Received: 22 December 2021 | Accepted: 21 June 2022

DOI: 10.1111/scs.13105

Scandinavian Journal of Caring Sciences

ORIGINAL ARTICLE

Health professionals' reflections on existential concerns among people with obesity

Britt Marit Haga BSW, PhD, Associate Professor | **Bodil Furnes RN, PhD, Professor** | **Venke Ueland RN, PhD, Professor**

Faculty of Health Sciences, University of Stavanger, Stavanger, Norway

Correspondence
Britt Marit Haga, Faculty of Health Sciences, University of Stavanger, N-4036 Stavanger, Norway.
Email: britt.m.haga@uis.no

Funding information
There has been no contribution to this study as a result of financial or personal relationships with other people or organisations.

Abstract

Purpose: This study aimed to describe health professionals' reflections on existential concerns among people with obesity when attempting to support them in their lifestyle change processes. For many of those affected by obesity, the condition becomes lifelong and causes existential concerns. The health professionals' reflections on existential concerns among people with obesity may influence central aspects of their practice and their patients' well-being.

Methods: Eighteen health professionals with relevant health education working in three different treatment programmes for people with obesity were recruited for three focus group interviews. The interviews were analysed and interpreted using a model for interpretation of meaning at three levels with a phenomenological–hermeneutical approach.

Findings: The analysis identified three themes. The health professionals reflected on existential concerns among people with obesity in terms of patients' repressed emotional difficulties and lack of self-respect. In addition, they reflected on their own experiences of powerlessness when presented with people with obesity's existential concerns.

Conclusion: The present study provides valuable insights into reflections on existential concerns among people with obesity, based on health professionals' descriptions. We believe that these insights add to the existing literature and have consequences for how people with obesity are met and cared for.

KEYWORDS

enduring suffering, existential concerns, focus groups, health professionals, hermeneutics, obesity, phenomenology, qualitative study

INTRODUCTION

Obesity (body mass index [BMI] ≥30 kg/m^2) is associated with negative health consequences on both physical and mental health [1, 2] as well as reduced quality of life and well-being [3, 4]. For many of those affected, obesity becomes a lifelong condition, often characterised by repetitive weight fluctuations [5, 6]. The condition places great limitations on everyday life and may cause existential struggle [7, 8].

Health professionals hold an important role in the currently dominant approach to the obesity challenge

[9, 10] as facilitators for patients in their lifestyle change processes [11, 12]. However, supporting people to change their lifestyle has proven to be challenging [10, 13]. The health professionals may overlook that living with obesity has an underlying existential character [8, 14].

Background

Interventions and treatment of obesity as well as obesity research involving both qualitative and quantitative methods are guided by a medical paradigm worldwide [15–17]. However, in recent years, studies have sought to bring back the focus of lived experiences of people with obesity as being relevant to how obesity is managed in the healthcare system. Qualitative research based on people with obesity's own descriptions has enhanced the understanding that living with obesity can appear as an existential challenge [8, 18], as the continued experience of having a large body appears to affect one's whole life [7, 19, 20].

Research focusing on existential concerns among people with obesity and that is based on a health professionals' perspective is limited. Nevertheless, several studies have reported how health professionals experience their encounters with people with obesity in healthcare settings [21, 22]. The health professionals appear to be aware that many people with obesity who are involved in lifestyle change processes struggle with complex life challenges and emotional distress [4, 10].

Therefore, to some extent, health professionals appear to acknowledge the complexity of living with obesity [23–25], possible existential concerns [10] and the complexity associated with how to approach the challenge [26]. However, ambivalent feelings and weight bias while caring for these patients are not unusual among health professionals [27–29]. According to earlier and recent research, many professionals consider their patients to be responsible for their condition and expect them to be capable of dealing with the consequences of their behaviour [21, 24, 30]. Sagsveen et al. [13] found that health professionals experience that some people with obesity who are involved in lifestyle change processes appear to lack ownership of their life and renounce responsibility for their plans, goals and life. The lack of responsibility influences the professionals' attitudes negatively [21, 24, 29]. However, health professionals also try their best to treat their patients with respect and understanding, despite their ambivalence [27, 28].

Thus, although some information is available, further knowledge regarding health professionals' reflections on existential concerns among people with obesity is required. Such reflections are relevant and valuable because they might influence central aspects of the professionals' practice, and in turn the process of enhancing the well-being of their patients. Exploring this issue can therefore reveal knowledge that might contribute to the advancement of the current approaches to obesity. Based on the above-mentioned considerations, the present study aimed to describe health professionals' reflections on existential concerns among people with obesity, by addressing the following key research question: What are the health professionals' reflections on existential concerns among people with obesity when attempting to support them in their lifestyle change processes?

METHODS

The present study used an exploratory qualitative design with a phenomenological hermeneutic approach. Human beings confront questions about the meaning of existence, the choices we must make and the responsibilities that we have. These can be referred to as existential concerns, and they are actualised when illness and suffering intrude on life [31]. Existential concerns relate to the existential world that all humans have. Therefore, a lifeworld approach was found to be appropriate to describe and interpret the phenomenon [31]. The lifeworld theory and methods allow researchers and practitioners to access the lived world of patients and professionals [32]. By combining phenomenological and hermeneutic approaches, we sought to gain a deeper understanding of the phenomenon by interpreting the meaning of the participants' expressions [33]. Phenomenological literature emphasises that it is possible to take in and understand other people's suffering, but one can never understand it to the same extent as the person who is suffering [31]. However, intersubjectivity, which means that we exist with others in an understanding way, somehow enables us to understand other human beings' challenges and concerns because we are part of and share the same world [31, 34, 35]. Through a reflective attitude to own experiences and impressions, a person can develop a deeper or new understanding of phenomena in the world [36]. Therefore, health professionals' reflections on existential concerns among people with obesity can be mediated through intersubjectivity, as described by Husserl [37] and Merleau-Ponty [38].

Recruitment and participants

We selected focus group interviews with professionals providing daily care and follow-up for people with obesity to collect data for the present study.* A focus group inter-

*Although the participants had different education and tasks in relation to people with obesity, they are all referred to as health professionals or professionals in the present study. People with obesity are referred to as patients as a collective term, even though they have different 'labels' in the actual healthcare setting, such as participants, patients and service users.

TABLE 1 Inclusion criteria for health professionals

Inclusion criteria
• being a health professional (for example registered nurse, physiotherapist, nutritionist, or occupational therapist) • providing daily care and follow-up of people with obesity • being active in clinical tasks • having at least 1 year of training • both genders

TABLE 2 Sample characteristics for health professionals ($N = 18$)

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

view is suitable when the aim is to explore a phenomenon that is relatively unexplored within a group, based on common experiences and meanings [39]. Unlike individual interviews, the interactions in focus groups can stimulate discussions that may bring forth tacit knowledge [40]. Focus groups work best for discussing topics that are well known to the participants, but that they do not talk about [40].

We established a purposive sample with variation in age, gender, health-related occupational background and experience—see Table 1.

The managers of centres that provided services to, among others, people with obesity, informed 20 professionals (18 women and two men) about the study both orally and in writing. All of them accepted the invitation to participate in the study. However, on the interview day, one male and one female professional had to withdraw from the study. Thus, 18 health professionals (17 women and one man) aged 26–56 years with 1–15 years of experience in the relevant clinical practice participated in the study—see Table 2.

We decided to use existing groups. This approach makes it easier to recruit participants and allows a relaxed atmosphere compared with the mixed groups approach [40]. Focus group 1 comprised six health professionals from five Healthy Life Centres located in a region in Norway. Focus group 2 comprised seven health professionals from a residential camp offering intensive lifestyle programmes for people with obesity (BMI ≥ 40 kg/m^2, or BMI ≥ 35 kg/m^2 with weight-related concomitant diseases). Focus group 3 comprised five health professionals associated with an outpatient clinic at a hospital that was following up on patients who underwent surgical treatment for morbid obesity. The health professionals in all groups supported people with obesity in their lifestyle change processes. The participants in focus group 1 were not working together daily but knew each other to a certain extent through a network for personnel working at Healthy Life Centres. The participants in groups 2 and 3 worked together daily and knew each other well.

Data collection

The centre managers organised the focus group meetings at the respective locations but did not participate in the groups themselves. The sessions varied from 60 to 90 min in duration and were conducted in a meeting room at one of the centres, with everyone seated around a large oval table. The participants permitted the interviews to be audio recorded. A moderator (the first author) initiated the interviews, using an open-ended question inviting the participants to describe their impressions of existential concerns among people living with obesity. Furthermore, the moderator asked the health professionals how they were affected when presented with such challenges, including the impact on their feelings.

The first author conducted two of three focus group interviews alone. The exploratory aim of the present study meant that we planned for a semi-structured discussion and low-level involvement from the moderator. It was an active choice to let the talk progress between the participants and let them address each other rather than the moderator [40]. However, the moderator intervened when the group wandered from the topic guide and led the discussion back on track again.

The interaction in the groups can be characterised as open, engaged and curious and with a great degree of consensus. No conflicts within the groups in the present study were identified.

The interviews were transcribed verbatim by a professional transcriber who signed a confidentiality agreement in advance.

TABLE 3 Model for interpretation of meaning at three levels

1. Self-understanding	The first level was to identify the participants' self-understanding through formulating what the participants themselves understood as being meaning-bearing in their comments. The first author read the three interview transcripts several times to ensure a first holistic understanding of the material. Thereafter, meaning units were collected, arranged and named under preliminary categories that closely reflected the content of the quotes. The co-authors were involved in further reading of transcripts, and consensus about the names of the preliminary categories was reached. Through this process, the notion of a whole was sensed. The participants self-understanding is presented as sub-themes in the Findings section
2. Common sense	The second level, the critical common-sense understanding built on what was considered as common sense, that is a broader frame for understanding than the participants' own. This means that the participants' self-understanding was reformulated, and a new level of abstraction emerged. At this level, themes were formulated through repeated discussions with the co-authors. These are presented as the main themes of this study in the Findings section
3. Theoretical understanding	At the third level, the empirical data were interpreted in the context of a theoretical framework. The interpretation at this level ends up beyond the participants' self-understanding and the common sense level and may further deepen the understanding of the findings. The theoretical understanding and interpretation are elaborated on in the Discussion section

Data analysis

The data were analysed and interpreted using a model for interpretation of meaning at the following three levels, inspired by the work of Brinkmann and Kvale [33]: self-understanding, common sense and theoretical understanding—see Table 3.

The process of moving from understanding to interpretation appears as a hermeneutical movement, moving back and forth between the particular, the universal and the whole. New understanding may arise when we are open to the unknown and may challenge our preconceptions [41]. An example of the analysis process is presented in Table 4.

Ethical considerations

Before their inclusion, the participants in the present study were informed both orally and in writing about the study, and a written consent form was completed. It was emphasised that participation in the study was voluntary and that they could withdraw from the project at any time. Confidentiality and anonymity were guaranteed. The project was conducted in accordance with the ethical principles of the Declaration of Helsinki. Ethics approval was obtained from the Regional Committees for Medical and Health Research Ethics (reference number: 2016/1530), the Norwegian Centre for Research Data (project number: 50184) and the research department at the hospital (ID number: 657). People with obesity are considered a vulnerable group in a research context [42], and throughout the process, we had in mind that we not only had an ethical responsibility towards the participants in the study, but also towards people with obesity. Therefore, we have interpreted and presented the findings with caution in line with the sensitive topic and what the participants feel sufficiently comfortable sharing with others [39].

FINDINGS

The analysis is presented using three themes and six subthemes. The first two themes present the health professionals' reflections on their impressions of people with obesity's existential concerns when attempting to support them in their lifestyle change processes. The third theme presents the health professionals' reflections on their own experiences when presented with people with obesity's existential concerns.

Theme 1: Health professionals' reflections on patients repressed emotional difficulties

The health professionals had the impression that many patients with obesity struggled with difficult emotions related to complex life experiences, including the obesity challenge, but that these feelings and vulnerabilities in some individuals were tried to be kept down, as if they repressed them.

Impressions of underlying struggle

The health professionals repeatedly experienced that people with obesity who sought treatment initially presented their challenge as a simple weight challenge. However, the professionals often experienced that the overall picture was more complex; the weight challenge was only a small part of the bigger picture.

TABLE 4 Example of analysis and interpretation

Self-understanding	Common sense	Theoretical understanding
Many are very restless and unable to be present in the relaxation exercises. I think they get a little too close to themselves so that difficult things emerge. They probably experience getting close to themselves as a little scary (Group 2)	Health professionals' reflections on patients' repressed emotional difficulties	The patient attempt to protect him/herself from what is perceived as a threat
Some of the people I talk to seem to think: 'I have to attack myself' rather than 'I have to take care of myself'. The attitude they have towards themselves is so dark (Group 1)	Health professionals' reflections on patients' lack of self-respect	The patient identifies as an entity or an object that is 'wrong' and should be changed or improved
Then you feel that you are falling short. Why can I not help them? Is it me that there is something wrong with or is it them? Could I have done something differently? It would be better if I was a psychologist (Group 3)	Health professionals' reflections on their own powerlessness when presented with people with obesity's existential concerns	Health professionals need mentoring, supervision or other support to deal with their own vulnerability when encountering patients in existential demanding situations

Sometimes, the health professionals could sense something 'beyond the words' in the conversations. However, the health professionals had the impression that the patient did not want to reveal more, and they therefore did not encourage further discussions.

According to the professionals, they carefully respected the patients' limits as if they were afraid to imply that people with obesity had other problems than weight problems or insist that they should open themselves up about their distress. The health professionals referred to situations when patients evidently felt uncomfortable because of underlying struggle, for example when doing yoga. A group 2 participant stated:

> *Many are very restless and unable to be present in the relaxation exercises. I think they get a little too close to themselves so that difficult things emerge. They probably experience getting close to themselves as a little scary*.

This observation indicates that the professionals assumed that some people with obesity experienced their underlying struggle as a threat.

Impressions of striving to hide their vulnerability

The underlying struggle contributed to making the health professionals' work more complex. They were supposed to support their patients in the best way, but it was not always evident to the professionals whether the patients themselves had a clear idea about their struggle or not. Those professionals who met patients both before and after bariatric surgery (group 3) had experienced that it was only after the surgery that the patients realised how much they had struggled emotionally before it. It was as if the patients allowed themselves to 'loosen up' the defence mechanisms and become aware of their actual feelings only when the challenging life situation was over.

The health professionals indicated that the patients who were the hardest to help were those who appeared to surround themselves with a shield of invulnerability. The professionals' impression was that the emotions related to the obesity challenge were so painful that the patients found it hard to relate to them, as explained by a group 2 participant:

> *A man who was very young... we asked if he needed to shower and help with personal hygiene... and when you are 21, it does not feel natural to say: "Well, in fact, I don't get around to washing myself or using the bathroom properly." You can understand that he chose to lie and said everything is fine. But we realised that things were not going well*.

The health professionals underlined that they tried to support the patients with the tools at their disposal, for example in the form of a shower stool or other practical aids. They observed that the patients suffered but were anyhow unable to help them.

Theme 2: Health professionals' reflections on patients' lack of self-respect

The health professionals sensed that some of the patients who attended the programmes were self-destructive—others shirked responsibility for themselves. Hence, some patients with obesity appeared to lack self-respect.

Impressions of self-destructiveness

The health professionals experienced that the patients often went 'all in' about attempting to change their lifestyle. This occurred often in the form of an extreme diet or rigorous exercise every day. Moreover, the health professionals experienced that when the patients failed or were unable to comply with their requirements, they were very hard on themselves. A group 1 participant stated:

> *Some of the people I talk to appear to think: "I have to attack myself" rather than "I have to take care of myself." The attitude they have towards themselves is so dark.*

The professionals had the impression that the patients harmed themselves with accusations and negative thoughts, and punished themselves, maybe believing that it would make them better at incorporating the required changes into their lifestyle. This thinking pattern appeared to lead to repeated failures and developed into a self-destructive downward spiral. Being too hard on themselves led to more mistakes, which the professionals assumed generated lack of self-respect.

However, cognitive training to increase self-compassion appeared to be their (only) 'medicine' to support patients in feeling better about themselves.

Impressions of shirked responsibility

According to the professionals, some patients, gave the impression that they had never thought about losing weight—they apparently did not consider their large bodies to be a challenge. They had never used a scale to check their weight and they had attended the programme because of external pressure, not an inner motivation.

The professionals could not avoid being provoked when the patients appeared to shirk responsibility for themselves or shift the responsibility over to the health professionals. A group 1 participant stated:

> *Again and again it happens, especially with adolescents or young adults. It's Coca Cola, chocolate, sleeping, and gaming. There is a lot that is not being taken care of, and I can sometimes be provoked if there is no kind of responsibility. I think we must take some responsibility ourselves. Things can't always be fun.*

Sometimes, the health professionals felt that their message did not reach the patients—as if they were resistant to advice and supervision. Some of the health professionals experienced that it was more difficult to show empathy towards these patients. In their conversations with the patients, they attempted to appeal to the patients' self-responsibility in a pleasant way, while being aware that they should not judge someone's life and morals.

Theme 3: Health professionals' reflections on their own powerlessness when presented with people with obesity's existential concerns

The health professionals reflected on their own experiences of powerlessness when presented with people with obesity's existential concerns in terms of experiences of shortcomings and contradictory encounters. Powerlessness appeared to arise because of differences between the health professionals' mission and the reality that they encountered.

Experiences of shortcomings

The health professionals expressed that working with people with obesity was meaningful to them. However, the repressed emotional difficulties and lack of self-respect sometimes overwhelmed them and made them feel like they were falling short. They experienced that the deeper they dug into the life experiences, the more complex the challenge became. In particular, participants in groups 1 and 2 had the feeling that their service served as a 'gathering place' for those who were almost given up on elsewhere in the healthcare system. Their service's mission was to support patients in their lifestyle changes, but they repeatedly experienced that the patients needed something else, which was more than they could offer. A group 3 participant reflected:

> *Then you feel that you are falling short. Why can I not help them? Is it me that there is something wrong with or is it them? Could I have done something differently? It would be better if I was a psychologist.*

The health professionals in these services believed that they did not have the right competence, time or other resources to support some of their patients with their emotional and existential concerns.

Experiences of contradictory encounters

The encounters with the patients with obesity appeared to cause contradictory feelings among the health professionals. On the one hand, they understood how difficult it was for the patients to modify their lifestyle. On the other hand, they admitted to being provoked and irritated when self-responsibility was abandoned. The participants in group 2 expressed that they really did not understand: 'How can some people with obesity reject our help when they need our help the most?' Furthermore, they stated: 'The obesity group creates a lot of feelings in us, feelings along the whole emotional scale'. The health professionals noticed that they became more emotionally involved by working with this patient group than other groups and mentally tired as they followed their patients ups and downs so closely. Engagement and commitment towards the patients could easily emerge as joy or frustration, depending on the patients' ability to cope or lack of it, respectively.

THEORETICAL UNDERSTANDING AND DISCUSSION

This present study aimed to describe the health professionals' reflections on existential concerns among people with obesity when attempting to support them in their lifestyle change processes. The analysis identified three themes: The health professionals reflected on existential concerns among people with obesity in terms of patients' repressed emotional difficulties and lack of self-respect. In addition, they reflected on their own experiences of powerlessness when presented with people with obesity's existential concerns. The findings are now interpreted and discussed considering earlier research and other theories.

The present study findings show that the health professionals reflected on the patients' emotional difficulties related to complex life experiences in terms of repressed emotional distress. Existential concerns and emotional baggage are considered to influence the patients' ability to change and maintain a new lifestyle [43–45]. Recent research has found that 77% of participants at the Healthy Life Centres in Norway experience psychological distress, compared with 11% of the national, representative sample and 16% of the national overweight and obese sample [45]. The professionals in the present study had the impression that some people with obesity instinctively attempted to hinder the underlying struggle. Hence, hindering underlying struggle and vulnerability from emerging may point towards attempting to protect oneself from what is perceived as a threat. According to Morse [46], in situations where people experience a threat to their self-integrity, some people might suppress their emotions. Thus, repressed emotional distress may be seen in some people with obesity as a supportive strategy in order to endure the difficult situation.

The health professionals in the present study experienced contradictory encounters when attempting to support their patients. They wondered why some patients who apparently needed their help would reject it. However, in a situation of emotional suppression, many attempts by the professionals to stimulate patients' reflections on the past or future will be fruitless or in vain [46]. When patients become dismissive, one reason may be that the patient is unable to receive help or guidance at the current time [47]. Instead, the person might provide the health professional with the impression that he/she lacks the will to take control of their lives [46]. According to Delmar [47], it is the professional's responsibility to identify what appeal for help the specific situation requires, including daring to take on the opportunity that a rejection provides. As some studies showed, knowledge about the existential ambiguity related to dealing with obesity should be applied in treatment approaches for people with obesity to improve their well-being [8, 48, 49]. Therefore, the health authorities need to expand care for this patient group beyond the support of self-management and standard obesity interventions.

The present study findings indicate that the professionals experienced powerlessness when meeting with the patients' existential concerns. Health professionals in the Norwegian primary care dealing with people with obesity are supposed to provide short-time interventions primarily consisting of advice related to physical activity and diet, as well as motivational interviews [12]. Nevertheless, the Healthy Life Centres is an example where participants are recruited who have both complex mental and physical challenges, which is not the primary target group [50]. As the present study points out, there is a gap between the mission in the healthcare services for people with obesity and the reality they encounter in the service. Several studies [44, 45, 51], suggested that there is a need to better address the psychological distress and existential concerns among people with obesity in the health service. We agree with Toft et al. [49] who called for a change to the health-provider training in order to achieve a different and more nuanced understanding of the obesity challenge.

The professionals in the present study reflected on the patients' difficulties in expressing their suffering. The sharing of one's existential suffering may be facilitated by healthcare professionals who succeed in being present in the situation and having the patience and courage to stay in the conversation and endure the patient's suffering [47, 52]. However, a previous study reported that health

professionals might be at risk to overlook suffering related to living with obesity [49]. Based on our findings and earlier research [53], we ask whether the current treatment offered to people with obesity can fully understand, accommodate and confirm their suffering? Therefore, there is a danger that existential pain related to living with obesity may remain unexpressed and contribute to suffering.

Our findings suggested that health professionals reflected on the patients' lack of self-respect. The professionals, particularly in focus groups 1 and 2, found that the patients had a self-destructive approach to lifestyle change. The existential pain of not accepting oneself and not being accepted the way one is may gradually lead to vicious circles of degradation of oneself [6, 34]. Normative expectations in the Western culture highlight bodily transformation and change as ideal [54], which generates a feeling in those who fail at this to being identified by oneself and others as an entity or an object that is 'wrong' and should be changed or improved [55]. Toft et al [49] confirmed the need for having a trusted person, such as a health professional, show genuine interest, empathy and sensitivity, so that patients feel that they are responded to as human beings when attempting to make and maintain lifestyle changes. Therefore, there is a need for a more nuanced approach to health promotion strategies: One that acknowledges that there is something more to one's sense of self than being something that should be changed or improved [34]. In line with previous findings [49, 56, 57], we suggest a more flexible and relaxed attitude to weight loss and a more holistic approach, originating in the lifeworld of people living with obesity.

Our findings showed that the professionals referred to feelings of provocation when the patients apparently shirked responsibility for themselves and their life. The present study and other previous studies showed that balancing responsibility in caring for people with obesity can be difficult [25, 27, 30]. However, from the perspective of caring science, responsibility and caring are two sides of the same coin. Responsibility should not be carried by the patient alone but by the patient and the health professional together, as partners [47, 58]. Today, however, because key features of caring are involvement and partnership, there is a danger that the responsibility is transferred and must be carried by the patient alone with the consequence that it may interfere with the opportunity to reconcile with one's life situation [47]. According to Delmar [47], one basic term of collaboration is the appropriate distribution of responsibility, wherein the focus is on how power is actively formed to maintain trust. The professional can support the patients' self-responsibility by entering a dialogue with them about how they can use their power [59]. In line with the findings of Wallinvirta [59], we suggest that health professionals should support patients with obesity in encouraging them to use their power to increase their dignity.

In the present study, the health professionals experienced inner turmoil in terms of their shortcomings and contradictory feelings when they encountered the existential concerns of people with obesity. In line with findings of Lundvall et al. [52], the health professionals in the present study became emotionally affected when the patients expressed existential concerns. According to Galvin & Todres [34], professionals need mentoring, supervision or other support to deal with their own vulnerability when encountering patients in existential demanding situations. They should be trained to deal with the emotional impact of the existential concerns that patients share with them [34]. Lundvall et al. [52] recommended support to prevent undue stress among the health professionals arising from their attempts to support and care to their patients. In our opinion, the present study shows that there is a need to strengthen the professionals' supervision and mentoring, to improve their ability to support people with obesity in their lifestyle change processes.

Methodological considerations

To ensure the present study's trustworthiness, we applied the conceptual approach reported by Graneheim & Lundman [60]. The participants in the focus groups varied in age, work experience and occupational background, and the three focus groups varied in organisational affiliation and service level according to the Norwegian healthcare structure. This diversity of the sample reinforces the credibility of the study because the groups offered rich and nuanced descriptions of the phenomenon of interest [60, 61]. However, because only one male professional participated in the study, the inclusion of mainly female participants could have influenced the data content and as such, the study's credibility and transferability.

In the analysis process, the three co-authors, having different backgrounds in nursing, caring science and social science, produced alternative interpretations at all levels of interpretation until consensus was reached. However, the findings are not to be considered objective facts but a reconstruction of the participants' experiences, perceptions of reality and understandings [62].

Confirmability of the present study has been achieved by providing a detailed description of the methodology, including the process of data collection, to allow readers to decide on their own the applicability of the study findings. Credibility, authenticity and overall trustworthiness of the study may also have been reinforced by having presented the findings along with several or single quotations on a given aspect, a detailed description of the analytical steps,

and an example from the analysis. The description of the participants and groups together with a rich description of the three contexts for the focus groups may have reinforced the transferability of the study. Thus, our findings may be transferred to other situations after considering the culture and context.

By emphasising that we have explored the professionals' reflections based on their *impressions* of people with obesity's existential concerns, we have made it clear that health professionals are only to a certain extent able to take in and understand patients' challenges. In addition, the findings are interpreted with caution. Consequently, we are aware that the findings from exploring the health professionals' reflections related to patients' existential concerns can at best complement or provide nuances to the descriptions of existential concerns provided by people with obesity themselves.

CONCLUSION

Drawing on the health professionals' reflections in a focus group format and further discussing the findings considering earlier research and theory have provided valuable insights into the existential concerns among people with obesity. The health professional' perspectives in the present study are unique, which are findings that we believe add to the existing literature. The existential concerns elucidated in this study appear to emerge through the reflections and experiences of health professionals, which may contribute to supplementing and providing nuances of existential concerns in people with obesity.

Implications for practice and further research

The present findings based on health professionals' reflections of existential concerns may contribute to the debate on how people with obesity are responded to and cared for. To avoid overlooking existential expressions, the professionals need to consider the patients' lifeworld, including nonverbal signals and communication, and allow for a deeper understanding that reaches beyond words. In addition, health professionals need to stay mentally present in the situation and create an inviting environment. Further studies on the same topic using different methodological approaches, such as individual interviews with health professionals and observation of the interaction between health professionals and patients, are recommended.

AUTHOR CONTRIBUTIONS

Haga, Furnes and Ueland designed the study. Haga drafted the manuscript. All authors contributed to the analysis and made critical revisions to the manuscript's scientific content.

ACKNOWLEDGEMENTS

We thank the health professionals for taking out time from their busy work schedule to contribute to this research. We also wish to thank the leading health professionals for their assistance in the recruitment process.

CONFLICT OF INTEREST

The authors declare no potential conflicts of interest with respect to the research, authorship and/or publication of this article.

ORCID

Britt Marit Haga https://orcid.org/0000-0002-0659-9849
Bodil Furnes https://orcid.org/0000-0002-1785-4331
Venke Ueland https://orcid.org/0000-0001-5600-3348

REFERENCES

1. Carey M, Small H, Yoong SL, Boyes A, Bisquera A, Sanson-Fisher R. Prevalence of comorbid depression and obesity in general practice: a cross-sectional survey. Br J Gen Pract. 2014;64(620):e122–7.
2. Grover SA, Kaouache M, Rempel P, Joseph L, Dawes M, Lau DC, et al. Years of life lost and healthy life-years lost from diabetes and cardiovascular disease in overweight and obese people: a modelling study. Lancet Diabetes Endocrinol. 2015;3(2):114–22.
3. Yazdani N, Sharif F, Elahi N, Hosseini SV, Ebadi A. Exploration of the quality of life in Iranian morbid obese people: a qualitative study. Int J Community Based Nurs Midwifery. 2019;7(2):138–49.
4. Rand K, Vallis M, Aston M, Price S, Piccinini-Vallis H, Rehman L, et al. "It is not the diet; it is the mental part we need help with." a multilevel analysis of psychological, emotional, and social well-being in obesity. Int J Qual Stud Health Well Being. 2017;12(1):1306421.
5. Grønning I. Fedmefortellinger: om vektnedgang og biografiske opprykk (obesity stories: about weight loss and biographical advancement). Sosiologisk tidsskrift (Journal of Sociology). 2014;22(3):227–48.
6. Owen-Smith A, Donovan J, Coast J. "vicious circles": the development of morbid obesity. Qual Health Res. 2014;24(9):1212–20.
7. Glenn NM. Weight-ing: the experience of waiting on weight loss. Qual Health Res. 2013;23(3):348–60.
8. Haga BM, Furnes B, Dysvik E, Ueland V. Putting life on hold: lived experiences of people with obesity. Scand J Caring Sci. 2019;34(2):514–23.
9. Alvarez C, Greene J, Hibbard J, Overton V, Alvarez C. The role of primary care providers in patient activation and engagement

in self-management: a cross-sectional analysis. BMC Health Serv Res 2016;16(86):85-.
10. Salemonsen E, Førland G, Hansen BS, Holm AL. Understanding beneficial self-management support and the meaning of user involvement in lifestyle interventions: a qualitative study from the perspective of healthcare professionals. BMC Health Serv Res. 2020;20(1):1–12.
11. Knutsen IAR. Striving towards normality: power and empowerment in treatment of patients diagnosed as morbidly obese. Oslo: Faculty of Medicine, University of Oslo; 2012.
12. The Norwegian Directorate of Health. Forebygging, utredning og behandling av overvekt og fedme hos voksne: nasjonale retningslinjer for primærhelsetjenesten (Prevention, Assessment and treatment of obesity and obesity in adults: national guidelines for primary health care). Oslo: Helsedirektoratet; 2010. https://www.helsedirektoratet.no/retningslinjer/overvekt-og-fedme-hos-voksne/Overvekt%20og%20fedme%20hos%20voksne%20%E2%80%93%20Nasjonal%20faglig%20retningslinje%20for%20forebygging,%20utredning%20og%20behandling.pdf/_/attachment/inline/24ec824b-646d-4248-951f-db6b867ce6cb:4e0740b933ffd5bc03c8f0fdcab00b4135fe4ae9/Overvekt%20og%20fedme%20hos%20voksne%20%E2%80%93%20Nasjonal%20faglig%20retningslinje%20for%20forebygging,%20utredning%20og%20behandling.pdf
13. Sagsveen E, Rise MB, Grønning K, Bratås O. Individual user involvement at healthy life Centres: a qualitative study exploring the perspective of health professionals. Int J Qual Stud Health Well Being. 2018;13(1):1492291.
14. Toft BS, Uhrenfeldt L. The lived experiences of being physically active when morbidly obese: a qualitative systematic review. Int J Qual Stud Health Well Being. 2015;10(1):28577.
15. Jepsen R. Physical activity and patient-reported outcomes during a two-year lifestyle intervention for severely obese adults. The Haugland Obesity Study. Bergen: The University of Bergen, The Department of Global Public Health and Primary Care; 2015.
16. Aasprang A, Andersen J, Våge V, Kolotkin R, Natvig G. Five-year changes in health-related quality of life after biliopancreatic diversion with duodenal switch. J Metab Surg Allied Care. 2013;23(10):1662–8.
17. Lier HØ, Aastrom S, Rørtveit K. Patients' daily life experiences five years after gastric bypass surgery – a qualitative study. J Clin Nurs. 2016;25(3–4):322–31.
18. Ueland V, Furnes B, Dysvik E, Rørtveit K. Living with obesity - existential experiences. Int J Qual Stud Health Well Being. 2019;14(1):1651171.
19. Rugseth G. Overvekt som livserfaring: et empirisk-teoretisk kunnskapsbidrag (obesity as a life experience: an empirical-theoretical knowledge contribution). Oslo: Det medisinske fakultet, Universitetet i Oslo; 2011.
20. Westland BS. Being large: an interpretive phenomenological enquiry into the lived world of problematic weight. London: Middlesex University; 2017.
21. Mold F, Forbes A. Patients' and professionals' experiences and perspectives of obesity in health-care settings: a synthesis of current research. Health Expect. 2013;16(2):119–42.
22. Dahl U, Rise MB, Kulseng B, Steinsbekk A. Personnel and participant experiences of a residential weight-loss program. A qualitative study. PloS one 2014;9(6):e100226-e.
23. Hunter J, Rawlings-Anderson K, Lindsay T, Bowden T, Aitken L. Exploring student nurses' attitudes towards those who are obese and whether these attitudes change following a simulated activity. Nurse Educ Today. 2018;65:225–31.
24. Brown I. Nurses' attitudes towards adult patients who are obese: literature review. J Adv Nurs. 2006;53(2):221–32.
25. Brown I, Thompson J. Primary care nurses' attitudes, beliefs and own body size in relation to obesity management. J Adv Nurs. 2007;60(5):535–43.
26. Groven KS, Heggen K. Physiotherapists' encounters with "obese" patients: exploring how embodied approaches gain significance. Physiother Theory Pract. 2018;34(5):346–58.
27. Robstad N, Söderhamn U, Fegran L. Intensive care nurses' experiences of caring for obese intensive care patients: a hermeneutic study. J Clin Nurs. 2018;27(1–2):386–95.
28. Shea MJ, Gagnon MM. Working with patients living with obesity in the intensive care unit: a study of Nurses' experiences. Adv Nurs Sci. 2015;38(3):E17–37.
29. Schwartz MB, Chambliss HON, Brownell KD, Blair SN, Billington C. Weight bias among health professionals specializing in obesity. Obes Res. 2003;11(9):1033–9.
30. Christiansen WS, Karlsen T-I, Larsen IB. Materiell og profesjonell stigmatisering av mennesker med sykelig overvekt (Material and professional stigmatization of people suffering from severe obesity). Nordisk tidsskrift for helseforskning. 2017;13(2).
31. Dahlberg K, Dahlberg H, Nyström M. Reflective lifeworld research. 2nd ed. Lund: Studentlitteratur; 2008.
32. Dahlberg K. Health and caring - from a European perspective. Int J Qual Stud Health Well Being. 2011;6(4):11458.
33. Brinkmann S, Kvale S. InterViews: learning the craft of qualitative research interviewing. 3rd ed. Thousand Oaks, CA: Sage; 2015.
34. Galvin K, Todres L. Caring and well-being: a lifeworld approach. London, New York: Routledge; 2013.
35. Lindberg E, Persson E, Hörberg U, Ekebergh M. Older patients' participation in team meetings-a phenomenological study from the nurses' perspective. Int J Qual Stud Health Well Being. 2013;8(1):21908.
36. Ekebergh M. Lifeworld-based reflection and learning: a contribution to the reflective practice in nursing and nursing education. Reflective Pract. 2007;8(3):331–43.
37. Husserl E. Cartesian meditations: an introduction to phenomenology. Dordrecht: Springer Netherlands; 1977.
38. Merleau-Ponty M, Smith C. Phenomenology of perception. 2nd ed. Hoboken: Taylor and Francis; 2002.
39. Malterud K. Fokusgrupper som forskningsmetode for medisin og helsefag (Focus groups as research method for medicine and health sciences). Oslo: Universitetsforlaget; 2012.
40. Macnagthen M. Focus groups. In: Seale C, Gobo G, Gubrium J, Silverman D, editors. Qualitative research practice. London: London: SAGE Publications Ltd; 2004.
41. Gadamer H-G. Truth and method. London: Bloomsbury Academic; 2013.
42. Liamputtong P. Researching the vulnerable: a guide to sensitive research methods. London: SAGE; 2007.
43. Toft BS, Galvin K, Nielsen CV, Uhrenfeldt L. Being active when living within a large body: experiences during lifestyle intervention. Int J Qual Stud Health Well Being. 2020;15(1):1736769.

44. Følling IS, Helvik A-S, Solbjør M. Previous experiences and emotional baggage as barriers to lifestyle change-a qualitative study of Norwegian healthy life Centre participants. BMC Fam Pract. 2015;16(1):73.
45. Sevild CH, Dyrstad SM, Bru LE. Psychological distress and physical-activity levels among people consulting a healthy life Centre for Lifestyle Change. Phys Act Health. 2020;4(1):76–85.
46. Morse JM. Toward a praxis theory of suffering. Adv Nurs Sci. 2001;24(1):47–59.
47. Delmar C. Professionel sygeplejefaglig omsorg - en rammemodel (Nursing professional care - a framework). Klin Sygepleje. 2021;35(3):219–41.
48. Haga BM, Furnes B, Dysvik E, Ueland V. Aspects of well-being when struggling with obesity. Int J Qual Stud Health Well Being. 2019;14(1):1699637.
49. Toft BS, Hörberg U, Rasmussen B. The ups and downs of lifestyle modification: an existential journey among persons with severe obesity. Scand J Caring Sci. 2022;36(1):265–74.
50. Samdal GB, Meland E, Eide GE, Berntsen S, Abildsnes E, Stea TH, et al. Participants at Norwegian healthy life Centres: who are they, why do they attend and how are they motivated? A cross-sectional study. Scand J Public Health. 2018;46(7):774–81.
51. Salemonsen E, Hansen BS, Førland G, Holm AL. Healthy life Centre participants' perceptions of living with overweight or obesity and seeking help for a perceived "wrong" lifestyle - a qualitative interview study. BMC Obesity. 2018;5(1):42.
52. Lundvall M, Lindberg E, Hörberg U, Palmér L, Carlsson G. Healthcare professionals' lived experiences of conversations with young adults expressing existential concerns. Scand J Caring Sci. 2019;33(1):136–43.
53. Furnes B, Dysvik E, Ueland V. Å lide når en lever med overvekt og fedme (To suffer when living with overweight and obesity – a challenge in care and treatment). Nordisk sygeplejeforskning. 2020;3:201–12.
54. Malterud K, Ulriksen K. "Norwegians fear fatness more than anything else"—a qualitative study of normative newspaper messages on obesity and health. Patient Educ Couns. 2010;81(1):47–52.
55. Haga BM. Existential experiences of living with obesity: perspectives from the views of individuals and health professionals: A qualitative study. Stavanger: University of Stavanger, Faculty of Health Sciences; 2020.
56. Brown J, Wimpenny P. Developing a holistic approach to obesity management. Int J Nurs Pract. 2011;17(1):9–18.
57. Ogden K, Barr J, Rossetto G, Mercer J. A "messy ball of wool": a qualitative study of the dimensions of the lived experience of obesity. BMC Psychology. 2020;8(1):1–67.
58. Beyene LS. The meaning of shared decision-making in mental care – a hermeneutical study. Stavanger: University of Stavanger, Faculty of Health Sciences; 2020.
59. Wallinvirta E. Ansvar och makt (Responsibility and power). In: Gustin LW, Bergbom I, editors. Vårdvetenskapliga begrepp i teori och praktik (Caring science concepts in theory and practice). Lund: Studentlitteratur; 2017. p. 379–92.
60. Graneheim U, Lindgren B-M, Lundman B. Methodological challenges in qualitative content analysis: a discussion paper. Nurse Educ Today. 2017;56:29–34.
61. Morgan DL. Focus groups as qualitative research. 2nd ed. Thousand Oaks, CA: Sage Publications; 1997.
62. Polit DF, Beck CT. Nursing research: generating and assessing evidence for nursing practice. 10th ed. Philadelphia: Wolters Kluwer; 2017.

How to cite this article: Haga BM, Furnes B, Ueland V. Health professionals' reflections on existential concerns among people with obesity. Scand J Caring Sci. 2022;00:1–11. https://doi.org/10.1111/scs.13105