and aims for new insights (Svenaeus, 2005). Based on the first-person perspective, findings

from phenomenological studies are relevant for practice, and might contribute to the current debates.

Phenomenology implies a critical stance towards the dominance of natural sciences within research, and often converges with qualitative designs. However, phenomenology does not imply rejecting the natural sciences or quantitative research as such (Giorgi, 2009, p. 5). The majority of bariatric surgery studies are rooted in the natural sciences, with emphasis on trends, tendencies and outcomes after surgery, in which guidelines for practice are based. This means that multi-layered meanings, variety and nuances largely are neglected in current scientific knowledge about bariatric surgery, despite being at the very core of how the intervention is experienced.

5.2 Methodological reflections

In all scientific research, its quality is valued according to validity criteria, and must include claims of generality (Dahlberg et al., 2008, p. 342). Validity points to the incorporation of rigor, subjectivity and creativity throughout the whole research process (Whittemore, Lewington & Sherliker, 2009). As such, there is an ongoing discussion concerning validity issues in relation to the tensions between qualitative and quantitative research, epistemological purism and pluralism, rigor and creativity (Whittemore et al., 2009). According to Lincoln and Guba, qualitative research shows that the knowledge produced can be trusted, and they have developed criteria for *trustworthiness* (1985, p. 290), which have been relevant for this research process. For example, the concept *credibility* relates to how research is conducted and involves the quality of study design, data gathering, analysis, description of findings and collaboration with others during the process. Thus, credibility points to the internal connection between epistemology, research questions and methods as necessary to produce sound qualitative research (Carter & Little, 2007; Lincoln & Guba, 1985, p. 328).[31] The bariatric surgery processes was multi-layered and implied variation,

[31] The concept of credibility relates to internal validity.

meaning that all participants described positive and negative experiences and expressed nuanced meanings. Furthermore, there was variety among participants, their backgrounds and living conditions. The richness and variety is part of the phenomenological descriptions (the constituents). We have argued that the findings hold strong (Natvik et al., 2014, 2015; Natvik et al., 2013).

It is possible that another approach, for example rooted in social constructivism, would have attended somewhat differently to the variation or other aspects of the data. It is not possible to know exactly how the results might have been presented from another point of departure. However, there is an aspect that I think could have been deepened further and possibly offered interesting insights, namely targeting the participants' *talk*. A phenomenological exploration usually does not target the *words* as such, but rather the meaningful lived experiences. However, I could not avoid noticing how the participants used the language with respect to terminology. The participants used the words *large, big* and *overweight* to describe body size, and not severe or morbid obesity. None of the participants mentioned BMI. I had decided to follow their lead with respect to language, and thus I did not use the words or concepts which they did not use. This means that I did not ask them about BMI or their height in order to calculate their BMI.

Furthermore, I discovered some interesting nuances in the participants' descriptions of eating. They had been informed that after the first years, they could expect to be able to have a "normal" diet. The participants expressed some confusion about what "normal" eating meant. Most of them seemed to understand it as eating like before surgery, yet far less amounts of food. I discovered that the terms food and eating were used for ordinary meals like breakfast, dinner and so forth, whereas snacks and the like was not topics of the conversations about food and eating practices. This does not mean that the participants avoided the subject; rather, they brought it up, often as a concern. It was just that they talked about snacking as something else than food and eating. To me, this is an example that although the phenomenological perspective was appropriate in this study and generated interesting findings, the

approach has boundaries, and thus some interesting aspects might not be captured or highlighted in this study.

Transferability indicates to which extent findings and insights from a qualitative study can offer meaningful knowledge in other situations and contexts beyond the actual study (Lincoln & Guba, 1985, p. 316).[32] In qualitative research, transferability cannot be decided upon in advance. A transparent description of the questions asked, the findings and the study context give access for others who are interested to consider transferability. To evaluate the findings from the current study related to other contexts or the same context over time involves empirical issues, according to Lincoln and Guba (1985, p. 316). In phenomenological research, results are presented as a general structure, including essential meanings and constituents. [33] Thus, research results which are presented at a more abstracted level reach beyond the concrete and varied examples at the individual level (Dahlberg et al., 2008, pp. 342-343), and therefore strengthen transferability. However, phenomenological research results are contextual and thus cannot be understood as universal, because meanings are infinite (Dahlberg et al., 2008, p. 343). I have provided relevant information about the sample and context. The results are discussed in light of a phenomenological understanding of the body, health and illness and research based literature (Natvik et al., 2014, 2015; Natvik et al., 2013). When the researcher's reasoning is thorough, it makes it possible for others to follow (Dahlberg et al., 2008, p. 337). Researchers should look for opportunities to show transparency in their writing, according to Polit and Beck (2008, p. 551). I have emphasised thoroughness and transparency during the research process, including the writing of current articles and this thesis. This is one reason that the texts I write are rather long.

If and when the knowledge provided is meaningfully put into play, transferability can be claimed (Andenæs, 2000, p. 318; Lincoln & Guba, 1985, p. 316). I have offered insight into the research process and aimed for clear and detailed

[32] The concept of transferability relates to external validity.

[33] As described on page 69.

phenomenological descriptions to show what bariatric surgery can imply and mean in the long term. To which extent the findings and insights from the current study are transferable depends on how *others* who are interested make sense of them and use them in practice, research or other activities related to bariatric surgery.

We have explored men's experiences exclusively in one of the studies. It has been argued elsewhere that this is gender segregation and that in phenomenology there are no arguments for doing that, because the lifeworld is not divided according to gender. Thus, one should consider other research approaches (Martinsen, Dreyer, Haahr & Norlyk, 2013). According to Beauvoir (1949/2000) there is no contradiction between a phenomenological outlook and an interest in gender or equality between women and men. Gender is part of the lifeworld and our being, and sometimes needs to be taken into consideration when describing a phenomenon. The point in our study was to address men's experiences which are nearly absent in bariatric surgery studies, because so few men participate. However, men undergo bariatric surgery, and knowledge about their perspectives and experiences is relevant to practice.

Methodological considerations and study limitations related to validity are discussed in the published articles, and will not be further discussed. The researcher's reflexivity and the trustworthiness of a qualitative study are interlaced. That is, reflexivity can make it possible for others to consider to which extent they trust the researcher and the findings presented (Polit & Beck, 2008, p. 538). Reflexivity is therefore discussed in-depth and related to my role as the researcher.

5.3 Turning the lens: My role as the researcher

The concept of *reflexivity* points to the researcher's active and ongoing process of thinking about her own position, knowledge and experience related to the phenomenon under scrutiny during the research process (Finlay & Gough, 2003; Guillemin & Gillam, 2004). I have described the methodological approach and how important it is to reflect upon pre-understanding throughout the process (Dahlberg et al., 2008).

Reflexivity and reflection are not mutually exclusive concepts and are used interchangeably, and Finlay suggested an understanding of the concepts related to a continuum; reflexivity can be understood as an immediate, continuing and subjective self-awareness, whereas reflection can be conceptualised as thinking about something from a certain distance and after the event (2003, p. 108). As such, reflexivity is a process and aims to facilitate and keep up the researcher's awareness of her subjectivity linked to the research. Examples are her position within the research field, the social and political context, and personal characteristics can be relevant, such as gender, ethnicity, sexual orientation and body size (Berger, 2015).

When I prepared the interviews, I acknowledged the relation between me as a researcher and the participant as asymmetrical with respect to *power* (Kvale & Brinkmann, 2009, p. 76). I am a physiotherapist/PhD candidate and my body size is "normal", whereas the participants had experience with severe obesity, bariatric surgery and related illness. Despite the participants' weight loss after surgery I consider body size a potentially sensitive topic when related to extensive weight problems, yet a crucially important topic in the current study. I understood that this implied negotiating moral dilemmas throughout the research process (Fog, 2004; Kvale & Brinkmann, 2009). I tried to facilitate a safe and respectful dialogue, and was sensitive towards the participant's responses to my questions. I learned that they shared my interest in exploring their experiences with bariatric surgery, and in that respect we established a common ground, which might have made asymmetry and differences less prominent. I sought insight in their personal experiences, and was humbled by their trust, openness and willingness to share.

In the current study, reflexivity points to my sensitivity towards the dynamics between the research, me, the participants, and the contexts in which their experiences were embedded and expressed. One example from the current study is the negotiating of experience and knowledge I had because I had worked clinically in the field of bariatric surgery. Initially this was an inspiration to the research idea, delving into previous research and developing initial research questions, and thus had impact on the study design. Inspired by other researchers, I put these reflections in writing and used

them as a preparation for the interviews. Because reflexivity is a process and might imply development or change, the reflective notes I wrote after each interview have been useful. Later, I read these notes and sensed that the location, the place where the interview was conducted, had meant a difference. In the home-interviews or at the participants' workplaces, I was treated and taken care of as a guest. For example, I was offered a lift from where I arrived, participants served me coffee and tried to make the situation comfortable. In the home-interviews I gained more information, because I met the participant in their daily life context. I was slightly more careful with what I asked and how far I could go in home-interviews, but it seemed like the participants talked freely and described profound experiences regardless of location. Home-interviews also involve some disadvantages. In one interview the participant stopped talking about a meaningful life event because other people came home. As such, the location was not insignificant, and overall seemed to affect me more than the participants. This might be related to social conventions and power. When I was a guest, I probably felt slightly less in control of the interview situation.

I negotiated my approach during the interviews, and tried not to be too careful or reluctant, and not to be too active or "push" the participants towards topics in *my* interest. For example, most participants spontaneously included experiences or general information about their childhood and parents, but in one interview the participant avoided this topic. It was a kind of an explicit silence that made me very careful, and I did not dig into it or ask him direct questions about his childhood or parents. Just as we were about to close the interview, the participant said:

> I try to leave the past behind and live my life as it is now. But I am aware that I have lost a lot. Something valuable, being together. The summers when I was 11, 12, 13 and so forth: I saw my mates passing on their bikes, as they were going for a swim [in the lake], and I chose to stay in, because I did not want to undress in front of my mates, right. And that is what it was like. As I grew older, I noticed when they started dating girls, talking about girls, sex and so on. In some ways I felt like them, going through in the same process [laughing a

> little, pointing a finger to his head], but I chose to stand on the outside. That is something I of course cannot get back.

He expressed sadness or sorrow with regard to a childhood restricted by the shame connected to the large body. I could have missed this important insight into his background, but I still think it was right to wait.

The impact of asymmetry between researcher and interviewee in obesity studies is discussed in research, and some suggestions to change this have been made. According to Brown and Gould, research interactions related to obesity is a context in which stigma can be reinforced, and have impact on the data (2013). They reviewed methods in qualitative obesity studies and concluded that the majority of researchers had not reported personal characteristics such as body weight and gender, and rarely had addressed obesity stigma (Brown & Gould, 2013). The lack of focus on stigma in qualitative bariatric surgery studies has been highlighted by others too (Trainer, Brewis, Hruschka & Williams, 2015). This can be discussed. Although stigma as a concept is not included in the theoretical framework of a study or targeted per se in the analyses, this does not mean that the meanings related to stigma are not addressed. For example in the current study, the findings address the intertwining between altering bodies and altering social interaction, including contradictory feelings of shame and relief, joy of life and scepticism (Natvik et al., 2014, 2015; Natvik et al., 2013). Although such findings were not framed within the concept of stigma, I think they highlight aspects of obesity stigma. Brown and Gould highlighted that especially when data gathering implies that participant and researcher meet face-to-face, the interviewer's body size should be reported in order to strengthen researcher's reflexivity (2013). Although I have recognised and handled aspects related to power issues, I have not problematized my own body size to that extent, and information about my body is not included in the articles. This can be understood as a reflexivity issue (Berger, 2015), and therefore I discuss it in further detail.

The researcher's positioning related to the field of study usually implies both challenges and benefits. An "insider" position usually means that the researcher is or could have been member of the group she studies. The clarity of my position as an "outsider" with respect to experiences with severe weight problems and being a woman interviewing men might have offered some advantages. The participants had an "expert position", and looking in from the outside can provide fresh perspective and generate new and different questions (Berger, 2015). Because of working experience, the field was somewhat familiar to me, which was helpful when I developed the research questions and interview guide. However, this might imply that my perspective was not that different or novel. [34]

Furthermore, there are indications that clarity with regard to the researcher's position can limit the risk of role confusion. In one study, it was assumed that similarities between researcher and participants with respect to gender and experience with severe obesity and weight loss would benefit the inclusion of participants, and the researcher drew actively on self-disclosure (Moore, 2015). [35] Here, self-disclosure implied that the researcher's weight loss process was shared via media, social media and other communications and linked directly to the participants in the invitation to participate in the study (Moore, 2015). The participants had become very interested in the *researcher's* weight loss process, which became a subject in the research interviews. According to the study, the participants had compared themselves with the researcher, and highlighted a difference between the researcher's successful weight loss processes without surgery as embodying "real masculinity" and having bariatric surgery as embodying "weakness" (Moore, 2015, p. 97). That is, the researcher's positioning between an insider/outsider perspective and the approach of self-disclosure seemed to have become an issue of profound significance, with respect to ethics and validity.

[34] Language is briefly discussed on page 89-90.

[35] The study was completed in 2012 and articles are submitted, but the findings are not yet published (Darren D. Moore, personal communication, August 25, 2014).

Reflexivity and ethics are closely connected, as stated by Kvale and Brinkmann: "The researcher's knowledge, experience, sensitivity and fairness is decisive for the soundness of the scientific quality and the ethical decisions in qualitative research" (2009, p. 74). Despite careful preparations and knowledge, issues like comparison or competition might not easily be avoided in conversations about body size, weight problems and related issues. I noticed an aspect of this in the current study. After one of the interviews, the participant (a woman who had shared painful experiences) sent me a text message: "Thanks a lot, and have a nice summer. Enjoy it. Lucky you, who can wear a bikini, be in the sun and take a bath among other people… Enjoy it [two smileys]". I became reflective about this, and asked myself whether a perceived "embodied imbalance" might be harmful in itself. Not all exchanges of views and meanings in interviews are voiced, and the text message made me aware of what that might mean. This example illustrates a challenging aspect connected to my outsider position as a researcher. My reflections support the notion that there are always both advantages and challenges connected to one's position as a researcher. Furthermore, there are limits to self-awareness and the ability to reach each other. Some experiences probably stayed with the participants and some questions stayed with me.

6. Concluding remarks and implications

The aim of this study was to describe patients' long-term experiences with bariatric surgery. The study has qualitative design rooted in phenomenology. Open in-depth interviews with 20 participants who had undergone surgery at least five years back in time provided a rich material. Analyses provided essential themes common across participants, including variation as expressed in the constituents. I wrote phenomenological descriptions to present the findings in the three published articles. The findings in this thesis highlight that bariatric surgery and the following embodied change are interlaced with an existential process, involving ambivalence and uncertainty.

To provide health care services with good quality, a dialogical approach and stronger emphasis on the patients' perspectives need to be incorporated into the bariatric surgery process. There seems to be a lack of open conversations. Psychological and social consequences following a radical process of change should be addressed in parallel with body weight, nutritional status, side effects, physical activity and work participation. A regular visit at the out-patient clinic five years after surgery seems not sufficient to meet the patients' needs – they call for a more comprehensive approach, support and strategies to handle the fear of weight regain. As such, patients' lived experiences offer knowledge and insights of value to strengthen clinical practice.

The current study offers new insights based on the first-person perspective that can contribute to the understanding and discussion of long-term outcomes after bariatric surgery. To make future research relevant for patients' needs, a multitude of research approaches are needed. Involving people who have had bariatric surgery in the whole research process could strengthen the integration of patients' perspectives and offer a fresh approach in future bariatric surgery studies.

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