

A Systematic Review of Phenomenological Research on Obese Adults.

by

J. J. Swart

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In quiet reflection, and upon thinking of all the beings that made my path possible, I am deeply moved and very privileged to have encountered you along the way. The experiences you have provided me with, both positive and negative, if such a distinction even really exists, have largely forged, influenced and shaped the being I am. This is despite my resistance to certain experiences at the time they occurred. Some beings are aware of their influences, others perhaps not as much, and of these beings some still here, others not, yet none will ever be forgotten. I thank each one of you deeply with all that constitutes me. I am indebted to you for the difference and possibilities you presented me with in my life, especially those who granted me the indescribable gifts of unwavering loyalty and love. Thank you.

ABSTRACT

Obesity is a worldwide problem which affects individuals regardless of age, culture or ethnicity. Obesity is associated with health risks, financial implications, and social consequences. There are numerous explanations for obesity, although even with these explanations, long-term treatment for obesity has not been highly effective. Focussing on the lived experiences of obese individuals may illuminate different understandings which could aid in explaining this. Phenomenology, as a branch of philosophy and employed in this dissertation is concerned with individuals' lived experiences. The present study conducted a qualitative systematic literature review on phenomenological research on individuals' experiences of obesity. Nine studies were analysed using a qualitative systematic literature review methodology. The data analysis revealed obese individuals' experiences in three main themes: control, acceptance, and restriction. The three themes were understood to have an interrelationship with one another, and to be in a continuous dynamic interplay, which cannot be separated and understood in isolation, regarding the participants' experiences.

Keywords: Obesity; Qualitative Systematic Review, Phenomenology, Adults.

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Chapter 1: Introduction



1.1. Introduction

The purpose of this section is to briefly provide an overview of obesity. The discussion includes information on the current status of obesity in the world, the implications of obesity for those who are overweight, and the implications for society at large. Reference to treatment options and outcomes are also included in the discussion. The introduction positions the importance of the present research, followed by a view of the aims of the research and how the research is structured.

1.2. Obesity

The term obesity is fairly simple to understand. An individual is described as obese when that individual has a body mass index (BMI) over a certain number (Pain, 2007). Mathematically, this number is calculated as follows (Campbell & Haslam, 2005; Pain, 2007): $BMI = \text{weight}$

(kg) / height (m²). Wilmore (2003) elaborates by explaining that before the severity of obesity was highlighted as a worldwide problem, there was no real classification systems put into place to identify obese individuals. Subsequently, leading experts from the World Health Organisation (WHO) consulted one another and made a recommendation to classify overweight and obese individuals on the basis of their BMI, which is an expression of an individual's weight-height ratio (Campbell & Haslam, 2005; Pain, 2007). The recommendation was accepted and, subsequently, anybody with a BMI of between 25 and 29.9 is considered overweight, and a BMI of greater than 30 is now classified as obese. The above explanation defines the term obese in an understandable way. Although the denotation of the term may be simple, its connotation is an entirely different scenario, and 'simplicity' does not enter into the obese individual's vocabulary.

An obese person struggles with the label in day to day life. These individuals do not only suffer from the related physical implications (Kumanyika & Brownson, 2007), but they encounter and endure psychological problems such as daily discrimination and stigmatisation (Pronk, 2003; Puhel, & Heuer 2009; Puhel & Brownwell, 2003; Sadock & Sadock, 2007). Obesity is not easily concealable. It is usually visible to all who encounter such individuals, illustrated in Figure 1 above. Obesity affects individuals regardless of age, culture, or ethnicity (WHO, 2007; Wilmore, 2003). The reader may better conceive the enormity of the problem by considering the WHO's (2007) estimate that over 1 billion individuals are overweight globally, and that 300 million individuals are considered obese. By the year 2015, the number of overweight adults will reach 2.3 billion and 700 million of these will be obese (WHO, 2010). These statistics are extremely staggering. Not only is obesity now considered a worldwide problem, it is becoming ever more prominent in South Africa. According to Van der Merwe (2003), it is estimated that nearly half of South Africans over the age of 15 years

are overweight or obese; that is, approximately 45% of the population. It seems as if South Africa is on course to becoming the world's fattest nation. This, in effect, puts a financial and human resources strain, on an already beleaguered healthcare system. This development may be conceptualised within the increasing worldwide prevalence of obesity, and the direct association with serious medical and psychological conditions (Baur, 2002; Mokdad et al., 2003; Munsch & Dubiu, 2005; Turconi & Cena, 2007). On a social level, obesity has negative economic consequences for a country (Kruger et al., 2005; Shelley, 2012; Turconi and Cena, 2007).

There have been numerous explanations with regards to the aetiology of obesity, incorporating psychological, social, and biological factors (Baranowski, Perry & Parcel, 1997; Degher & Hughes, 1999; Goodspeed-Grant & Boersma, 2005; Kumanyika & Brownson, 2007; Sadock & Sadock, 2007; Shelley, 2012). Obese individuals may choose from a variety of options should they wish to lose excess weight (Mentz, 2003, Wilmore, 2003). Treatment normally involves a given form of dieting restriction, accompanied by structured programmes which comprise nutrition advice; dietary counselling; exercise timetables and facilities; lifestyle modification suggestions; behavioural, cognitive behavioural, and psychodynamic therapy; and drug therapy or surgery (Adolfsson et al. 2005; Campbell & Haslam, 2005, Goodspeed-Grant & Boersma; 2005; Ogden & Sidhu, 2006; Sadock & Sadock, 2007; Sarwer, Foster & Wadden, 2004; Shelley, 2012; Wilmore, 2003; Wysoker, 2005). Although there are a variety of treatments available, the sustained treatment of obesity over the long-term has failed (Bidgood & Buckroyd, 2005; Jeffrey et al., 2004). These findings are supported by Ogden and Sidhu (2006) who comment that the successful treatment for weight reduction with obese individuals is extremely poor. These authors claim

that 90% to 95% of obese individuals who manage to lose significant amounts of weight will regain their weight over three to five year follow-ups.

Healthcare professionals have come to play an ever-increasing role in the management and treatment of the obesity pandemic, yet they have been criticised for offering services which are uncoordinated and inconsistent (Brown, 2006; Goodspeed-Grant & Boersma, 2005). Some researchers explain that the problem is situated in where the control and responsibility for the problem lies (Brown, 2006; Epstein & Ogden, 2005). Some healthcare professionals view obesity as a medical problem which falls within their professional domain and, because of this view, they assume responsibility for its management. Other healthcare professionals feel that obesity is ultimately a problem that has both been caused by obese individuals' themselves and therefore should be managed by them (Epstein & Ogden, 2005). There is a divergence of views, but ultimately the majority of healthcare professionals view the treatment of obesity as the responsibility of obese individuals themselves (Brown, 2006; Epstein & Ogden, 2005). According to Epstein and Ogden (2005), this is because an assumption exists that the primary cause of obesity is due to factors within the patient's control, such as eating too much. Consequently, it is construed that obese individuals are personally responsible for their weight. Obesity is, therefore, associated with various negative personal traits, namely laziness, lack of self-discipline and passivity (Brown, 2006, Epstein & Ogden, 2005). Some obese individuals do not view the problem in the same way - they believe that the treatment for their obesity is the responsibility of the medical professional (Epstein & Ogden, 2005).

Rothblum (1999) offers an eloquent summary of the above analysis and description: To paraphrase, he asks how many studies need to be published before established opinion about obesity is changed? These studies demonstrate that obese individuals do not respond to treatment – they do not lose much weight, and the weight is regained after the termination of treatment. The implication of these studies affect various domains of obesity such as its aetiology and treatment, the professionals who provide obesity healthcare, and how statistics of obesity is reported, not to mention the lived experience of the obese individuals. Rothblum (1999) advocates that a drastic change is needed with regards to how obesity is presently researched. The current situation clearly demonstrates this. In the researcher's opinion, the term obesity has a variety of meanings to a variety of different people, which Deacon (2005) calls conceptual inflation. The term obesity may be seen as a social scientific gloss which actually reveals less about the experience of the person interpreted, and more about the work practice of researchers who rely on the term for interpretation and explanation (Manzo, 2004).

1.3. Aim and Justification of the Research

Brown (2006) poignantly shares the idea that a change in perspective is needed. The idea of change according to Brown (2006), follows on from Rothblum's (1999) advocacy. Brown (2006) asserts that informational change should originate from the sources themselves, that is, from the perspective of obese individuals. He therefore recommends that it is important to explore the complexity of attitudes beyond the common stereotypes to understand beliefs about causes and personal responsibility of obese individuals. These reflections by Brown (2006) the researcher believes are significant, and offer value.

Therefore, a focus on how individuals' experience their obesity may offer something different and provide some hope in changing the current trajectory with regards to obesity. Schneider and May (1995) describe phenomenology as focussing on the personal, subjective experience of the individual, their world and relationships with others, their embodiment, which shapes their perception of the world. Phenomenology may thus be used as the foundation upon which the resulting knowledge can be developed (Schneider & May, 1995). Therefore, a focus on phenomenological research, concerning how adult obese individuals experience their condition, seems to offer potentially significant implications. The implications of such research may, in turn, give an indication for the direction of further research, especially the psychological dimensions of interventions and treatment. An investigation which focuses on phenomenological research of adults' experiences of obesity is a study worthwhile pursuing, as it offers a change in perspective. It also answers the salient recommendation made by Brown (2006), which is to conduct a potentially different and significant study regarding obesity. The aim of this research is therefore to answer the following research question: "What would a qualitative systematic review elucidate about phenomenological research on adults' experiences of obesity?"

The methodology of this research falls within the realm of qualitative research. It is a systematic method used for combing qualitative research findings. More specifically, to qualitatively systematically review studies on phenomenological research regarding adults' experiences of being obese. The qualitative systematic review method is chosen as it can focus on phenomenological research of adults' experiences of obesity, and provide the potential for offering new understanding. This is because the purpose of a qualitative systematic review is to enhance the interpretative understanding of information, and the creation of new findings, which are greater than those found in the individual studies

themselves (Meadows-Oliver, 2006; Petticrew & Roberts, 2006; Sandelowski & Barroso, 2006). Additionally Tricco et al.'s (2011) asserts that the combination of knowledge is of primary importance to close the gap between research and decision-making. A qualitative systematic review may accomplish this. It is hoped that in conducting this qualitative systematic literature review, future researchers may apply the knowledge, and begin to address the current status quo of unsuccessful long-term treatment of obesity; and, in doing so, reduce the suffering of obese individuals, mentally, physically, socially and financially. Additionally, future researchers may make use of the knowledge gained and, with the application of that knowledge, in some small manner address and diminish the idea of conceptual inflation as explained by Deacon (2005), as it applies to obesity. This research does not look to evaluate interventions and does not aspire to develop an intervention plan.

1.4. Structure of the Research

The structure of this dissertation entails a qualitative systematic review of phenomenological studies on obese adults from 2005 to 2011. The findings of the studies are arranged into themes and added to these themes are subthemes. The thematic interpretations were established with the research question in mind.

1.5. Outline of the Chapters

Herewith follows the structure employed in this dissertation: Chapter two's literature review provides detailed coverage of salient ideas and concepts which are related to obesity. The chapter describes obesity in the context of eating disorders, its diagnosis, and epidemiology. Also described is obesity in South Africa, its relation to gender, aetiology, and other

psychological research conducted on obese individuals. The chapter's focus shifts to medical professionals who treat obese individuals, the costs, and the health and social consequences of obesity, concluding with the treatment approaches for obesity. The third chapter, on phenomenology, provides an account of the origins of phenomenology, a detailed description of descriptive and interpretative phenomenology, and concludes with a description of the epistemological and ontological underpinnings and implications of understanding which are offered in the studies which will be used for the qualitative systematic review. This is followed by the fourth chapter on the research methodology which situates the qualitative systematic review within the broader context of qualitative research. Within the fourth chapter, the following topics are addressed: The research design; how the qualitative systematic review is actually performed; and how the study endeavours to be trustworthy. The fifth chapter contains the three established main themes and their subthemes which result from the study. These themes are systematically reviewed. Finally, the sixth chapter of this research concludes with a discussion of the findings.

1.6. Researcher

The researcher is a 30 year old male. According to the BMI classification, the researcher falls within the normal range. Physically, the researcher is in good shape and has good health. Therefore, the experience of obese individuals seems very far removed from the researcher's personal experience. From the researcher's position, by reading and immersing himself into the studies used in this qualitative systematic review, the researcher was moved in countless ways, in some cases, far beyond description. By exploring the phenomenological research on adult obese individuals, the researcher has come to understand that he did not remotely grasp, nor understand, the world of an adult obese individual. Due to the researcher's experiences in

conducting this research, and having being emotionally moved, the researcher tries to provide an integrative understanding of what it is to like to live the life of an obese individual which is discussed more fully in the discussions chapter. The researcher feels it pertinent to convey his shared experience, and the manner in which he has been emotionally moved and forever altered. This research is conducted in the hope that other individuals, especially those who are not obese, may perhaps, in some small manner, also be moved, and share the researcher's new found understanding and, thereby, respect the difficulty obese individuals experience on a daily basis.

1.7. Conclusion

At present, there is no long-term treatment which is effective in treating obese adult individuals, despite massive amounts of research publications, and time and money having been spent in the endeavour to improve the current situation. Researchers of obesity have recently described the futility of current avenues of focus and suggest a change of focus to an understanding of obese individuals themselves. This dissertation's aim is to systematically review studies on phenomenological research regarding adults' experience of obesity, in the hope that future researchers may apply the knowledge, and begin to address the current status quo of unsuccessful long-term treatment of obesity. In doing so, it is hoped that obese individuals may experience less suffering mentally, physically, socially and financially.

Chapter 2: Literature Review

2.1. Introduction

The aim of this chapter is to provide a detailed coverage of the relevant ideas which relate to obesity. This is done by putting forward a foundation, which importantly provides the ground work to understanding the figure of this research. The focus of this research is obese adults and, although there is a vast amount of research on childhood and adolescent obesity, the literature focusses exclusively on the adult population. This chapter firstly focusses on contemporary thoughts about obesity. Obesity is then placed within the context of eating disorders. The focus is then shifted to the diagnosis of obesity, its epidemiology in the context of the world and, in particular, South Africa. This is followed by the thorny issue of aetiology and the variety of current theories and ideas. For both society and the individual, the impact and consequence of obesity is illuminated, specifically cost implications, and the negative effects of health consequences and psychosocial difficulties. The chapter concludes with an understanding of the relevance of weight loss, and explores the long-term inefficacy of current treatments

2.2. Obesity

Bray (2005, p. 81) asserts: "It [obesity] is a chronic, incurable disease". In stark contrast to Bray (2005), Groven, Raheim and Engelsrud (2010) state that the concept of obesity may be regarded as a modern lifestyle problem which leads to or causes serious illness in individuals. These are two rather different views which are merely five years apart. Therefore, they may both be seen to be contemporary, yet opposing, perspectives. These two views highlight the

difficulty in understanding obesity. Gard (2011) states that the term obesity is a fairly simple concept to understand, that is, an individual is described as obese when the individual has a BMI over a certain number, but he also includes the concept of associated physical implications. As the concept of obesity is unpacked, it becomes clear that it encompasses many different aspects, and is not simply a number over a certain value. Obesity is associated with life changing struggles for those individuals who are branded with that label. These individuals do not only suffer from the associated physical implications, they also experience psychological problems, and endure daily discrimination and stigmatisation. Obesity is not simply a term; it is a scourge, and one which is growing rapidly worldwide, irrespective of class, race, or gender (Kumanyika & Brownson, 2007).

Bagchi and Preuss (2007) state that the upshot of obesity having been defined as a worldwide epidemic by the World Health Organisation (WHO), is that a new term has been coined. The new term used to describe the upsurge of overweight and obese individuals throughout the world's population is globesity. How big is the problem on a worldwide scale? Currently, it is reported that more than 1.5 billion adults are overweight, and at least 315 million are clinically obese (Zimmet & Jennings, 2008). To further highlight the situation, WHO (2010) estimates that by 2015, 2.3 billion adults will be overweight and 700 million people from this population will be obese. Gard (2011) adds that some researchers argue that society has become so accustomed to the sight of obese individuals that we no longer recognise ourselves as dangerously overweight. Supporting this statement, Lewis et al. (2010) elaborate that there have been numerous research studies conducted on the identification of health beliefs and behaviours of obese individuals, and their understanding of the associated health risks. The studies reveal that obese individuals, in many circumstances, underestimate their weight. This contributes to their defence or their denial that their weight is a health risk. It is important to

understand that obesity in industrialised countries is recognised as the leading cause of preventable death (Sadock & Sadock, 2007).

Furthermore, Gard (2011) contends that governments have been either too short sighted or insufficiently brave to introduce rigorous anti-obesity policies. As a result, many countries are perceived to be sleepwalking into a public health disaster. South Africa is not excluded. It is estimated that nearly half of South Africans over the age of 15 are obese or overweight; which equates to roughly 45% of the population (Van der Merwe; 2003). Olshansky et al. (2005) explain that, in light of the current evidence and trends, the forecasting on obesity predicts the brewing of a threatening storm and, if these forecasts are left unchecked, they will have a detrimental effect. Furthermore, although the knowledge is widespread, with regards to the reduction of the severity of obesity, the observed trends continue to worsen. Olshansky et al.'s (2005) opinion about this phenomenon is that obesity strongly threatens to diminish the health and life expectancy of current and future generations. Kopelman (2000) states that "obesity should no longer be regarded simply as a cosmetic problem affecting certain individuals, but an epidemic that threatens global wellbeing" (p.635). Delpeuch, Maire, and Holdsworth (2009) conclude:

To sum up: the more you are overweight, the sooner you die. The optimum size, for anyone who aspires to live to be a hundred, can be expressed as a BMI score of between 18 and 25. It seems probable that life expectancy, which has steadily risen in the developed world, may soon become shorter as a result of obesity. Unless we can overcome this epidemic, today's young people may well have unhealthier and shorter lives than their parents enjoyed before them (p. 29).

2.2.1. Obesity in the context of eating disorders.

The brief discussion which follows situates obesity within the context of eating disorders. According to Pla (2007), an eating disorder may be thought of as a marked disturbance in an individual's eating behaviour. According to the American Psychological Association (APA), as reflected in the Diagnostic and Statistical Manual of Mental Disorders (*DSM-IV-TR 4th ed. text rev.*, 2000), there are three classifications of eating disorders, specifically anorexia nervosa and bulimia nervosa and eating disorders not otherwise specified. Anorexia nervosa is characterised as a disorder in which the individual refuses to maintain a minimal average weight (*DSM-IV-TR 4th ed. text rev.*, 2000; Sadock & Sadock, 2007). Bulimia nervosa is characterised by binge eating which is combined with inappropriate means of stopping weight gain (*DSM-IV-TR 4th ed. text rev.*, 2000; Sadock & Sadock, 2007). According to the *DSM-IV-TR 4th ed. text rev.* (2000) "a disturbance in perception of body shape and weight is an essential feature of both anorexia nervosa and bulimia nervosa" (p. 583).

Eating disorders not otherwise specified (Pla, 2007) refer to eating disorders which do not fully meet the criteria for any specific eating disorder (*DSM-IV-TR 4th ed. text rev.*, 2000; Pla, 2007; Sadock & Sadock, 2007). Binge eating disorder (BED) falls into this category, and may be described as a sudden and compulsive ingestion of a great quantity of food in a relatively short timeframe, which may then be followed with self-condemnation accompanied by low self-worth on the part of the given individual. According to Pla (2007) and Sadock and Sadock (2007) individuals with BED experience a feeling of a lack of control during the eating episode in which they battle to stop or control how much and what they eat. The eating may continue to the point whereby individuals feel awkwardly full or may eat at a far greater speed than usual (Herzog & Kamryn, 2007). The individual is left feeling greatly distressed

regarding the eating binges, and concurrent feelings of self-loathing and disgust for their body and shape are combined with a feeling of frustration with their inability to control their eating behaviour. They may also feel embarrassed, guilty, depressed, and exhibit somatic concerns (Herzog & Kamryn, 2007; Pla, 2007; Sadock & Sadock, 2007). Reactions to stress seem to play an important role in binge eating (Pla, 2007; Sadock & Sadock, 2007). Herzog and Kamryn (2007) state that, similar to anorexia nervosa and bulimia nervosa, individuals with BED are preoccupied with their weight and shape, and place an undue importance on these aspects as they relate to their self-worth. Herzog and Kamryn (2007) describe BED as concurrent binge eating episodes which can also be marked with distress in the absence of regulatory compensatory behaviours. They comment on the difference between bulimia nervosa and BED in that the disorders are both characterised by binge eating episodes - bulimia nervosa is characterised by purging, or the use of inappropriate means to stop gaining weight, whereas BED is not.

Night eating syndrome (NES) is not included in the DSM-IV-TR, but comparable to BED, anorexia nervosa and bulimia nervosa share an emotional correlate (Pla, 2007). A characteristic of individuals diagnosed with NES is that they tend to eat excessively despite having had an evening meal. It seems as if the syndrome is precipitated by stressful life events and, when these events are present, eating generally reoccurs on a diurnal basis until the stress is alleviated (Pla, 2007). Night eating syndrome seems to indicate morning anorexia and evening hyperphagia. The individual may wake up at night to eat high-calorie foods (Pla, 2007). The comorbid condition featured with NES is depression. It differs from BED in that it is more often associated with a specific precipitating stressful event. Unlike BED, NES is more periodic. For both BED and NES, the individual consumes an excessive amount of food.

According to Yager (2000), obesity is classified as a medical condition and not a psychiatric disorder. He states:

Simple obesity is included in the International Classification of Diseases (ICD) as a general medical condition but does not appear in the DSM-IV-TR because it has not established that it is consistently associated with a psychological or behavioural syndrome. However, when there is evidence that psychological factors are of importance in the aetiology or cause of the particular case of obesity, this can be indicated by noting the presence of psychological factors affecting the medical condition (p. 583).

Although psychological factors are important in understanding the development of obesity, the link between the two is not clearly established (Sadock & Sadock, 2007). It is apparent that the mechanisms which control food regulation in the human body are largely influenced by the external environment - family and cultural factors seem to contribute to the development of obesity. Other factors may contribute to the development of obesity are the individual's family history, personality structures, or unconscious conflicts (Freidman & Brownell, 1996; Sadock & Sadock, 2007). It is indicated that some obese individuals with emotional instability overeat to cope with their psychological problems. Consequently, when some individuals obtain a normal weight, they lose their habitual way of coping, and they develop serious mental disorders (Sadock & Sadock, 2007). Although these brief descriptions are areas of influence and concern, upon closer examination, there are further complexities in trying to understand obesity, specifically, how obesity is formally diagnosed.

2.2.2. Overweight, obesity, and severe obesity.

Sadock and Sadock (2007) state that obesity refers to an excess in body fat in an individual. A healthy individual's body fat usually accounts for 25% of the body weight in women, and 18% of the body weight in men. Any proportion above 30% is considered obese. According to Klein (2000) and Wilding (2001), obesity can be defined as having an excess amount of body fat, which is connected to an increased risk of medical conditions and health impairments.

Obesity is diagnosed in an individual by assessing either the amount of body fat or an individual's waist circumference (Kumanyika & Brownson, 2007; Ogden, 2003; Turconi & Cena, 2007). In practical terms, however, this is rarely practised, and an individual's BMI is used. The BMI is calculated by measuring an individual's weight (in kilogrammes) and dividing this number by the individual's height (in squared metres). Mathematically, the BMI is written as follows (Campbell & Haslam, 2005; Pain, 2007): $BMI = \text{weight (kg)} / \text{height (m}^2\text{)}$. As mentioned previously, if the individual has a BMI of 25 to 29.9, they are classified as overweight. If the individual has a BMI greater than 30, they are considered obese (Campbell & Haslam, 2005; Kumanyika & Brownson, 2007; Ogden, 2003; Sadock & Sadock, 2007; Turconi & Cena, 2007). Turconi and Cena (2007) state that obesity may be further subdivided on the basis of severity. Therefore, a BMI of 30.0 to 34.9 is classified as obesity class-1, which is seen as moderate; a BMI of 35.0 to 39.9 is classified as obesity class-2, which is seen as severe; and a BMI equal to or greater than 40.0 is classified as obesity class-3, which is very severe (Campbell & Haslam, 2005; Kumanyika & Brownson, 2007; Turconi & Cena, 2007). Distinguishing degrees of obesity may be important for practical considerations, such as surgery.

2.2.3. Severe obesity.

Lewis et al. (2010) state that obesity is becoming a serious public health issue which is associated with a complex range of causes and health and social consequences. The researchers continue to explain that although severely obese individuals generally comprise only a small portion of the obese population, studies indicate that the prevalence of severe obesity is growing at a rapid rate. More specifically, the rise of morbid obesity over the already exponential rise of obesity in the past 25 years, can actually be characterised as an epidemic, according to Buchwald (2005). He explains that between the years of 1986 and 2000, the prevalence of obesity class-1 (BMI > 30) doubled, morbid obesity class-2 (BMI > 40) quadrupled, and class-3 super obesity (BMI >50), increased fivefold in US adults. Severely obese individuals may experience a heightened prevalence of morbidity and mortality from chronic health conditions, and experience far greater healthcare costs than individuals with obesity (BMI 30 to 39.9). The severity of the obesity also determines the individuals' prospects for surgery. Ogden et al. (2006) state that surgical management of obesity is only recommended for individuals with a BMI over 40, or a BMI of over 35, if there are resultant complications due to the obesity.

2.3. Body Mass Index (BMI)

Why is the BMI the most frequently used method to identify obesity? Kopelman (2000) explains that, in clinical practice, the BMI is the most common method employed to determine obesity. The crux of this idea is that most often the variations in an individual's weight depends on their fat mass, as their height is usually constant. Therefore, the formula that is most often employed is the BMI). Kopelman elaborates that a graded classification for

overweight and obese individuals by employing the BMI is of immense value in that it provides information about increasing or decreasing body fatness. The BMI enables researchers to make meaningful comparisons on weight status between, and within, different populations and, through this, they are able to identify individuals at risk of morbidity. It enables practitioners to screen for risks of mortality and interventions may be implemented for those with the highest priority.

The BMI is not without criticism and heed should be taken in its indiscriminate application as a diagnostic tool. Body proportions differ and the BMI may not correspond with the same level of fatness across different populations. As a result, it does not account for the wide variation in the nature of obesity between different individuals and populations (Kopelman, 2000; Kumanyika & Brownson, 2007). Supporting this sentiment, Pain (2007) states that although the use of the BMI is widely accepted, it fails to distinguish general body fat from abdominal obesity, which is far more serious. It also does not distinguish between muscle weight and fat weight (Kumanyika & Brownson, 2007). Yet another implication is that an individual may have a high BMI, with relatively low body fat, such as athletes or fit individuals, whose body composition is low for fat but high for lean muscle mass (Campbell & Haslam, 2005).

According to Kopelman (2000), another issue is how to define a healthy weight for individuals in particular societies using the BMI. Kopelman elaborates that the current definition is based on total mortality rates. This, he states, can be misleading because of the concern around confounding factors which may distort the association between body weight and mortality, such as smoking (Kopelman, 2000). Although there are problems with the

utility of the BMI for defining obesity ($BMI \geq 30$), it is still, at present, the gold standard and accepted manner for identifying obesity (Campbell & Haslam, 2005).

2.4. Epidemiology

According to Zimmet and Jennings (2008), the obesity epidemic is the greatest public health concern, and is the single most important challenge facing healthcare systems in the 21st century. They explain that time is not a luxury in dealing with the epidemic, because obesity is as large a threat as bird flu and global warming. Obesity may be viewed as the most prevalent, chronic, and potentially fatal relapsing disorder of the 21st century (Zimmet & Jennings, 2008).

Although Pain (2007) argues that there is limited global prevalence data available, there does seem to be convincing evidence indicating an increasing prevalence. Bagchi and Preuss (2007) and Zimmet and Jennings (2008), state that it is estimated that nearly 1.5 billion adults in the world are overweight and that 300 million of these are obese. The WHO (2010) estimates that 2.3 billion adults will be overweight in 2015, and 700 million will be obese! Turconi and Cena (2007) claim that obesity, and its concomitant medical conditions, was originally thought to only be a real concern (and problematic) for affluent countries. Obesity, however, has become increasingly noticeable in less developed countries, first described by Popkin and Doak (1998) who saw a sharp rise in obesity in developing nations such as Mexico and South Africa. More recently, Turconi and Cena (2007) suggest that countries in economic transition have also been impacted, from undeveloped to developed, such as Brazil, China, and particularly South Africa.

These researchers state that, in the developing world, obesity reflects a profound change in society to a sedentary lifestyle and consumption of high fats, and energy-dense diets, in the past two to three decades. Kruger et al. (2005) and Pain (2007) additionally explain that starvation and malnutrition actually coexists with obesity in many developing countries. The idea is supported that obesity is a problem for developed and developing countries. Further support for this notion is that obesity has increasingly become prevalent in all population groups in South Africa, irrespective of age and economic levels (Kruger et al., 2005; Van der Merwe & Pepper, 2006).

2.5. Obesity in South Africa

Kruger et al. (2005) state that in South Africa, during the period from 1960 to 1980, a huge amount of misinformation about health was spread, which culminated in the idea of benign obesity. The result of this was the compounding problem of treating obesity and its comorbid conditions which had been neglected. Van der Merwe and Pepper (2006) elaborate that for those decades, the notion of benign obesity was propagated specifically for the South African black population, without proper examination of the associated comorbid diseases. Recently, results have been published which clearly document that obesity does produce hypertension, glucose intolerance, and diabetes in black ethnic groups in South Africa (Van der Merwe & Pepper, 2006). The idea of benign obesity has now been put to rest by other authorities.

According to WHO (2007), being overweight or obese is listed as one of the top ten leading risk factors for the increase in mortality in both developed and developing countries.

According to Turconi and Cena (2007), some African countries experience a prevalence of obesity of up to 75%. Puoane et al.'s (2002) reveal that, in 1998, a survey of the South

African population was conducted which indicates that nearly half the South African female population, and one third of the male population, are overweight or obese. The researchers comment that, although the increase is observed in black urban African women, this may be extrapolated to different ethnic groups in regional studies, such that the conclusion is that rural women are equally affected. This corresponds with the more recent study by Van der Merwe and Pepper (2006) who state that there has been a progressive increase in the prevalence of obesity in South Africa, especially in the female population, which has been documented over a number of decades.

Van der Merwe (2003) estimates that nearly half of South Africans over the age of 15 are obese or overweight; this is approximately 45% of that population. Research by Senekal, Steyn and Nel (2003) examine individuals in the South Africa population and it is illustrated that over 55% of white men and 42% of white women, are overweight or obese. They illustrate that just less than 50% of black males, and nearly 75% of black females, are in this category. Individuals with mixed-race ancestry comprise 45% of males, and just over 66% of females, in this category. In the Asian group, 35% of men and 37% of the female population fell within the overweight or obese range.

In summary, these studies demonstrate and highlight the seriousness and ever-growing problem of obesity in Africa. More importantly, and alarmingly, is the growing prevalence in the South African context. Statistics reveal and demonstrate that no race or gender is exempt from obesity.

2.6. Gender and Obesity

Pain (2007) explains that there is no gender which is exempt from obesity, yet women, in general, appear to have a higher rate of obesity than men. Ogden (2003) supports this and elaborates that it is specifically working class women who have a higher incidence of obesity. The female predominance in obesity rates also hold true for South African women (Van der Merwe & Pepper, 2006). In reviewing findings from Senekal et al.'s (2003) research, Pain (2007), Van der Merwe and Pepper's (2006) confirm a larger female prevalence. One possible explanation is that there seems to be an increase in women's BMI with successive pregnancies (Pain, 2007).

2.7. Energy Intake and Energy Expended: A Basic Understanding of Obesity

“Common wisdom holds that obesity results from overeating” (Freidman & Brownell, 1996, p. 377).

At its simplest, obesity is caused by excess of energy taken in, compared to energy expended, over a period of time (Campbell & Haslam, 2005; Cope, Fernandez & Allison, 2004; Wilding, 2001). This simply means that if there is an excess of energy intake over an individual's daily requirement, it will result in that energy being stored. The manner in which this energy is stored is fat, and it is deposited throughout an individual's body. This is the simplest and most undeniable way of understanding any approach to weight and the way in which it operates (Campbell & Haslam, 2005; Martinez, 2000; Stunkard, 1996; Wilding, 2001).

Although Vogele (2005) agrees with the energy consumption/energy expenditure view, he argues that it is not as straightforward as it seems because a multitude of factors may complicate the delicate weight balance. Campbell and Haslam (2005) contend that understanding weight regulation it is a great deal more complex than the simple energy consumption versus energy expenditure model. To put these remarks into context, Vogele (2005) explains that, at the level of energy intake, satiety regulation is crucial – these are eating behaviours which relate to psychological and physiological processes of hunger. Sadock and Sadock (2007) support this contention by highlighting the importance of an individual's satiety in the understanding obesity.

Other factors that influence food intake are susceptibility to food cues and how palatable the food is. It appears that obese individuals have a higher susceptibility to food cues that they are exposed to. They appear to be strongly influenced by the palatability of food. These individuals also seem to have difficulty to terminate eating episodes if food is readily available (Rodin & Striegel, 1989; Sadock & Sadock, 2007). Obese individuals also seem to have a greater vulnerability to external stimuli to eating. Ferster, Nurnberger and Levitt (1962) comment that obese individuals have high, and sometimes unpredictable, responsiveness to external food cues. According to Sadock and Sadock (2007), obese individuals may remain relatively unresponsive to the usual internal signals of hunger, and also seem to be unable to distinguish between hunger and other kinds of dysphoria.

In summary, it is clear in understanding obesity's aetiology, that it is multifactorial, and the identification of a single factor which causes obesity is not possible (Pain, 2007). At its most basic level, obesity is seen to occur as a result of excess fat disposition and insufficient energy expenditure. Obesity is thus a consequence of excessive energy intake over a

prolonged period of time (Campbell & Haslam, 2005; Vogele, 2005). Exactly how this imbalance is achieved is far more difficult to discern. What follows is an exploration of the multiple causes of obesity.

2.8. Aetiology of Obesity

“Determining the causes of obesity is central to any effort to tackling it. However, despite years of research, uncertainty over the aetiology of obesity remains one of the chief barriers to designing effective strategies for prevention and treatment” (Vogele 2005, p. 62).

Sadock and Sadock (2007), Turconi and Cena (2007) and Kopelman (2000) confirm the statement above, and explain that obesity is a complex disease, which results from a variety of combinations and can be viewed as a multifactorial chronic disease. Risk factors include genetic susceptibility, increased access to high energy foods, and decreased need for physical activity due to certain aspects of modern society. Campbell and Haslam (2005) elaborate that in order to understand the development of obesity, an examination of a variety of factors must be taken into account including genetic, environmental, neurological, physiological, psychological, biochemical, cultural, and socioeconomic issues. These all have an impact on individuals developing obesity.

Gard (2011) holds a somewhat different view, and stresses environmental factors. He explains that the obesity epidemic may be best conceptualised as a complex social movement, not as a simple sum total of small changes of bodily exercise and dietary habits. To him, obesity has taken place as a result of supermarkets, authority figures, public health, and television which affects the mind-set of the average individual. He concludes that, perhaps, a

comprehensive understanding of what the obesity epidemic is, and how it has come about, is beyond our understanding, and a smorgasbord of interpretations is the best we can hope to offer.

In summary, it is impossible to accurately identify the precise aetiology of obesity. It is the result of a multitude of possible causes, and the manner in which they interact (Ogden 2003; Sadock & Sadock, 2007). Aetiological factors may be roughly divided into two groups: genetic and non-genetic factors. The former is discussed presently.

2.9. Genetics and Obesity

According to Beamer (2003), if you eat too much you become obese. Realistically, it is not that simple. This idea has been highlighted in the previous section. Obesity is a complex disorder with multiple genetic and non-genetic influences (Beamer, 2003; Campbell & Haslam 2005; Ogden 2003; Vogele, 2005). The complexity is understood thus: A certain disease with one sufficient and identifiable cause is simple yet, if there are dozens of possible interacting causes, it is complex (Beamer, 2003). When researching obesity, it is clear that it is a complex disease/disorder with both non-genetic and genetic influences. This section will first focus on genetic influences.

According to Vogele (2005), the dramatic increase in rates of obesity in the last few decades is often interpreted as the dominant role of environmental factors. This is due to the changes having occurred in a relatively constant gene pool. It is important to understand that it highlights the importance of distinguishing direct genetic causes and genetic predisposition to

obesity. Vogele (2005) claims that genetic causes only account for a small minority of obese cases (Vogele, 2005).

2.9.1. Genetic contribution to obesity.

There are some rare mutations to single genes which may account for obesity (Beamer, 2003; Wilding, 2001). The most compelling is mutation of the genes coding of the leptin hormone (Beamer, 2003 Campbell & Haslam, 2005; Eikelis, 2007; Ogden 2003; Vogele, 2005).

Leptin, according to Beamer (2003), is a hormone which is secreted by the adipose tissue in amounts which are proportional to the individual's fat stores. This creates a feedback to the hypothalamus, which controls appetite regulation, which reduces appetite and increases levels of energy expenditure (Cope et al., 2004). Some individuals experience an obesity problem when there is a deficiency or mutation of this hormone. Consequently, these individuals can eat and still feel very hungry, and so continue to eat and, therefore, put on weight (Eikelis, 2007). Campbell and Haslam (2005) and Vogele (2005) explain that profound obesity in a minority of obese individuals is found to be due to a problem with leptin, which is essentially involved in the regulation of body fat and appetite control. Beamer (2003) elaborates that vast samples of obese individuals have been screened for the leptin gene mutation, but very few individuals were identified as having rare mutations which could actually cause significant obesity.

It is frequently said that obesity tends to run in families (Kopelman, 2000; Vogele, 2005; Wilding, 2001). This is supported by molecular genetics and genetic epidemiology. Research demonstrates that mutations of the melanocortin-4-receptor (Mc4r) is correlated with extreme obesity (Cope et al. 2004; Rama, Dwivedi, & Mirkin, 2007; Vogele, 2005). This, however, is

only true for 3% to 5% percent of morbidly obese individuals as not all individuals with the mutation are obese. This suggests that obesity may depend on other genetic variations for these individuals. Hence, there are a multitude of genes which are involved in the process that affects an individual's body fatness (Vogele, 2005). Except for certain rare obesity-associated syndromes, the genetic influence appears to operate through susceptibility genes (Wilding, 2001; Yager, 2000). These genes can influence an individual's risk of developing obesity, however, they cannot explain the development of the disease (Kopelman, 2000). The following section aims to put this comment into context.

2.9.2. Genetic influence and predisposition to obesity.

Stunkard, Harris, Pedersen, & McClearn (1990) estimate that as much as 66% to 70% of a predisposition to obesity is a result of an individual's genes. Genes appear to be good candidates for influencing obesity, and as many as 250 different genes are currently under investigation (Campbell & Haslam, 2005). Rama et al. (2007) have more recently estimated that 425 genes are responsible. Very few mutations have actually been found to be the primary cause, as genes only account for obesity in a small portion of individuals (Beamer, 2003; Campbell & Haslam, 2005; Cope et al. 2004).

According to Rama et al. (2007) the genetic influence and predisposition to obesity is supported by twin studies. Twins were exposed to periods of positive and negative energy balances. The research concludes that the difference in the rate of weight gain show greater similarity within pairs than between pairs, so there is a higher concordance rate for obesity in identical twins, even if they are exposed to different environments (Rama et al. 2007). This suggests that genetic susceptibility possibly determines those who are most likely to become

obese in any given set of environmental contexts (Bouchard, 2007; Kopelman, 2000; Stunkard et al., 1990, Stunkard et al., 1986; Wilding, 2001).

Beamer (2003) states that there is great variability in the degrees of obesity, the age of onset, and management of associated features of obesity. These factors provide circumstantial evidence of the multiple genetic and non-genetic factors which influence and individualise body weight (Ogden, 2003). In the general population there is no obesity gene. Instead, it seems, that there exists a cluster of genes which can, with a compounding effect, lead to a greater tendency to obesity within the context of a permissive environment. Beamer (2003) explains that a permissive environment refers to an environment in which food is excessively available and physical activity is reduced for individuals. This combination seems to significantly contribute to individuals becoming overweight and obese.

To summarise this section, Kopelman (2000) states that the influence of the genotype as an aetiology for obesity is exacerbated by non-genetic factors. Besides certain rare obesity associated syndromes, the genetic influence seems to operate through susceptibility genes (Wilding, 2001). These genes may influence an individual's risk of developing obesity. They cannot explain, however, the development of the disease (Kopelman, 2000). In families with the mutation, the pattern should be clearly demonstrable by inheritance, yet the numbers are too small to account for worldwide obesity. The increase in the worldwide prevalence in obesity in the last few decades has led to heightened interest in the role of environmental factors. Particularly, the availability of high- energy foods has been highlighted (Campbell & Haslam, 2005). This corresponds with Beamer's (2003) notion of a permissive environment. In addition to genetics and the environment, there are also aspects specific to the individual, such as dietary habits and physical exercise that contribute to obesity.

2.10. Dietary Habits and Physical Exercise

Human beings have evolved genetically to be able to store fat in times of plenty; an adaptive quality of human beings to survive during times of need. This means that those of us, who have survived, are descendants of these fat stores (Campbell & Haslam, 2005). The difficulty is that today we hardly experience times of need for food, and our ability to consume and absorb energy as fat is no longer necessary. This explains why we are able to accumulate body fat mass from an evolutionary point of view. In support of this idea, Vogele (2005) suggests that reports of obesity prevalence in our time are not about changes in psychological or social conditions, but a combination of factors. Such factors include an environment which favours a positive energy balance with an appetite control system which evolved when the food supply for humans was limited. We are now surrounded by highly palatable foods in abundant supply. The current obesity epidemic should therefore be seen as a normal reaction to an abnormal environment (Campbell & Haslam, 2005; Epstein & Ogden, 2005; Henderson & Brownell, 2004; Wilding, 2001).

The environment thus seems to contribute significantly to excess weight and obesity (Beamer, 2003; Freidman & Brownell, 1996; Wilding, 2001). Vogele (2005) points to the evidence that physical activity levels have dramatically declined in the last number of decades in the general population. Society has created an environment with easier lifestyles, where physical activity is, to a large extent, not as necessary as before. High rates of obesity therefore seem, potentially, due to the decreased physical activity. Looking at a how society has progressed over the last number of decades, energy used to be expended on agriculture, then industry, and presently energy is expended on information (Freidman & Brownell, 1996; Ogden, 2003). In support of this line of thought, Vogele (2005) states that past generations

had large-scale workforces who were paid for their physical labour; however in today's society, work is much more sedentary. At the same time, transportation systems and industrial mechanisation means that human beings expend reduced amounts of energy in everyday life.

The obesity epidemic is a modern phenomenon, particular to the last two decades, and points to a greater contribution from environmental factors (Campbell & Haslam, 2005). This idea is supported by a number of researchers (e.g., Epstein & Ogden, 2005; Freidman & Brownell, 1996; Hill & Peters, 1998; James, Leach, Kalamara, & Shayeghi, 2001; Vogeles, 2005; Wilding, 2001). If human beings have evolved to store energy, it is not surprising, according to these researchers, that individuals are now overweight.

In summary, reduced physical activity may influence an individual's weight gain and lower energy expenditure leads to lower thermogenesis. This results in a small increase in metabolic rate with the amount of food eaten. An increased metabolic rate contributes to a reduced resting metabolic rate which may then lead to an energy imbalance between intake and expenditure, causing weight gain (Vogeles, 2005). Research thus indicates that a correlation exists between decreased activity and increased obesity (Ogden, 2003).

2.11. Eating Behaviour

Campbell and Haslam (2005) explain that environmental pressures are very powerful. The environment encourages individuals to eat. To avoid food altogether is impossible.

Individuals seemingly find it easy to eat, as it is comfortable, satisfying, and relatively inexpensive. Not only are human beings subjected to very strong physiological signals that

make us want to eat; we possess very weak signals to make us stop. According to research over the last two decades (Vogele, 2005), obese individuals consume 46% more fatty calories than the daily calorie consumption. This is significantly higher than the recommended 30% consumed by non-obese individuals. Dietary fat is one of the primary contributors to body fat in individuals, and many overweight and obese individuals prefer dietary fat. This is an important aetiological factor for their weight gain and weight maintenance (Campbell & Haslam, 2005; Freidman & Brownell, 1996; Ogden, 2003; Vogele, 2005; Wilding, 2001).

According to Freidman and Brownell (1996), there has been an increase in the consumption of dietary fat in the general population, as the percentage of fatty calories consumed has risen from 32% to a staggering 43%. Wilding (2001) reports a general increase in fat consumption in society. There seems to be a positive association between body weight and fat consumption, however, the evidence thus far does not display a positive correlation with carbohydrate intake (Vogele, 2005).

To summarise the aetiological factors discussed thus far, there seems to be evidence for a genetic basis for influencing obesity ((Beamer, 2003; Campbell & Haslam, 2005; Eikelis, 2007; Kopelman, 2000; Ogden 2003; Stunkard et al., 1990, Stunkard et al., 1986; Vogele, 2005; Wilding, 2001). However, there is no single gene that directly causes obesity, as genetic mutations create susceptibility for becoming obese in certain circumstances (Beamer, 2003; Kopelman, 2000). The obesity prevalence has also increased at a similar rate to the decrease in physical activity. Obesity also potentially correlates with fat consumption, as obese individuals seem to ingest greater portions of fat than non-obese individuals. According to the International Obesity Task Force (2002), the current obesity pandemic

reflects a profound change to society in the past few decades; an environment exists in which a sedentary lifestyle and a high fat energy-dense consumption diet is promoted.

Vogele (2005) highlights the following important point: He argues that the evolutionary perspective may be able to account for the increase in prevalence rates on the level of the population. However, it does not explain why so many individuals are overweight and obese, when others are exposed to identical mechanisms, and are able to preserve a stable body weight. Some individuals maintain a low body weight whereas others cannot. This raises important aetiological questions, and directs one to consider psychological influences. The next section will focus on the possible psychological influences on obesity.

2.12. Psychological Influences on Obesity

Sadock and Sadock (2007) argue that although psychological factors are important in understanding the development of obesity, it has not been clearly established how psychological factors contribute to the development of obesity. Thus, more certainty is needed with regards to which psychological factors play a role. What follows is an exploration of possible psychological factors which have been identified to have an influence on obesity.

Rothblum (1999) states that media portrays obese individuals as able to control their weight. He elaborates that research indicates that diets do not work and that obesity has a genetic component. However, usually in the last section of research articles on obesity exists the contradiction that a stricter diet or better self-control may be what is needed. Rothblum (1999) states that the articles, therefore, put the individual at fault with their weight gain. In

simple terms, most research indicates that weight is not under an individual's control and simultaneously encourage an individual to take personal control of his/her weight loss (Rothblum, 1999). The researcher is in agreement with the observations of Rothblum (1999).

Before exploring various research ideas linked with control, and how it relates to psychological influences on obesity, an examination of the experiences and feelings of healthcare professionals who treat obesity is explored. In this way, Rothblum's (1999) comments are situated in context. Healthcare professionals play an important role in obese individuals' lives, as they are experts, and have frequent contact with them. Therefore, the relationship between the healthcare professional and the patient (the obese individual) is important in understanding potential aspects of psychological influences.

2.13. Healthcare Professionals' Views of Obese Individuals

Obese individuals frequently have contact with individuals in the healthcare system. In these encounters or interpersonal contexts, meaning is created concerning obesity. By exploring the views of some conducted research of healthcare professionals who work with obese individuals, psychological influences in the development of obesity is elucidated. A tentative foundation is laid for a subsequent section in this chapter which explores the treatment of obesity. It emerges that treatment for obesity has not had great success.

Healthcare professionals are increasingly tasked with helping to assess, treat, and manage obesity due to the health risks presented in the condition (Barlow & Dietz; 2002; Epstein & Ogden, 2005). They are criticised, however, for offering obesity management that is uncoordinated and inconsistent (Epstein & Ogden, 2005). Healthcare professionals seem to

evidence a general lack of interest and ambivalence about their role with obese individuals for many reasons (Brown, 2006),

Some healthcare professionals evidence a reluctance to investigate the topic and their perception of the value of their intervention (Brown, 2006, Epstein & Ogden, 2005).

Healthcare professionals describe the management of obesity primarily in terms of issues of responsibility and control (Brown, 2006, Epstein & Ogden, 2005). Some healthcare professionals feel that obesity is a medical problem which falls within their professional domain and, because of this, they should take responsibility for its management (Epstein & Ogden, 2005). Other healthcare professionals feel that obesity is ultimately a problem that has been caused by the patients (obese individuals) and should therefore be managed by them (Brown, 2006, Epstein & Ogden, 2005).

Epstein and Ogden (2005) conclude that healthcare professionals ultimately see the treatment of obesity as the patient's responsibility, because the majority of healthcare professionals feel that the primary cause of obesity are eating too much, which is in the patients' control.

Attitudes of healthcare professionals demonstrate that they believe that individuals are personally responsible for their weight, and that obesity is therefore associated with negative personal traits of laziness, lack of self-discipline, and passivity (Brown, 2006, Epstein & Ogden, 2005).

The healthcare professionals recognise, however, that the patients do not see the problem in the same way, and that they believe the treatment of obesity is the responsibility of healthcare professionals (Brown, 2006, Epstein & Ogden, 2005). This is further exacerbated by a lack of faith of treatment options from healthcare professionals (Brown, 2006, Epstein & Ogden,

2005). Healthcare professionals sometimes offer inappropriate treatment as a means to maintain good relationships (Epstein & Ogden, 2005).

Research by Chang and Christakis (2002) provides a possible explanation for these occurrences. These researchers highlight that these occurrences are due to medicalisation. Medicalisation, according to Chang and Christakis (2002), is described as a procedure in which certain behaviours or conditions are described as medical problems, instead of moral ones. Medical treatment is viewed as the centreline of focus of cure. Chang and Christakis (2002) describe that, in this century, fatness has moved from a moral conception of personal failing, to the modern view of fatness as a sickness through medicalisation. Therefore, obesity which was seen as a socially deviant condition has become a medical condition. This has, therefore, created an impurity with regards to responsibility. According to Chang and Christakis (2002) description, what was once intentional and bad, has turned into something unintentional and related to sickness.

There are two sides to medicalisation with regards to obesity. On one side, responsibility shifts away from the individual to social and environmental contexts, blurring an individual's accountability (Chang & Christakis, 2002). Therefore, there is tension between society and the individual, which is similar to the sociological debates concerning structure and agency as to who is responsible. On the other side, however, Chang and Christakis (2002) state that medical conditions are subtended by unspoken postulates that individuals' behaviours are voluntary and are freely modifiable, with emphasis, therefore, on personal accountability. In this way, systemic influences are given a lower profile. Conditions which include societal and environmental influences, such as obesity are unfortunately played down in favour of isolated

individual factors, such as personal behaviour. The end result is that obese individuals are left in a double bind.

Medicalisation, according to Chang and Christakis (2002), takes place on three tiers, namely the conceptual, the institutional, and the doctor-patient relationship. This discussion centres around the first and third tiers. The medicalisation of obesity has taken place on a conceptual level, however, on the grassroots level, in the doctor-patient relationship, this is not evident, and it is where obese individuals experience the double bind. To shed further light on this, Strong (1970) and Verweij (1999) describe that the medicalisation of alcoholism, for example, often leaves doctors sceptical over the value of medical treatment and intervention. With regards to obesity, this scepticism is similarly described in the research by Epstein and Ogden (2005). Elaborating on this argument, Strong (1970) and Verweij (1999) describe how doctors prefer to manage conditions which are straightforwardly biological; clear-cut cases in terms of both cause and treatment. Regarding obesity, doctors are sceptical as to how to manage obesity medically (Epstein & Ogden, 2005); its aetiology is not clear cut (Vogele, 2005) and there is no long-term effective treatment plan (Ayyad & Andersen, 2000; Byrne, Cooper, & Fairburn, 2003; Henderson & Brownell, 2004; Jeffrey et al., 2004; Wadden, 1993; Wilson, 1995). This highlights the potential discrepancy in the two tiers of the medicalisation of obesity. Although conceptually identified as a medical condition, medical professionals treat obese individuals differently in terms of the third tier, the doctor-patient relationship.

How do the patients feel about their obesity? What can research offer by illuminating their experiences? What are the psychological explanations for the development of obesity? In exploring research studies on obese individuals, a glimpse is provided into obese individuals'

experiences, and possibly reasons are provided why they are, or perceive themselves to be, obese. Insight is provided into psychological influences for developing obesity.

2.14. Psychological Understanding and Influences for Developing Obesity

Sonntag et al. (2010) reaches the conclusion that the psychological explanations of locus of control and attribution tendencies in obese patients may aid in understanding obesity. Scoffer et al. (2010) elaborate that obesity may be considered a maladaptive attitude towards eating and weight control, but literature reveals that disordered eating comes from a complex interaction of personal and contextual factors (Sadock & Sadock, 2007). In certain instances, obese individuals identify their family context as a major contributing factor. One of the main themes identified are the obese individual's early life encounters, especially regarding feeding time, warmth and nurturance, or difficulty and harm (Goodspeed-Grant & Boersma, 2005). On one hand, food is seen as a key component of the family culture and represents security and wellbeing. On the other hand, Goodspeed-Grant and Boersma (2005) state that it also represents a battleground for control in terms of the giving or withholding of food, and demonstrates the power of wills between child and parent. These conflicts around control become internalised, and later relates to control issues around food. In support of this idea, Scoffer et al. (2010) explains that "self-regulation of eating attitudes refers to the individual's capacity to control his or her own eating behaviour or carry out an activity" (p. 165). Scoffer et al. (2010) explain that self-regulation may be seen to develop through an array of reciprocal influences between the given individual and society, which, may then imply the contribution of personal and broader social and moral standards.

Issues of self-control are evidenced in the following description: "It's not easy. It takes a lot of self-control, and I don't think I've ever had the self-control" (Goodspeed-Grant & Boersma 2005, p.217). Boutelle, Libbey, Neumark- Sztainer, and Story (2009) have conducted a cross-sectional study on a group of 62 adolescents who lost weight, and a group of 68 adolescents who did not lose weight. Their findings reveal that those who lost weight reported using healthy control behaviours in the form of consuming less soda, increasing exercise levels, consuming diets high in protein, and spending less time watching TV. Research conducted by Baranowski et al. (1997) also highlights this. In their study, participants' capacity for self-regulation impacted their control over the intake of fruit and vegetables.

In other cases, it is believed that food is addictive, and controls them. A participant explains: "I was really addicted to food at that point. There were times when I sit down to eat and it's hard to stop - like there is no off switch" (Goodspeed-Grant & Boersma 2005, p.217).

Another participant explains: "I'm not mad at God because I'm fat or anything, but sometimes I think, how come you had to make me a fat person?" (Goodspeed-Grant & Boersma 2005, p.217). In understanding these quotations, Scoffer et al. (2010) offer the idea of locus of control. The idea of locus of control, which was originally defined by Rotter (1966), refers to the individual's generalised expectations about their control over life events. Rotter (1966) distinguished between an internal and external locus of control. Those with an internal locus of control believe that they are in control of their lives, and those individuals with an external locus of control believe that fate, or other external factors, determine their lives. Yalom (1980) states that "internals have an internal locus of control and feel they control their personal destiny, externals place control external to themselves and look outside themselves for answers, support and guidance" (p.157). According to Adolfsson et al. (2005) and Rodin and Striegel (1989), obese individuals are prone to have an external locus of control, as they

possibly feel that they have less personal control over the environment, and over their impulses and desires. Scoffer et al. (2010) concludes that an internal locus of control has a positive influence on eating attitudes in the context of social interactions, which also confirms research conducted by Bandura (1997).

The research conducted by Goodspeed-Grant and Boersma (2005) demonstrates that obese individuals' also consider genes to be a reason for their condition. One individual explains "my family does not run skinny" (Goodspeed-Grant & Boersma, 2005, p.217). Although genes are described as a contributing factor, obese individuals are highly frustrated with their weight loss failure, and blamed themselves. Degher and Hughes (1999) state that obese individuals utilise the following two kinds of attribution strategies: Firstly, the individuals admit that their weight status is unacceptable, but deny responsibility for having become overweight. These individuals explain that it is someone else's fault; the result of events that they could not control. They blame medication with side effects, pressure from family members, or their genetic make-up. Secondly, obese individuals provide reasons for remaining obese, and although they accept responsibility for being overweight, they provide socially acceptable reasons for their behaviour, such as eating to cope with personal tragedy, social pressures, family obligations, or punishing themselves (Degher & Hughes, 1999). These explanations are evidenced in Goodspeed-Grant and Boersma's (2005) research: Early childhood abuse is a theme which emerges. Half the obese individuals in the study had been sexually, physically, or emotionally abused by a parent during childhood. Accompanying the abuse were feelings of sadness, rebellion, anger, and pain which were related to the experience. In certain cases, food is identified as having a numbing effect on the physical and emotional abuse. One participant comments "I was numb when I was eating. I didn't feel anything and it felt good" (Goodspeed-Grant & Boersma 2005, p.216).

Another aspect relating to the Degher and Hughes (1999) explanation is interpersonal problems. Goodspeed-Grant and Boersma (2005) demonstrate that food is recognised as comforting when individuals have nobody to turn to stressful times. Food is seen as a replacement to fulfil the social need. One participant comments "I found comfort in food. It was my best friend, my parents separated, a dream that ended. I didn't have anybody in my life" (Goodspeed-Grant & Boersma 2005, p.216). Although research indicates that healthcare practitioners agree with the hypothesis that responsibility and control lie with the obese person, it is not confirmed. Food is seen as a way to deal with and help compensate for loneliness and longings in relationships. Food is an association to good family memories of childhood, and the eating of the food is, in a sense, an attempt to re-establish the pattern and connection of kinship and togetherness.

The reviewed literature reveals two opposing positions regarding the question of personal control in eating behaviour for obese people. On the one hand, most of the research shows that obese individuals have an ability to make a choice or a decision to control or regulate their eating behaviour. The research conducted incorporates locus of control, self-efficacy, self-regulation, and attribution tendencies to confirm this (Baranowski et al., 1997; Degher & Hughes, 1999; Scoffer et al. 2010). This notion is held by nurses and doctors who interact with obese individuals (Barlow & Dietz, 2002, Brown, 2006). On the other hand, obese individuals' experiences reveal a different picture. Obese individuals indicate that they feel that they have little control and that the responsibility of weight management should come from the medical practitioners (Goodspeed-Grant & Boersma 2005). An important aspect of obesity is revealed, psychological influences seem to play an important role in understanding aspects of it. However these influences seem to be as further investigated increasingly complex.

2.15. Cost of Obesity

As obesity is further unpacked, more aspects come into focus, such as the considerable economic impact of obesity. Kruger et al. (2005) states that obesity is associated with increased significant healthcare costs, which has surged in recent times (Henderson & Brownell, 2004; Ogden, 2003; Sadock & Sadock, 2007).

Turconi and Cena (2007) concur that obesity may be estimated to account for up to 8% of the total healthcare costs in Western countries and, as a result, represent a massive burden for individuals, significant costs to employers, taxpayers, and society at large. This represents a huge sector of national healthcare budgets and, as this total of 8% relates to Western countries, the potential impact on healthcare resources in less developed healthcare systems may be far more severe.

According to Pronk (2003), if one examines obesity, it includes more than just the apparent cost of medical treatment. Added to the direct costs for obesity are associated medical costs which include physicians, hospitalisation, and medication, and a reduced quality of life (Turconi & Cena, 2007). Indirect costs to society may include a loss in productivity, which impacts on sick leave, prematurely withdrawn pensions, and premature death (Pronk, 2003; Turconi & Cena, 2007).

Obesity is associated with a range of comorbid conditions and, therefore, the costs linked to the medical treatment of obesity are also related to these related conditions including heart disease care, gallbladder care, and clinical depression (Pronk, 2003; Sadock & Sadock,

2007). In a country such as South Africa, where healthcare services are severely stretched, the additional strain may be prevented, and possibly open up treatment vacancies.

2.16. Negative Effects and Health Consequences

Lewis et al. (2010) explain that the links between obesity and risk areas may be broadly placed into two categories: Associations with obesity and physical health risks, and poor emotional health. In reference to the former, Wechsler, Leopold and Bischoff (2005) state that there are numerous diseases which are associated with being overweight or obese, and Turconi and Cena (2007) adds that obesity is one of the primary contributors to ill health in modern society. Obesity seemingly exacerbates different health problems and is often associated with adverse effects on health. Gard (2011) strongly argues that obesity has transformed the American Society into not only the most diseased individuals on the planet, but the most diseased group of individuals in the history of human civilisation. Van der Merwe (2003) estimates that nearly half of South Africans over the age of 15 are obese or overweight. This is approximately 45% of our population. The picture Gard (2011) paints for American society may easily be painted with the same brush for South African society. This does not bode well for the already beleaguered South African healthcare system.

A list of associated complications for obesity include hypertension, asthma, arthritis, stroke, dermatological conditions (necrobiosis lipoidica, acanthosis nigricans, ulcers, infections), osteoarthritis, cancers (breast, testicle, liver, cervix, ovary, pancreas, gall bladder, kidney, colon, renal, endometrial, prostate, oesophageal), diabetes mellitus, dyslipidemia, mental health risks (depression, anxiety and binge eating disorder), coronary heart disease, gallbladder disease and hypercholesterolemia, high blood cholesterol, sleep apnoea, dental

disease, gallstones, pulmonary abnormalities, musculoskeletal injury, increased surgical risk, menstrual irregularities and infertility, pregnancy complications and, finally, mortality (Baur, 2002; Brown, 2005; Campbell & Haslam, 2005; Henderson & Brownell, 2004; Kumanyika & Brownson, 2007; Mentz, 2003; Mokdad et al., 2003; Pronk, 2003; Mitchell, Swan-Kremeier & Myers, 2007; Sadock & Sadock, 2007; Turconi & Cena, 2007; Wechsler et al., 2005; Wilding, 2001).

This comprehensive list raises concern. Henderson and Brownell (2004), Kruger et al. (2005), Sadock and Sadock (2007) and Zimmet and Jennings (2008) concur that the health risks of obesity increase morbidity and mortality, and Turconi and Cena (2007) support this by stating that obese individuals have a 50% to 100% increase in chance of potential death, due to associated conditions, compared to individuals who have a healthy weight.

2.16.1. Mental health.

Obese individuals do not experience greater adverse psychological symptoms than non-obese individuals (Henderson and Brownell, 2004). In contradiction, Lewis et al. (2010) state that there is still debate as to whether obesity leads to poor mental health, or whether poor mental health leads to obesity. Regardless of the consequences, or antecedence debate, obese individuals do seem to experience psychological distress. Ogden (2003) supports the idea of mental health issues being associated with obesity - obese patients awaiting bariatric surgery, and other obese individuals, rate themselves as more depressed than the average weight patients. However, depression was not clinical in its severity.

Weschler et al. (2005) claim that mental health disorders are usually found in tandem with obesity and that, in most instances, these disorders are a consequence, not a cause, of the individual's obesity. There is, therefore, no clinical picture of the comorbidity of mental disorders and obesity (Weschler et al., 2005). Obese individuals, however, are associated with a variety of different health risks (see above), and mental health risks may develop into psychological problems, such as depression, anxiety (Baur, 2002; Mentz, 2003; Mokdad et al., 2003; Munsch & Dubiu, 2005; Turconi & Cena, 2007; Weschler et al., 2005). Thus, it appears that obesity may be a risk factor, or cause greater vulnerability, in the development of mental disorders.

Overweight or obese individuals have anxiety and depression levels that are three to four times higher than the general population (Turconi & Cena, 2007; Weschler et al., 2005).

Weschler et al. (2005) comment that depression is nearly doubly diagnosed in obese individuals than in normal weight peers. Muller and Weber (2005) are of the opinion that the depression is reactive, due to the individual's weight situation.

Mitchell et al. (2007) claims that eating disorders, and substance abuse disorders, may also be associated with obesity. In terms of eating disorders, BED is frequently associated with obesity or overweight individuals, as indicated by population-based, community, and clinical samples (Munsch & Dubiu, 2005). Obese individuals also view themselves as socially unattractive, assume that other individuals are speaking about them behind their backs (Wechsler et al., 2005), and suffer from low self-esteem (Turconi and Cena, 2007). Patients with extremely dangerous and disabling morbid obesity are often severely self-disparaging (Yager, 2000).

In some cases, after successful weight loss, the mental health conditions of obese individuals dramatically improve. Nearly 90% of individuals in one research study revealed that they would more easily imagine accepting an amputated leg or going blind, instead of becoming extremely obese again (Wechsler et al., 2005). This finding concurred with other research in which certain obese individuals, following successful weight loss surgery, explained that they would rather be dyslexic, deaf, diabetic, have heart disease, or acne, than go back to the way they were (Rand & McGregor, 1991). These expressions reveal the negative psychological impact that obesity had on these individuals' lives.

Obese individuals do experience some form of psychological difficulties or distress from their condition. Lewis et al. (2010) corroborate that there are multiple associated risks, and links, between obesity and physical health risks. Furthermore, there are now links between obesity and mental and emotional health.

2.16.2. Psychosocial consequences of obesity.

What are the social consequences and implications of obesity? Faith, Matz and Allison (2003) reiterate what has been stated in previous research - that the medical complications of obesity justify weight loss recommendations (Baur, 2002; Brown, 2005; Campbell & Haslam, 2005; Henderson & Brownell, 2004; Kumanyika & Brownson, 2007; Mentz, 2003; Mokdad et al., 2003; Pronk, 2003; Mitchell, Swan-Kremeier & Myers, 2007; Sadock & Sadock, 2007; Turconi & Cena, 2007; Wechsler et al., 2005; Wilding, 2001). However, another challenging area, of equal importance, for obese individuals is the psychological discourse of obesity in society. The anti-obesity attitude is common in society, and often translates into discriminatory practices (Kruger et al., 2005; Neumark & Haines, 2004). This

notion, ushered in by Nyman et al. (2010) are confirmed by several other researchers (for example, Colditz & Stein, 2007; Friedman & Brownell, 1996; Henderson & Brownell, 2004; Muller & Weber, 2005; Puhel & Brownwell, 2003; Puhel & Heuer, 2009; Sadock & Sadock, 2007; Wang, Brownell, & Wadden, 2004). Research findings confirm that obesity is a condition associated with negative social attitudes and discrimination. According to Feldman (2001), discrimination are the actions, which can be negative or positive, taken against members of a certain group as a result of them belonging to a particular group.

Sadock and Sadock (2007) argue that, as a result of the discriminatory practice against obese individuals, they face limited access to healthcare, and can receive biased diagnoses and treatment from both medical and mental healthcare providers. Obese individuals are portrayed as lazy, passive, lacking self-discipline, stupid, cheaters, and ugly (Friedman & Brownell, 1996; Puhel & Brownwell, 2003).

Friedman and Brownell (1996) elaborate that modern culture not only condemns the obese individual's physical appearance, but also assigns blame to him/her for the condition. Faith et al. (2003) add that as a result of being obese, obese individuals are stigmatised.

Stigmatisation refers to the idea that an individual is seen as unworthy or disgraceful (Oxford Dictionary, 1991). Through stigmatisation, obese individuals may suffer in a variety of ways which has a detrimental effect on their body image appraisal, self-esteem, and other psychological characteristics (Faith et al., 2003; Wang et al., 2004). Stigmatisation against obese individuals encourages discrimination. Discrimination, according to Feldman (2001), is a negative act targeted against an individual of a specific group, because of their affiliation to that group. Obese individuals, through discriminatory practices, are more likely to have a poor quality of life and a decrease in social mobility (Colditz & Stein, 2007).

2.16.3. Discrimination and stigmatisation.

Puhel and Brownwell (2003) state that obese individuals are vulnerable to stigmatisation, as it is assumed that these individuals are impulsive and have a lack of will power, motivation, and personal control. Alongside discrimination is an association with poorer health and negative outcomes. Puhel and Brownwell (2003) elaborate that attributions of blame from society are a central component of the negative attitudes towards obese individuals, and that perceived controllability in the aetiology of obesity is important.

In addition to the social consequences, obesity also impacts on an individual's intimate relationships, for example, marriage. According to research conducted by Ledyard and Morrision's (2008) their obese participants described sexual and emotional distancing as a result of their weight. Ledyard and Morrision (2008) educe themes which include the fear that obese individuals have of infidelity and abandonment by their spouses.

According to Wang et al. (2004) there is an increasing amount of research which indicates that obese individuals are discriminated against and stigmatised. The most prominent locales where discrimination and stigmatisation occur include schools, social settings, workplaces and exchanges with health professionals. Baum and Ford (2004) show that obese individuals are also paid lower wages. Additionally, research by Neumark and Haines (2004) explain that obese individuals earn less than normal weight individuals. Compared to other minority groups, the stigma and bias for obese individuals is somewhat different. The negative attitudes towards obese individuals are encouraged and actually accepted (Puhel & Brownwell, 2003; Wang et al., 2004). This is supported by Chang and Christakes (2002) that obesity is the last domain of socially allowable discrimination, due to mounting social and

medical pressure to lose weight. Many obese individuals comment that, in public, they are subjected to ridicule when choosing food; they are teased because of their weight; they are scolded for ordering or eating desert (Wang et al., 2004). This finding is supported by other research which similarly describes the blame that obese individuals endure for their condition. They are subjected to teasing and bias (Puhel & Brownwell, 2003; Puhel & Heuer, 2009; Sadock & Sadock, 2007). This same modus operandi is paralleled on a societal level. Certain television programmes constantly ridicule characters who are overweight, and generally stereotype them as gluttonous, underemployed, and failure to maintain healthy relationships (Wang et al., 2004).

The important consequence is that the pervasiveness of the stigma may affect the beliefs of the obese individual (Wang et al., 2004). Obese individuals may thus hold negative attitudes of themselves due to the internalisation of the weight stigma. Obese individuals' behaviour is therefore different from other minority groups who are also subjected to discrimination based on their race or ethnicity, because they do not internalise the negative attitude (Wang et al., 2004). Wang et al.'s (2004) research conclude that obese individuals appear to internalise the powerful social stigma that is evidenced in society. Consequently, it is determined that obese individuals hold strong and consistent implicit negative associations about being overweight. The participants in Wang et al.'s (2004) study explicitly comment that overweight individuals are lazier than thin individuals. These findings are supported by research by Durso and Latner (2008) who describe the idea of self-stigma concerning the anti-obesity attitude by interviewing obese individuals themselves. Durso and Latner (2008) believe that this form of self-stigmatisation is formed when overweight individuals internalise negative social messages.

Wang et al. (2004) hypothesise a variety of different reasons to explain the stigma against overweight individuals. Firstly, weight may be perceived as controllable, which differs from other stigmatised traits of individuals, such as race or gender. Therefore it is inferred that obese individuals lack responsibility or motivation for a condition that is seemingly under their control. Wang et al.'s (2004) hypothesis is supported by Tiggermann and Anesbury's (2000) research, which concludes that if a medical explanation is provided for an individual's obesity, it reduces the individual's perceived controllability, and makes them more likeable. It is delineated from this argument that if an individual fails in a controllable situation, then they are less likeable. Therefore, any individual who is perceived to have a great amount of control over a situation, and who does not attempt to use self-control, is devalued.

Wang et al. (2004) explain that the refractory nature of weight loss provides evidence of the negative stereotyping of obese individuals. When the individual fails to lose weight, or cannot keep it off, others think that these individuals are lazy, or lack will power. Another aspect may be the discourse of the benefits which seem to be clearly associated with being thin - these individuals have greater power socially and economically. The stigma against obese individuals is significant, and Wang et al. (2004) comment that, unlike other minority groups, obese individuals' lack the in-group protective barriers that race or gender have. Obese individuals therefore suffer from greater negative consequences. These, in turn, lead them to attempt drastic and dangerous behaviours to avoid negative events in the future. Bagchi and Preuss (2007) state that an unlimited variety of weight loss strategies, products, and programs have been generated which may induce rapid weight loss, yet be detrimental to the individual who utilises them.

2.17. Why Lose Weight?

According to Mitchell et al. (2007), obese and overweight individuals tend to have a lower quality of life. Fontaine and Bartlett (2003) relate that weight reduction dramatically improves an obese individual's overall quality of life. Most importantly, it improves an individual's health (Henderson & Brownell, 2004). The basis of this statement is that research into obese individuals who lose weight as a result of surgery, report improvements in a variety of different areas. These individuals experience an overall improvement in physical functioning, mobility, work capacity, confidence, self-esteem, sexual activity, social interactions, and mental health. Other studies also report positive changes in terms of quality of life for weight reduction (De Zwann et al., 2002; Ogden et al., 2006; Pyyziferri, Blankenship & Wolfe, 2006). The results indicate an improvement in psychological health and, as a result of this, generalisations to other areas of life. This improves the individual's psychosocial functioning. Ogden et al. (2006) further elaborate that the improvement is also seen in the individual's health perceptions, social interactions, physical activity and mental health.

Fontaine and Bartlett (2003) conclude that all the research points in the direction that weight reduction promotes significant improvements in health-related quality of living for individuals, even if only a minimal amount. Turconi and Cena (2007) state that weight reduction, even when modest, may reduce the risk of serious health conditions. Individuals who lose weight improve physically, metabolically, and endocrinologically, often in dramatic ways.

According to Fontaine and Bartlett (2003), obesity may adversely affect an individual's capacity to live a full and active life. The researchers explain that it is clear that obesity is not just associated with an exacerbation of medical conditions, but it also appears to have a substantial impact on an individual's overall quality of life. Fontaine and Bartlett (2003) explain that obesity is associated with poorer functional status, which includes an individual's capacity to perform a variety of activities such as climbing stairs, walking, taking part in sporting activities and occupation. Together with these are other areas of impairment, which may include pain, worry, restriction of activities, and a negative general health perception. It is evident that the greater the weight impairment of the individual, the poorer the individual's functioning and quality of life.

To summarise, weight reduction may improve an individual's life. Unfortunately, most of the individuals who experienced improvements from weight loss had undergone successful surgery. This raises two important points. Firstly, in developed Western countries, surgical management of obesity is only recommended for individuals with a BMI of over 40, or a BMI of over 35, if there are complications because of the obesity. It is problematic for individuals with a BMI of 30 to 39.9, without complications, as they do not have access to surgery as a form of treatment. Secondly, in the South African context, surgery is not the best option due to a lack of resources. Wilmore (2003) highlights this issue and states that often the individual cannot afford the costs associated with gastric bypass surgeries. Surgery is therefore only available to a minority of obese patients (Ogden & Sidhu, 2006). Again, the majority of obese individuals, especially in the South African context, do not have access to this form of treatment.

2.18. Treatment

It is identified and explained in the previous section that successful treatment (weight loss) for obesity may result in improved psychological and physical health (De Zwann et al., 2002; Ogden, 2003; Ogden et al., 2006; Pyzziferri et al., 2006). However, Bray (2005) is not optimistic about the treatment of obesity. He comments that a cure for obesity is rare. Treatment is really aimed at alleviating obesity, similar to diseases such as hypertension or hypercholesterolemia; treatment is not a cure.

Bray (2005) does not paint a promising picture for obesity. However, a great deal of energy and hard work has been expended in trying to find interventions for obesity (Gard, 2004). Goodspeed-Grant and Boersma (2005) concur but state that, despite global interest and investment, effective treatment for obesity over the long-term has had very little success. Consequently, obesity levels have not diminished, and are still unaffected (Gard, 2004). This view of its relatively poor prognosis is supported by Sadock and Sadock (2007) and Ogden and Sidhu (2006), who comment that successful treatment for weight reduction is extremely poor. A high percentage of 90% to 95% of individuals who lose significant amount of weight regain this weight in three and five year follow-ups. A plethora of other researchers report similar findings (Ayyad & Andersen, 2000; Byrne, Cooper, & Fairburn, 2003; Henderson & Brownell, 2004; Jeffrey et al., 2004; Wadden, 1993; Wilson, 1995). In some cases, treatment has made the problem worse for the obese individual (Krieshak & Karpouriitz, 1988).

Wilmore (2003) states that public healthcare must mobilise resources to combat the obesity epidemic. More effective strategies need to be developed for treating people who are overweight and obese. It is evident that there has been an effort to do this, however, a

solution at the moment is elusive. Rothblum (1999) sums up the situation by asking when people will realise that the majority of individuals regain their lost weight after treatment, as a proliferation of published studies report. Gard (2004), too, supports this, by stating that the passion to find a solution is coupled with a widely accepted dearth of clear solutions. In turn, this has generated a complex and unpredictable policy regarding treatment. According to Adolfsson et al. (2005), the main treatments for weight reduction are diet, physical activity, gastric surgery and drug therapy, which may all be availed of separately, or in combination with one another. Herein follows is a more specific look at some of the current treatment options.

2.19. Types of Treatment for Obesity

2.19.1. Eating and exercise.

Eating is energy consumption; and exercise is energy expenditure. Goodspeed-Grant and Boersma (2005) claim that treatment options for obesity usually include some form of dieting restriction, accompanied with structured nutritional programmes. These programmes help the individual with suitable nutrition, dietary counselling, exercise, lifestyle modification, behavioural, cognitive-behavioural, psychodynamic therapy, and drug therapy. The last resort is surgery. Sarwer et al. (2004) agree that exercise accompanied with a balanced diet are the key aspect of any treatment plan, and that treatment normally revolves around a low to very low calorie diet. A low calorie diet refers to an intake of 800 calories to 1200 calories per day; whereas a very low calorie diet refers to an intake of up to 800 calories per day. This type of diet is usually ingested as a liquid meal replacement (Sarwer et al. 2004). Campbell and Haslam (2005) highlight that physical activity is also significant. They explain that

efforts should be concentrated on increasing an individual's activity, and that such an individual should also be given lifestyle advice.

Many obese individuals turn to pharmacological and surgical interventions as a result of their disappointing results from conventional methods. Wilmore (2003) recommends the following solution: He states that the way forward is to address the problem by integrating nutritional and exercise interventions. In conjunction with this, psychological treatment options may be considered, for example behavioural, cognitive behavioural, and psychodynamic therapy (Sadock & Sadock, 2007).

2.19.2. Psychological interventions

This section explores the psychological treatments which may be offered in conjunction with other interventions such as nutrition and exercise. According to Sadock and Sadock (2007), some of the most prominent psychological treatments for obesity include insight-orientated psychodynamic therapy, cognitive behavioural therapy (CBT), and group therapy.

Unfortunately, psychological treatments are not demonstrably successful. For example, during the course of psychotherapy, an individual may uncover the causes for overeating, yet this does not mean that they will alter their behaviour. Obese individuals may, in some cases, also become dependent on their therapist (Sadock & Sadock, 2007). Furthermore, some individuals overeat due to stress, and will continue along the same path even after psychotherapy has ended. Although there are a variety of psychological treatments, the most predominantly used technique for obesity is behavioural therapy (Campbell & Haslam, 2005; Ogden & Sidhu, 2006; Sarwer et al., 2004). Sarwer et al. (2004) corroborate this and they claim that it is also the most widely researched intervention.

2.19.3. Behavioural therapy.

According to Campbell and Haslam (2005), behavioural therapy is the collective name of various methods and strategies which are aimed at bringing about change in an individual's lifestyle. Behaviour therapy for obesity is aimed at tackling specific areas of a person's lifestyle, namely, the tendency of obese individuals to overeat, and their tendency to under-exercise. Although it is an oversimplification, the focus of behavioural therapy comes down to helping an individual identify and modify inappropriate eating behaviours, promoting exercise, and encouraging individuals to think about the habits that contribute to their weight problem (Sarwer et al., 2004). Its basic premise is to alter the intake or expenditure of energy, or if possible both (Laessle, 2005).

According to Laessle (2005), obese individuals treated with behavioural therapy typically regain about 30% to 35% of their lost weight one year after treatment has terminated. This is supported by, for example, Ayyad & Andersen, 2000; Byrne et al., 2003; Henderson & Brownell, 2004; Jeffrey et al., 2004; Wadden, 1993; Wilson, 1995. Usually, after 5 years after treatment has terminated, 50% of these individuals will most likely return to their original baseline weight (Laessle, 2005). Wadden et al. (1990) found similar results 15 years prior.

In summary, the psychological intervention of behavioural therapy for obesity only delays, but does not prevent, weight gain. Behavioural therapy does not work over the long-term for obese individuals (Laessle, 2005). Campbell and Haslam (2005) confirm Laessle's (2005) observation, and argue that whereas short-term weight loss may be achieved, long-term

outcomes are poor, if not, insignificant. One of the strongest proponents of psychological treatment for obesity is behaviour therapy; however, weight reduction using this technique is inconsistent, and seems, ultimately, to have a poor outcome (Ogden & Sidhu, 2006).

According to Adolfsson (2005, p. 55), "the success of behavioural change programmes may be the result of the participants assuming responsibility for their treatment outcome, rather than any specific component of treatment" (Adolfsson et al. 2005, p.55).

2.19.4. Surgery and medication treatment.

What about the other treatment modalities such as medication and surgery mentioned by Wilmore (2003)? According to Ogden and Sidhu (2006), the majority of obese patients are treated with interventions which involve either cognitive or behavioural techniques designed to facilitate change in their diet and exercise regimes. In light of the general failure of these interventions, many patients and clinicians have turned to medical solutions, such as surgery and medication (Ogden & Sidhu, 2006; Wilmore, 2003).

2.19.4.1. Surgery.

Mitchell et al. (2007) state there has been an increase in the use of bariatric surgery for treating individuals with obesity. Groven et al. (2010) explain that, as a result of the failure of traditional methods, there is a prolific rise in the number of individuals who are turning to surgery. Wysoker (2005) contributes that obese individuals taking advantage of surgery has increased by 450% in the short time-frame between 1998 and 2002. This has been especially true for obese individuals with a BMI over 40 or over 35, with comorbid conditions like

hypertension or diabetes (Henderson & Brownell, 2004; Mitchell et al., 2007; Ogden et al. 2006).

Gastric bypass is, in essence, a surgical procedure in which the stomach is made smaller by stapling, or transecting, the stomach curvatures (Ogden & Sidhu, 2006). Surgery is only available to a minority of obese patients (Ogden & Sidhu, 2006). Henderson and Brownell (2004) state that surgery may be lifesaving for the individuals concerned, however, it is reserved for morbidly obese individuals; and it is expensive. Surgery has been demonstrated to be effective for both weight loss and weight maintenance, especially for individuals for whom other methods have failed (Ogden; 2003). Wilmore (2003) highlights, though, as previously mentioned, that economies cannot afford the costs associated with gastric bypass surgeries for most individuals. This leaves another alternative, namely, medication.

2.19.4.2. Medication.

Ogden and Sidhu (2006) declare that long-term drug use is another solution for overweight individuals. Patients who meet the prescribing guidelines of a BMI greater than or equal to 30, or greater than or equal to 27 with a comorbid condition, may be candidates for medication. These individuals should be motivated to undertake current lifestyle changes (Bray, 2005). Sarwer et al. (2004) indicate the utility of weight loss medication. The ingestion of Sibutramine (Meridia) leads to a decrease in appetite; Orlistant (Xenical) prevents the absorption of fat in the digestive system. Individuals will usually only lose 7% to 10% of their original weight by ingesting medication and, after prolonged use of medication, this latter figure drops to a weight loss of 8% (Sarwer et al. 2004).

Mentz (2003) sees obesity as a chronic disease, requiring continued treatment, and considers that short-term drug treatment is probably not effective. He raises the point that treatment with medication is likely to be necessary for years; and that the data on the long-term safety and efficacy of medication is very limited and appears to be very disappointing. Bray (2005) also comments that a vast majority of doctors are wary of prescribing medication in managing and treating obesity. Firstly, certain medication has been associated with negative consequences - some medications may be addictive; others are associated with injury, and even death (Sarwer et al. 2004). In addition, the side-effects of weight-loss medication are extremely unpleasant because fat is being removed from the body, such as liquid stools and anal leakage (Ogden & Sidhu, 2006). Secondly, according to Sadock and Sadock (2007), although drug treatment may be effective, tolerance to the effect of appetite suppression may develop after number of weeks, and render some drugs ineffective. Medication is, therefore, not routinely recommended in the treatment of obesity, according to The National Task Force on the Prevention and Treatment of Obesity (1996).

2.19.5. Summary of treatments.

"Most obese persons will not stay in treatment of obesity. Of those who stay in treatment, most will not lose weight and of those who do lose weight, most will regain it" says Stunkard (1958, p.79). In summarising treatment options for obesity, it seems that very little has changed since 1958. Gard (2004) states that losing weight is not difficult. Substantial amounts of weight loss is achieved when individuals seek treatment themselves. Follow-up studies indicate that the lost weight is regained. Many diets, or other interventions, do result in weight loss, however, almost none appear to work for very long (Gard, 2004).

Gard (2004) contends that the individuals find it difficult to adhere to weight loss interventions, but that it is not the intervention itself which does not work. Hence, the long-term maintenance goal of weight loss is not easily achieved (Campbell and Haslam, 2005). Earlier it was mentioned that the aetiology of obesity may be key to understanding how to treat it (Vogele, 2005). Despite years of research, there is still uncertainty as to the basic causes for obesity. He explains that this uncertainty remains one of the biggest obstacles to creating an effective strategy for prevention and treatment of obesity. He makes the point that the reason why treatment has been ineffective in the long-term is because we have not understood its causes.

2.20. Conclusion

The reviewed literature has shown that treatment fails over the long-term. There are opposing positions regarding the question of personal control in eating behaviour among people who are obese. On the one hand, it is implied in the research that obese individuals have the ability to make a choice to regulate their eating behaviour. The research regarding locus of control, self-efficacy, self-regulation, and attribution tendencies substantiates this (Baranowski et al., 1997; Degher & Hughes, 1999; Goodspeed-Grant & Boersma, 2005; Scoffer et al. 2010). Similarly, research conducted on the experience of nurses and doctors who work with obese individuals substantiates this too (Barlow & Dietz, 2002, Brown, 2006). For obese individuals, themselves, their experiences indicate that they feel that they have little control over their weight, and that weight management should be the responsibility of healthcare professionals (Goodspeed-Grant & Boersma 2005).

As mentioned above, there has been very little long-term successful results for obesity, despite the prolific interest and investment that has been directed towards the subject (Ayyad & Andersen, 2000; Byrne, Cooper et al., 2003; Henderson & Brownell, 2004; Jeffrey et al., 2004; Wadden, 1993; Wilson, 1995). There has not only been substantial investment financially, but also extensive hours have been spent in trying to address the issue of obesity. The returns on the investment, however, have not been positive, and the obese individual still suffers mentally, physically, socially, and financially (Baur, 2002; Mentz, 2003; Mokdad et al., 2003; Pronk, 2003; Puhel & Heuer, 2009; Puhel & Brownwell, 2003; Sadock & Sadock, 2007; Withers, 2008).

The following points are short summaries of the main findings regarding obesity from the reviewed literature above:

- The reviewed literature highlights obese individuals' experiences of discrimination and stigmatisation,
- The reviewed literature highlights the inadequacies of all main treatment modalities for obesity.
- The reviewed literature points to the fact that after treatment has been terminated, individuals fail over the long-term to keep off their weight.
- The reviewed literature highlights the discrepancy regarding issues of responsibility for weight loss and weight management.
- The reviewed literature highlights deficiencies in understanding of the aetiology of obesity.

From the reviewed literature, there seems to be a great dissatisfaction with the treatment of obesity, or the implementation of such treatment. The question arises as to how practitioners or researchers may go about changing the current situation. Goodspeed-Grant and Boersma (2005) state that there are many reasons why individuals find it difficult to maintain a healthy body weight, and any attempt to gain greater knowledge of this issue should be educed from the personal experience of the individuals who struggle with the issue. Brown (2006) expresses that information should come from the sources themselves; from the perspective of the obese individuals whose perceptions and meanings are surely critical to understanding the attitudes that influence the healthcare service experience. Brown (2006) therefore recommends that it is important to understand the complexity of attitudes, beyond the common stereotypes, to understand the beliefs about causes and personal responsibility of obese individuals, and how this affects their quality of life.

The researcher agrees with Brown (2006) and Goodspeed-Grant and Boersma (2005) as the term obesity has been conceptually inflated, according to Deacon's (2005) description of the term. This means that obesity and its meaning changes according to a variety of different people. According to Manzo (2004), obesity has to-date been socially scientific gloss in that it reveals less about the experience of the person interpreted, and more researchers' interpretation and explanation of the term.

In summary, the researcher contends that information must come from the personal experience of the individuals who struggle with the issue, as per Goodspeed-Grant and Boersma (2005) and Brown (2006). In the following chapters, the theoretical frame from the studies that are analysed for the qualitative systematic review is explored, the research

methodology is explained, and then the data is analysed. Finally, the results are discussed and explored.

Chapter 3: Phenomenology: Theoretical Basis of the Studies Analysed

3.1. Introduction

The previous chapter proposes that information should come from the personal experiences of individuals struggling with obesity (Brown, 2006; Goodspeed-Grant & Boersma, 2005). Therefore, the theoretical framework of the studies which are analysed in this qualitative systematic review, are phenomenological, because phenomenology is primarily concerned with the lived experiences of individuals (Harper, 2012). In this chapter, phenomenology in psychology is explored, with an initial focus on its philosophical origin. The chapter then discusses descriptive phenomenology and interpretative phenomenology. The focus shifts and concludes with a description of the epistemological and ontological underpinnings and implications of understanding, offered in the studies which will be used for the qualitative systematic review.

According to Dowling (2005), there are a variety of schools of phenomenology, and although they share commonalities, they have specific features. For that reason, the shared assumptions of phenomenology are discussed first.

3.2. Philosophical Origins of Phenomenology

Phenomenology refers to both a philosophical tradition and a research methodology, which, according to Walters (1995) are inseparable; often it is difficult to distinguish one from the other. Phenomenology's origin may be traced back to Kant and Hegel; however, Husserl has been described as the founder of phenomenology (Giorgi, 1997; Vandenberg, 1997; Walters,

1995). Groenewald (2004) states that Husserl rejected the belief that objects which are in the external world can exist independently and, on this basis, he rejected the validity that one can ascertain independent information from those objects. Consciousness, Husserl believed, is therefore the only way in which individuals can be certain about how things appear or present themselves (Ashworth, 1993; Giorgi, 1997; Groenewald, 2004). To arrive at a point of certainty, anything which exists outside immediate experience must be ignored; the external world is reduced to the contents of personal consciousness (Giorgi, 1997; Groenewald, 2004; Harper, 2012; Van Manen, 1984). Thus, one's reality is treated as pure phenomena and this is considered the source of the absolute data for the researcher (Groenewald, 2004). The aim of phenomenology is, therefore, to return to the objects themselves (Ashworth, 1993; Giorgi, 1997; Groenewald, 2004). The view of phenomenologists is that the subjective experience is the only real world which may be described with adequacy.

There are a variety of philosophical schools of phenomenology. The two main philosophical schools of phenomenology in psychological research are descriptive and interpretative (Harper, 2012). These two main philosophical schools of phenomenology will make up the data pool of studies, to be used for the qualitative systematic review. It is important to understand the distinction between descriptive and interpretative phenomenology, as they have different assumptions which influence their research design, the methodology, and strategies. Therefore, these two schools are to be explored in further detail.

3.2.1. Descriptive phenomenology.

According to Lopez and Willis (2004), Husserl's philosophy adopts the postulate that there is value in the experience of human consciousness and, consequently, this should be the object

of scientific investigation. Walters (1995) says that the descriptive phenomenological approach conceptualises the individual as a subject in the world of objects and, therefore, retains the Cartesian notion of the object and the subject. According to Walters (1995), the object of study is the manner in which consciousness is focussed onto the world, that is, how an individual's consciousness intentionally perceives things in the world. Simply stated, the object of study is the relationship between a person's consciousness and the world. Emphasis is placed on describing the full appearance of the object of enquiry (Wojnar & Swanson, 2007). In doing so, the use of bracketing suspends naïve realist awareness. This concept is elaborated on in the following paragraph. The core idea is that humans are free agents who are responsible for influencing the environment, and therefore context is of peripheral importance at most, which for interpretive phenomenology is of central concern (Wojnar & Swanson, 2007).

It is essential that the prior personal knowledge of the researcher is shed, in order to grasp the lived experience of those who are studied. All prior conscious knowledge, and personal bias, is actively stripped (Lopez & Willis, 2004). The aim, according to Lopez and Willis (2004) is to achieve transcendental subjectivity. Hence, the impact of the researcher is constantly assessed, and all bias, and any preconceptions, are neutralised. This is because the prior knowledge of the researcher should not influence the object in the given endeavour (Harper, 2012). This is achieved by bracketing (Giorgi, 1997; Wojnar & Swanson, 2007). According to Wojnar and Swanson (2007), bracketing is used so that all prior knowledge is suspended. In doing so, a clear description may be formed about the phenomena, and there is no interference from the interpretative influences. The researcher effectively sets aside all pre-existing experiences, knowledge, and values.

In summarising the descriptive approach, the researcher focusses on describing the universal essences (Wojnar & Swanson, 2007). The individual is perceived as a representative of the world in which they live, and consciousness is shared between humans (Lopez & Willis, 2004). Giorgi (1997) explains that the researcher adopts a process of self-reflection, which suspends his/her previous knowledge and aids in the presentation of a free description. This is one way to establish scientific rigour; to ensure the accurate description of universal essences (Giorgi, 1997; Wojnar & Swanson, 2007). Giorgi (1997) argues that through bracketing, there is biased free interpretation.

3.2.2. Interpretative phenomenology.

According to Lopez and Willis (2004), phenomenology is a philosophical and research approach. Lopez and Willis (2004) state that phenomenology has developed and changed over time. This is evident in the manner phenomenology has changed as a consequence of Heidegger's influence. It is Heidegger's influence on phenomenology that has resulted in interpretative phenomenology. Interpretative phenomenology, according to Walters (1995), transcends the epistemology of intentionality, and questions the whole mode of thinking whereby the subject and the object are signified as a basic epistemological distinction. The interpretative approach is rather concerned with exploring the relationship between human thought and human existence, without any presumptions that the examination be subordinate to the search for objective knowledge.

Wojnar and Swanson (2007) explain that, for Husserl, context is peripheral; but for Heidegger, context is of central concern. Lopez and Willis (2004) explain that humans are embedded in the world, so their experiences are inextricably linked with social, cultural, and

political concepts. This idea is conveyed via the concept of situated freedom: Individuals are free to make choices, however, the freedom is not absolute because it is circumscribed by the conditions of the daily life. All meaning arises from the total existential reality, of the human being, or the situated freedom, referred to earlier (Lopez & Willis, 2004). This differs from other phenomenological methodologies, which are based on Husserl's approach.

Interpretative phenomenology does not require that the researcher bracket his/her own preconceptions during the process. According to Crist and Tanner (2003), for interpretative phenomenology, the significance of the existing world and its meaning for the researcher is included, as the assumption is that individuals are inextricably situated in a world. Heidegger sees phenomenology as the examination of the totality of human existence, and uses the term *dasein* to indicate that the person and the world are inseparable. Heidegger describes the relationship between the individual and the world as "being in the world" (Dowling 2007, p.216), which is another way of understanding the relationship - without the world, humans would not exist, and without humans, the world would not exist.

Heidegger's ideas are in direct opposition to descriptive phenomenology's concept of radical autonomy. In essence, Lopez and Willis (2004) elaborate that interpretative phenomenology does not seek purely descriptive categories of the real world in the narratives of individuals. It focusses, instead, on describing the meaning of the individual's being in the world. That is, meaning is made up of choices, which are, in turn, influenced by different forces.

Interpretative phenomenology is an analysis of the historical, social, and political forces that shape and organise our experience. It is the interpretation of the narratives which are provided by the participants in relation to the various contexts which is fundamental (Lopez & Willis, 2004).

The focus for interpretative phenomenology is the interpretation of the conditions, or contexts of human experience, as understood by those who live it. According to Wojnar and Swanson (2007), Heidegger developed his approach to phenomenology based on the premise that humans are situated in, and are constituted by their cultural, social, and historical contexts. They then bring that understanding to their interpretation and attach a meaning to it, which is their lived experience. Interpretative phenomenology is a process and a method for bringing out, and making manifest, what is normally hidden in human experience and in human relations (Crist & Tanner, 2003). It goes beyond the description of the core concepts in essences, and consequently focusses on looking for the meaning which is embedded in common life practices. Meaning, however, is not always apparent to the individual, but it can be gleaned from the narratives which are produced by them. Therefore, the focus of interpretative phenomenology is on the individual's experience, rather than on what they consciously know (Crist & Tanner, 2003).

How is phenomenology relevant to research on obese adults? How does this contribute to psychology? Ashworth (1993) asks the same question by asking how a phenomenological theory may be of use in psychology, and asks how meaning may be found in its descriptions. Ashworth (1993) elegantly answers these questions by stating that, in essence, descriptions contain words and sentences, which are capable of depicting a situation as it exists for the individual experiencing it. These words and sentences convey meaning. Meaning is like a bridge which connects and can actively reveal much about the consciousness which produces it. He concludes that psychology is the study of conscious beings, hence the analysis of the meaning by conscious beings leads to further psychological discoveries.

In the introduction to this chapter, the reader is reminded of Brown's (2006) and Goodspeed-Grant and Boersma's (2005) statements that information must come from the personal experience of the individuals struggling with obesity. Phenomenology concerns itself with the subjective experience of the individual. Therefore, phenomenological studies have been chosen for analysis, which corresponds to this dissertation's topic. To be clear, phenomenology in this study concerns the epistemological and ontological framework in which obese individuals are understood, within the studies which will be used for the qualitative systematic review.

To clarify, Harper (2012) explains that epistemology refers to what is feasible to understand in the studies, and ontology refers to what there is to understand in the studies, otherwise known as the realism-relativism continuum. He elaborates that varied traditions approach these questions in different ways, and that there are a number of different aspects to the solutions to these questions. However one significant aspect is the variation of the answers, namely whether the facts reflect reality. This is better understood as the realism-relativism continuum in the answers (Harper, 2012). Realism is where gathered facts reflect reality, and relativism is where there are many acceptable explanations of a fact (Harper, 2012).

According to Harper (2012), phenomenology is not on the realist side of the continuum, but is neither on the relativist side of the continuum. Phenomenology, rather, adopts the notion that there is a correspondence between what an individual states and their subjective experience. In light of this, phenomenology is generally understood to be located in the centre of the realism-relativism continuum (Harper, 2012).

Phenomenology is relevant to this study as the researcher will qualitatively systematically review studies which explored the subjective experience of the individual (Zambardo, 1995).

The understanding of things in these studies, therefore stem from the individuals' viewpoints of experience, or their truths (Ashworth, 1993; Harper, 2012; Giorgi, 1997; Groenewald, 2004; Zambardo, 1995). In summation, through the qualitative systematic review of phenomenological studies on obese individuals, psychological discoveries may emerge from meaning-making, as Ashworth (1993) explains.

3.3. Conclusion

This chapter highlights the role of phenomenological theory in this research. Phenomenology is the philosophy and research method that is used in the studies which will be analysed in this qualitative systematic review. It concerns the epistemological and ontological framework in which obese individuals may be understood within the data pool which will be used for the qualitative systematic review.

In analysing phenomenological studies, for the purpose of this qualitative systematic review, the implication of these assumptions is that the researcher will achieve an increased phenomenological understanding of the lived experiences of the obese individual.

Phenomenology acknowledges subjectivity. As such, the obese individuals' descriptions are not seen as either universal truths (realist assumption) or truths so relativist that nothing can be summarised from them in the research findings. The world of the obese individual can be known through the process of inter-subjective meaning-making. Interpretations are therefore of primary importance. These are not the assumptions of the present study, but are the assumptions of the studies which are analysed.

This chapter is a discussion and exploration of the theoretical underpinnings of the studies which are included and analysed in the qualitative systematic review. The following chapter discusses and explores the research methodology.

Chapter 4: Research Methodology

4.1. Introduction

"I can easily understand all the explanations I have ever heard, but I cannot understand the thing itself" (Bion 1982, p. 272). This quotation eloquently encapsulates the theme of the literature review chapter. Although there are a plethora of explanations regarding obesity and its treatment, practitioners are no closer to a solution to the problem. Furthermore, poor treatment outcomes emphasise that "the thing itself" (obesity) is not fully understood. This qualitative systematic review therefore set out to address the issue of gaining a better understanding of "the thing itself". The outcome of this research may improve our understanding of obesity and, therefore, inform future research. Tricco et al. (2011) comments that the combining of knowledge, which is the aim of this research, is of primary importance in terms of narrowing the gap between research and decision-making.

The methodology of this research falls within the qualitative research paradigm. It is a qualitative method that is used for combining qualitative research findings. More specifically to this research, to systematically review studies on phenomenological research regarding adults' experiences of being obese. This chapter begins by defining and describing qualitative research, and then moves on to focusing on the research methodology relevant to this research project. This is then extrapolated, and the chapter concludes with a discussion on the soundness of the research.

4.2. Qualitative Research

Fouché and Delport (2005) explain that qualitative research comes from the interpretative alternative to positivistic and empiricist traditions. It is idiographic and holistic, and primarily aims to understand social life, and the meaning people attach to everyday life. They further elaborate that qualitative research procedures are not strictly formalised, and the scope is more than likely undefined because a more philosophical stance is adopted. Babbie (2002) extrapolates that the distinction between quantitative and qualitative research is a distinction between numerical and non-numerical data; the latter referring to qualitative research. Neuman (2003) supports this, by stating that the difference is in the nature of the data, whereas qualitative research uses soft data such as words, symbols, and sentences, quantitative research uses hard data in the form of numbers. Jones (2004) sums it up by stating that numbers are abandoned for the enigma of words. However, it must be noted, that although research may be divided along a qualitative and quantitative paradigmatic line, this is not a fixed distinction. Within current research, there is now an emphasis on mix-methods designs, which is challenging clear-cut distinctions. The research method of this research is a qualitative systematic review.

4.3. Qualitative Systematic Review

The broad gamut of review studies may be divided into qualitative, quantitative, and mixed-method approaches (Sandelowski & Barroso, 2006). Within this range, the term ‘systematic review’ may be confusing. Generally, the term refers to a quantitative approach, whereby data from primary studies are statistically analysed in an aggregative manner (Petticrew & Roberts, 2006). As such, it falls under the ambit of meta-analysis, which aims to produce an

aggregative synthesis (Sandelowski & Barroso, 2006). For a qualitative systematic review, however, the research is analysed interpretatively (Dixon-Wood et al., 2006). It is explained that the synthesis of numerous findings on the same topic in qualitative research is an important part of increasing its utility and relevance (Sandelowski, Voils and Barroso, 2007). Therefore, the purpose of the qualitative systematic review is to enhance the interpretative understanding of information, and the creation of new findings, which are greater than those found in the individual studies themselves (Meadows-Oliver, 2006; Petticrew & Roberts, 2006; Sandelowski & Barroso, 2006). Therefore, it is not just a summary of research results. Hughes, Closs and Clark (2009) make mention that the methodology is still in early phases, and there is debate as to whether it is epistemologically appropriate.

To briefly outline this statement regarding epistemology: Dixon-Woods et al. (2006) explain that the debate seems to be whether there is an appropriate match between the frame offered by conventional, quantitative, systematic review methodology, and qualitative epistemological expectations and research practices. The argument lies in trying to conclude whether a systematic review designates a very precise methodology with very distinct features, or whether it is a wide framework which can permit multiple forms of evidence syntheses to be undertaken. To dig deeper into the debate, no consensus is yet reached as to whether it is appropriate to synthesise research from differing perspectives. Furthermore, no consensus has yet been reached as to the quality of synthesised qualitative research (Dixon-Woods et al., 2006). These are some of the issues concerning qualitative systematic reviews methodologies, which will not be resolved anytime soon and which are beyond the scope of this research. The qualitative systematic review is used in this research, although this method like other research methods is not free from critique. However, this research took the

epistemological critique into account, and will discuss the solution reached to avoid this in this qualitative systematic review.

Qualitative systematic reviews are also not the same as systematic or critical literature reviews. The latter usually forms part of a backdrop against which a body of research may be understood (Sandelowski & Barroso, 2006). These approaches to literature do not aim to answer a specific research question, which is the case of qualitative systematic reviews, but to give an overview of relevant literature (Petticrew & Roberts, 2006). Critical literature reviews draw from a wide range of sources, for example, books, journal articles, and movies as data, whereas the data of qualitative systematic reviews are the primary findings of the studies (Meadows-Oliver, 2006; Sandelowski & Barroso, 2006).

In consideration of the generalisation of the findings, Petticrew and Roberts (2006) state that qualitative findings do not rely on numerical data, but on the conceptual analyses and presentations. In this regard, trying to place qualitative research into a different research paradigm will likely result in a loss of meaning and understanding from where the data is drawn. They further argue that good qualitative research generates new hypotheses. For the purpose of this research, Hughes et al. (2009, p. 1139) describes that a qualitative systematic review is "an attempt to integrate findings across studies to arrive at new understandings".

Sandelowski and Barroso (2006) clarify the idea of generalisation with regards to qualitative systematic reviews further, with the concept of idiographic generalisation. They elaborate that the qualitative systematic review is an attempt to generalise findings. However, it does not claim to, or aim to, make broad overarching generalisations as would be made by quantitative reviews. Rather, its aim is to create idiographic generalisations - knowledge of

the particular. With regards to this research, this is generalisable idiographic knowledge of the experiences of being an obese adult.

The generalisations are drawn from informationally representative cases, simply meaning that the studies are about the same thing. The following definition encompasses the viewpoints of the authors mentioned above: As a result of the richness, depth, and thickness of description from these contexts, there is the ability to generalise from and around these contexts, across to different contexts.

According to Sandelowski, Voils and Barroso (2008), a qualitative systematic review is one of the most objective and laborious, transparent and reproducible, methods of combining results in the social sciences. It is objective in that it explicitly states what occurred procedurally in the research process, making all the steps taken transparent, and documenting the progression of the research. All this aids in the review's credibility, its applicability, and – importantly - its usefulness (Tricco et al., 2011). Jones (2004) states that systematic is, by definition, a system, or an organised method. This research is a qualitative systematic review, modelled after the steps of progression outlined by Tricco et al. (2011). The decision to follow Tricco et al.'s (2011) model was based on the authors' examination of a variety of systematic reviews. The authors describe a general method for conducting a systematic review, which may be seen as applicable, and standard to most qualitative systematic reviews. However, there is always flexibility in terms of the steps followed in producing a systematic review. This is explored and explained in the following sections.

4.3.1. Qualitative systematic review method.

The following section describes the steps which were taken in this qualitative systematic review. The steps are not to be seen as linear or rigid. Sandelowski (2008, p. 105) elaborates that “although systematic reviews are by definition methodical in that they mandate adherence to an orderly and communicable system for conducting them, no one method, nor one execution of any one of these methods, is used to conduct any one of the stages prescribed for them”. As such, the steps are iterative and adaptable. Jones (2004) summarises the process in stating that the hallmark of good qualitative methodology, in this case a qualitative systematic review, is to be found in its flexibility, rather than its standardisation. The process can be understood as follows:

4.3.1.1. Developing a review question.

Eakin and Mykhalovski (2003) suggest that the review question should be regarded, not as an anchor, but rather as a compass. Dixon-Wood et al. (2006) support this by explaining that the review question may be modified in response to the search results, and the content or quality of findings. The review question, therefore, is thus preliminary and serves as a guiding function. With the review question in place, locating the relevant studies may commence.

4.3.1.2. Locating studies.

According to Tricco et al. (2011), the research question guides the location of the relevant studies, and usually involves database searches. The search starts off broadly, for example, with a Google Scholar Search, to determine if such a research study may be viable, in that

there are sufficient potential studies from which to draw data. If viable, then the search may be made more specific to electronic health-related databases, and other subject-specific databases (Tricco et al., 2011). The search may be enhanced with ancestry or descendency approaches (Sandelowski et al., 2008), or the search may be conducted in consultation with an experienced subject librarian (Xu, 2008). Other forms of searches, which are described as “berry picking”, according to Barroso et al. (2003), may include hand-searching journals, searching reference lists of studies that are indicated, or trial registries.

4.3.1.3. Selecting studies.

After potentially relevant studies have been identified, it is necessary to determine which of these match the purpose of this study. That is, do they answer the initial research question? Screening criteria are developed, and studies are reviewed against this. One of the possible contentious screening issues is the determination of whether a study seems to be weak in terms of methodology or findings.

Findings, in qualitative work, according to Sandelowski et al. (2008) are not differently weighed on account of their sample size. Rather, qualitative research findings gain their significance from the capacity to illuminate or explain. This means that even single case-study research may be included. In addition, according to Pawson (2006), the value of any report in a systematic review is only really determined in the course of conducting the review. There is, therefore, a distinction made between the quality and utility of a study; even some of the weakest methodological studies may potentially be of value in the development of knowledge. According to Tricco et al. (2011), regardless of which studies are chosen, the inclusion criteria are to be thoroughly considered, properly defined, and transparently

reported. This ensured that any ambiguity is avoided during the review process, and enhances the credibility of the review that is undertaken.

4.3.1.4. First reading of studies.

In this step, the researcher becomes familiar with the landscape of each study. Preliminary notes are made and possible themes are identified. Due to the flexibility of the process, the studies may be revisited and read over again, repeatedly (Hughes et al., 2009; Tricco et al., 2011). This step also helps to determine whether the selected studies are suitable for analysis.

4.3.1.5. Identifying and extracting findings.

According to Sandelowski and Barroso (2006), the findings from the qualitative research reports provide the hard data for the systematic review. Hughes et al. (2009) assert that it is vitally important to immerse oneself in all the relevant findings in the study. A finding according to Sandelowski and Barroso (2006, p.152) is specifically defined as an item “consisting of research interpretations of the interviews, observations, and other data they collected or generated in their studies”. When data from the different research studies have been identified and established, the process commences of extracting this information and grouping the information into themes. According to Noblit and Hare (1988), extraction of information and subsequent grouping into themes can be achieved by creating a metaphor or a list of themes, juxtaposing these themes, and then ascertaining how the themes are related.

The qualitative systematic review should be rigorous and transparent, but it is acknowledged that a study’s process is inescapably subjective (Harden et al., 2004). According to Harden et

al. (2004), the situation in which the reviewer deconstructs a study in order to reconstruct the information in a usable report is a displaced encounter. This aspect is highlighted because as Sandelowski et al. (2008) explain, showing the subjectivity of a systematic review does not argue against it, but instead demonstrates an exercise in the transparency towards which it is directed.

4.4. The Research Process: Applied Methodology and Method

This section is a discussion of the research process. The steps described above are elaborated upon as they were applied to this research study.

4.4.1. Developing the review question.

The review question was initially informed by the researcher's intellectual curiosity regarding obesity. This curiosity impelled the researcher to thoroughly consult the general literature on obesity. The various literature included books, and numerous research articles, located in both qualitative and quantitative paradigms. From previous perspectives and current debate in the literature, a general impression regarding obesity was established. Brown (2006) is one of the poignant researchers who motivates for a qualitative research study, with an emphasis on phenomenology. The research question was influenced by the demands of the method and methodology, and the decision of reviewing phenomenological studies, as they address, specifically, the experience of obesity.

Instead of the contribution of yet another phenomenological study on obesity, the choice was made to conduct a qualitative systematic review. The researcher took into consideration

Tricco et al.'s (2011) assertion that the combination of knowledge is of primary importance to close the gap between research and decision-making. With regards to conducting the qualitative systematic review, the researcher was not working in a team and this is a mini dissertation with time and financial constraints, while also keeping Brown's (2006), statement in mind. The focus on only one type of qualitative research was chosen. This would allow the researcher, to have a manageable amount of studies, all within a broad tradition of phenomenology. By conducting the qualitative systematic review in this manner, the researcher also avoided any unresolved dilemmas at present, regarding synthesising qualitative research findings from different epistemological stances as previously mentioned in this chapter.

After an analysis of the material, and in consultation with the researcher's supervisor, the preliminary review question became as follows: "What would a qualitative systematic review elucidate about phenomenological research on adults' experiences of obesity?" As previously discussed, Dixon-Wood et al. (2006) states that the review question may be modified in response to the search results, and the content or quality of the findings in the studies identified. The researcher points out that as the search yielded positive results, a sufficient number of studies were identified from which data was drawn. Therefore the preliminary review question was not modified throughout the research process. Instances wherein it would have been necessary to alter the review question would have been if there were too many, or too little, phenomenological or adult studies on obesity. Too many studies would be too vast and unmanageable for a minor dissertation, because of time and financial constraints. Conversely, too few studies would be insufficient to conduct the qualitative systematic review.

4.4.2. Locating studies.

The research question was formulated based on the general literature review, and the requirements of methodology as discussed in the previous section. Following the establishment of the review question, specific search terms needed to be identified to commence with locating relevant studies for the research. Based on the sources reviewed and discussion with the researcher's supervisor, the search terms identified and used were: obesity; overweight; fat; adult; experience; and phenomenological. The researcher and the researcher's supervisor independently conducted searches on Google Scholar to determine the feasibility of the study. It was ascertained that there were studies to analyse. This led, in turn, to more extensive searches of other databases. The databases that were searched were: Academic Search Premier, Africa-Wide, CINAHL, EBSCOhost, Elsevier, Humanities International Complete, Infotrac, Informaworld, Proquest, Science Direct, SiVERSE, and Wiley. In addition, an electronic search was conducted for similar dissertations to the proposed study, which yielded a negative result, to confirm that such a study may be feasible.

Finally, the psychology subject librarian was also consulted for assistance in locating relevant studies. According to Sandelowski (2008), a qualitative systematic review must be transparent, rigorous, and systematic. With regards to data collection, Sandelowski (2008) avers that a study should be repeatable. In total, the literature search yielded a sample size of 54 articles. Certain articles were excluded from the research sample based on the inclusion and exclusion criteria referred to below.

4.4.3. Selecting studies.

Screening, in the broad sense, started at the application of search terms in trying to locate relevant studies. In order to ensure inclusion of only those studies relevant to this research project, the following criteria was applied:

- The research must have been phenomenological (both method and theory).
- Research must have sampled adult obese individuals (of any gender).
- Only English publications were consulted.
- No restrictions were placed on the publication dates of the journals.
- Research must have been published in peer-reviewed journals.

As per the first bullet point, this study concentrated only on phenomenological studies. The rationale behind this decision was based on the argument by Brown (2006), that information about obesity must come from the personal experience of the individuals struggling with the issue. Secondly, by staying with the phenomenological paradigm, there was greater theoretical soundness. In this way, this study avoided the trap of an epistemological dilemma, described earlier in the section on the qualitative systematic review, as it focused on only a specific paradigm.

As per the second bullet point, only research which involved obese adults of any gender were used. The rationale behind this decision was that there are many phenomenological studies on childhood and adolescent obesity available, which would have rendered the study too large. Furthermore, it made more sense, theoretically, to work within the same developmental age of a population – especially as the given aim of this study is not comparative, but descriptive.

This study does not compare, for instance, developmental groups, but rather arrives at a thick description of a specific population. Sandelowski and Barroso (2006) express this idea as idiographic generalizations of a specific population. According to Carr and McNulty (2007), and Sadock and Sadock (2007), adulthood is characterised by the interaction of the mind, the body, and the environment; and never one of these variables in isolation. Adulthood is the developmental period wherein an individual confronts and adapts to certain circumstances which includes the establishment of an independent identity, forming a personal partnership, raising children, establishing and maintaining a career, and accepting the disability and death of parents. Adulthood is the longest phase of human life, and is roughly divided into three stages: young adulthood (ages 20 to 40), middle adulthood (ages 40 to 65), and late adulthood or old age (Carr & McNulty, 2007; Sadock & Sadock, 2007). For the purpose of this research, adults fell into any of these three stages.

As per the third bullet point, the rationale behind the exclusive use of English publications was because this is a minor dissertation and that the researcher is English. Furthermore, time and volume limitations were taken into account. Therefore, of paramount importance was the researcher's accessibility to the available material, in English.

As per the fourth bullet point, it helped to identify the possibility of temporal developments of themes in the relevant studies.

The rationale behind the last bullet point was that there is still no consensus or clarity on how to exclude weak qualitative studies. Dixon-Wood et al. (2006) state that there is considerable debate as to whether quality appraisal is an important inclusion criterion in qualitative systematic reviews. Dixon-Wood et al. (2006) further elaborate that this is because there is

still no consensus or clarity on how to determine, attenuate or exclude weak qualitative studies. There seems to be little agreement on what exactly constitutes good qualitative research. Dixon-Wood et al. (2006) elaborate that because of the diversity of research designs, the possibility of creating a specific, universally agreed upon criterion for quality in research is actually rendered improbable. This sentiment is shared by Guba and Lock (2005), who explain that a universal criterion is problematic and fruitless. Sandelowski (2008) adds that because there is a lack of consensus as to what constitutes quality, controversy surrounds the proper use of quality criteria for qualitative systematic reviews. What usually happens is that it ends up as a largely idiosyncratic affair.

Tracy (2010) disagrees and states that although quality criteria are problematic because they are always fallible and critiqued, they are useful in that they are guidelines which may help researchers to learn, practise and, in her sense, produce perfect research. The quality of qualitative papers may rely on more detailed appraisals, which may make use of a checklist-type approach. Taking the above into consideration, this study made use of only peer-reviewed studies to try ensure a higher quality of data. However, no quality appraisal criteria regarding the methodologies were exercised. After filtering the studies with the inclusion and exclusion criteria, nine studies were identified as suitable for this research.

The nine studies were sufficient for the undertaking of this qualitative systematic review. To situate this statement, Sandelowski and Barroso (2006) aver that an adequate number of studies rests on their quality; one of the most thought provoking issues, which challenge a universal solution of a specific number to be used in a qualitative systematic review. They state that the definition of quality is still being deliberated (compare the last bullet point above). Xu (2008) adds that the ideal situation for a qualitative systematic review rests upon

the idea that there are a sufficient number of quality studies related to the topic under investigation. However, in reality, to obtain both is a challenge (Xu, 2008). Therefore, the number of studies may be sufficient, but the quality of the studies may be poor. This may render the qualitative systematic review impossible. Conversely, the number of quality studies may be low and, therefore, the decision rests upon the researcher to determine whether or not to pursue a qualitative systematic review (Xu, 2008).

With regards to conducting this qualitative systematic review, the number and quality of the research articles were sufficient. Quality was potentially achieved through the quality filters employed in this qualitative systematic review, namely the inclusion criterion to only use peer-reviewed studies. The quantity of nine studies was sufficiently thorough, as there was richness and thickness in the descriptions provided. Therefore, the data available was manageable for a single researcher with financial and time constraints, while keeping within the scope of a minor dissertation. This is why, as stated earlier, the review question was not changed during the research process. The nine studies are presented in the following table:

Table 1

List of Studies Used in the Qualitative Systematic Review

NAME OF AUTHORS	YEAR	COUNTRY OF STUDY	PARTICIPANTS	METHOD	TITLE OF STUDY
Wysoker, A.	2005	USA	Criterion-based Sampling 8 Participants 5 Women 3 Men Ages 38 to 57 BMI > 35	Interviews, open-ended questions Lasted 1 hour to 1.5 hours	The Lived Experience of Choosing Bariatric Surgery to Lose Weight
Goodspeed-Grant, P., & Boersma, H	2005	USA	Criterion-based Sampling 11 Participants 9 Women. 2 Men Ages 33-62	Interview was informal and conversational with open ended questions, and focussed on specific	Making Sense of Being Fat: A Hermeneutic Analysis of Adult's Explanations for Obesity

			BMI > 40	questions	
				Two 90 min interviews, one structured and one unstructured	
Ogden, J., Clementi, C., & Aylwin, S.	2006	UK	Criterion-based Sampling 15 Participants 14 Women 1 Man Mean Age 41 Mean BMI 47.47	Interview, open dialogue with open-ended questions Lasted 40 to 90 minutes	The Impact of Obesity Surgery and the Paradox of Control: A Qualitative Study
Ledyard, M.L., & Morrision, N.C.	2008	USA	Criterion-based Sampling 22 Participants 11 Women 11 Men Mean Age 46 Mean BMI 34.4	Interviews made use of open-ended questions, and specific questions Two sets of interviews: individual and couple	The Meaning of Weight in Marriage: A Phenomenologica Investigation of Relational Factors Involved in Obesity

Merrill, E., & Grassley, J.	2008	USA	Criterion-based Sampling 8 Participants 8 Women Ages 20 to 61 Mean BMI N/A	Interviews, open dialogue with open-ended questions Lasted 50 to 90 minutes	Women: Stories of Their Experiences as Overweight Patients
Nyman, V.K., Prebensen, A.K., & Flensner, G.	2010	Sweden	Criterion-based Sampling 10 Participants 10 Women Ages 24 to 37 Mean Age 41 BMI 34 to 50	Interview, open dialogue with open-ended questions Lasted 35 to 90 minutes	Obese Women's Experiences of Encounters with Midwives and Physicians during Pregnancy
Groven, K.S., Raheim, M., & Engelsrud, G.	2010	Norway	Criterion-based Sampling 5 Participants 5 Women	In-depth individual interviews based on open narrative	My Quality of Life is Worse Compared to My Earlier Life

				interview	
			Ages 20 to 55		
			Mean BMI 43 to 54		
Forhan, M.A., Law, M.C., Vrkljan, H., & Taylor, H	2010	Canada	Criterion-based Sampling 10 Participants 7 Women 3 Men	Interviews with open-ended questions, and specific questions Lasted 40 to 60 minutes	The Experience of Participation in Everyday Occupations for Adults with Obesity
Engstrom, M., Wiklund, M., Olsen, M., Lonroth, H., & Forsberg, A.	2011	Sweden	Criterion-based Sampling 23 Patients 14 Women 9 Men	Interview, open dialogue with open-ended questions Lasted 20- 60 min	The Meaning of Awaiting Bariatric Surgery Due to Morbid Obesity.
			Mean Age 40.9 Mean BMI 52.2		

Throughout the research process, follow-up searches were done to ensure that new publications, or publications previously missed, could be included. However, no additional studies were identified which qualitatively added to the already identified nine studies. These

nine studies are thus the data pool from which the systematic review was undertaken, beginning with a first reading of the various articles.

4.4.4. First reading of studies.

The researcher read through the nine different studies in no particular order, to become familiar with their contents. The researcher initially read the studies in no particular order to minimise, to the greatest degree possible, bias or influence from past experience. It must be noted that the studies were read numerous times and later revisited frequently. Later, the studies were read chronologically, to really understand the essence of these studies.

4.5. Identifying and Extracting Findings

After multiple readings, the researcher then moved to identify the findings in these studies. As specified earlier, Sandelowski and Barroso (2006) define findings as research interpretations. However, not all findings fall under the definition of research interpretations, and thus were not used in this research. Research findings which were incorporated were based on the criteria outlined by Hughes et al. (2009). They describe what findings constitute research interpretation as described by Sandelowski and Barroso (2006). If the study interpretation was positive for any of the following, the findings were omitted and not incorporated into the systematic review:

- Any references to direct quotations that come from the interview data that are seen to support the result. This is primary research data.

- Any statements which are not direct quotations, but are seen as portions of the interview. This is primary research data.
- Any remarks on matters of clinical, educational, research implications or findings which are offered by the researchers. This means other researchers' interpretation of other studies.
- Any comments which are seen to refer to results from other studies or academic literature.

The process of the extraction of findings from the nine different qualitative studies followed these guidelines. In the extraction of findings for this research, subtlety was required. The difficulty and the complexity of identifying the research findings are described by Hughes et al. (2009), and were experienced by the researcher. To achieve the extraction of the findings, multiple readings of all the studies were necessary, so as to become as familiar as possible with their findings. The findings from the different research studies were identified and extracted. This was done by extrapolating the identified findings into word processing files. The original authors' words were used, except when the findings were edited or rewritten to maximise their clarity. According to Sandelowski and Barroso (2006), this is done so any individual who may be unfamiliar with the study should still be able to understand the original sense of the rewritten extracts. The findings were then grouped into themes.

4.5.1. Grouping findings.

The process of grouping themes was complicated because the focus of the different studies varied. Firstly, to keep direction, the aim was stated; that is, the initial research question. This

was never far from the researcher's mind and acted like a compass. The original studies were frequently revisited, to clear up the context of the extracted themes. For this research, it was not considered necessary that the research question be changed or altered as there was richness and depth of findings within the data pool, that is, quality themes. Secondly, to determine correspondences between the different studies, Noblit and Hare (1988) describe the process of the creation of a metaphor, or a list of themes, and then they suggest that the researcher juxtapose these themes. Although this sounds simple, it is not. This difficulty is described below.

4.5.2. Translating studies into one another.

Atkins et al. (2008) expressed difficulty in using the original method and comparing themes from one study, to themes from another. The difficulty, they expressed, was similar to the researcher's experience, in how to go about this feat. They believe that this difficulty is resolved by making use of reciprocal translation, a concept developed by Noblit and Hare (1988) which is widely used by scholars in the field.

The researcher therefore used this method in this research. As the studies are similar in their essence, it was possible to use reciprocal translation. The researcher began with a random study and, from there, made comparisons between the first study and the second study. The synthesis of these two studies was then synthesised with the next study. The researcher continued with this approach and made comparisons between all the studies. This process rests on the establishment of initial themes, but the process was always open to newly emerging ones. Every study was thus explored in-depth, and related to a theme. As the different studies were compared, the initial themes were clarified by combining and dropping

certain themes. This means that overlapping themes which may have initially seemed distinct, but were very similar in their essence, were later combined. Conversely, themes that had little support from the overall findings were dropped. By adopting this pragmatic approach, prescribed by Noblit and Hare (1988), the issue is highlighted of synthesising disparate studies, and the possibility that initial groupings made may limit the emergence of new themes. This means that it is important to understand the order in which studies are compared, as it may influence the formation of new themes (Atkins et al., 2008). With this in mind, the researcher proceeded as described. Upon consultation with the researcher's supervisor, the studies were revisited again, and then reread chronologically to determine, and to detect, whether temporal developments may be discovered, which may have had a bearing on the research findings.

4.5.3. Abstracting findings.

According to Sandelowski and Barroso (2006), in order to prepare the data for interpretation, the grouped findings are explored again. The exploration of the themes were conducted by the researcher and the researcher's supervisor. Some of the different themes identified in the primary studies, and themes identified by the researcher, were revisited and combined where possible. This was done in terms of their relationship to one another, to try to discover any patterns which may be additional, overlap, be compared - or be seen - as redundant. This process, called the abstraction of findings, is achieved by summarising the data; aiming to dynamically strengthen the understanding of the themes, between and within studies (Sandelowski & Barroso, 2006). To demonstrate: After repeated reading, the theme of the experience of restriction was identified as a recurring finding. The findings were grouped into three major themes, namely, obese individuals' experiences of control, obese individuals'

experiences of acceptance, and obese individuals' experiences of restriction. One potential theme, which was called obese individuals' experience of structure was pursued, but upon further investigation, and consultation with the researcher's supervisor, there was only minimal evidence to warrant its existence as an autonomous theme. Furthermore, it also did not overlap sufficiently with another theme to warrant integration; it was thus abandoned. On reflection, certain subthemes, such as intimacy and fertility, were either merged or moved to different sections, to provide the subtheme with more depth, and to make the themes more meaningful. This is highlighted here as a demonstration of the transparency in the research process.

4.6. Soundness of Research

Marshall and Ross (De Vos, 2005 p. 351) state that research should be evaluated for its trustworthiness. This study is evaluated against Lincoln and Guba's (De Vos, 2005 p. 351) criteria of credibility, transferability, dependability, and lastly, conformability to demonstrate its trustworthiness.

According to De Vos (2005), credibility relates to whether the descriptions used are accurately identified and described. This research has been presented to the researcher's supervisor so that her interpretations of the data may be compared to the interpretations of the author's, to ensure credibility. To ensure transferability, the researcher referred to the original methodological framework to demonstrate that the data was collected and analysed according to the standards of a qualitative systematic literature review (De Vos, 2005). The dependability of the research was achieved by the provision of a comprehensive description,

and detailed account, of the research methodology and by the independent analysis of the literature through the participation of an external evaluator, or supervisor (De Vos, 2005).

Confirmability, according to De Vos (2005), means that the findings of the research study may be confirmed by another. In this research, confirmability was attended to during the integration of the independent analyses of the data. In an external evaluation of interpretation of the research, the personal characteristics that may permeate the interpretation were mitigated and interpretations were thus confirmed.

Chapter 5: Analysis

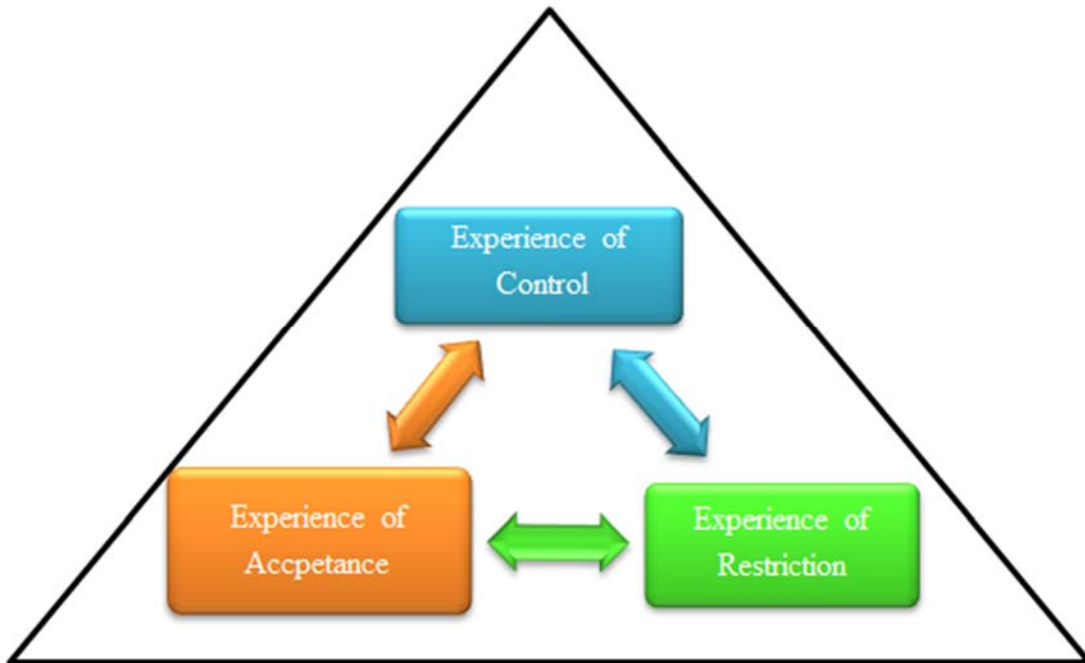
5.1. Introduction

Some medical professionals view obesity as a medical problem which falls within their professional domain. Hence, they take responsibility for the management of obesity. Other medical professionals consider obesity to be a problem which is caused by, and should be managed by, the obese individuals themselves. Although this difference in viewpoints exists, the majority of medical professionals view the treatment of obesity as the patient's responsibility (Brown, 2006; Epstein & Ogden, 2005). The authors Epstein and Ogden (2005) take this stance because their assumption is that medical professionals view the primary cause of obesity as overeating; medical professionals see this latter activity as within the control of the patient.

Agger (1991) comments that difficulty educates us, and that the idea of simplicity brings with it false clarity. To take such a simple, linear, isolated view of understanding participants' experiences of obesity brings about false clarity, and with this, a false understanding of obese individuals' experiences. Berman conducted research over 38 years ago (1975) and his research examines why overweight individuals start but then cease their diets. The surprising finding of the study is that 32% of the participants discontinue dieting because they feel that they do not deserve the weight loss. This simple, yet immensely important finding, indicates that one variable cannot dictate the success of understanding weight loss. In the case of the research by Berman, the overweight individuals showed weight loss but then abandoned their diets. It is clear, therefore, that other variables or experiences have an influence on these individuals, besides controlling their eating.

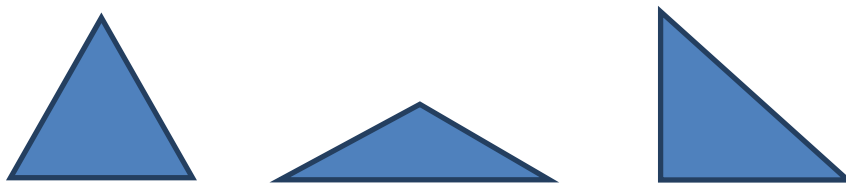
After repeated readings and analysis of the different studies, three central themes emerged, with related sub-themes within each one of these central themes. The three central themes are: Obese individuals' experiences of control, obese individuals' experiences of acceptance and lastly obese individuals' experiences of restriction. With these in mind, the order of discussion does not merit more importance or weight to one theme of experience over the others as will be discussed and elaborated on. Obese individuals' experiences of control is initially discussed, followed by the experiences of acceptance and restriction. Although the themes of control, restriction and acceptance are discussed as separate themes within obese participants' experiences in life, they are inseparable from one another. This might not be initially clearly evident, but as the various findings are discussed in greater detail, the links and relationships will become clearer, along with the aid of the figures and descriptions discussed below.

To commence, all three themes of experience described can be explored on their own. However these three themes are interwoven with each other, in this research, in a reciprocal triangular relationship with obese individuals' experiences. Each experience therefore has an influence on each other, in a dynamic interplay, which is constantly in flux. This notion can be understood as depicted below. The three themes are joined in a triangle, with each corner and related angle representing a theme of experience.



■ *Figure 2.* Representation of the interrelationship and reciprocal dynamic interplay between the three themes of experience

As the angle of one corner, for instance the experience of control is in flux, in either becoming more obtuse or acute, it has an immediate influence on the other two corners angles, being the experiences acceptance and restriction as depicted below.



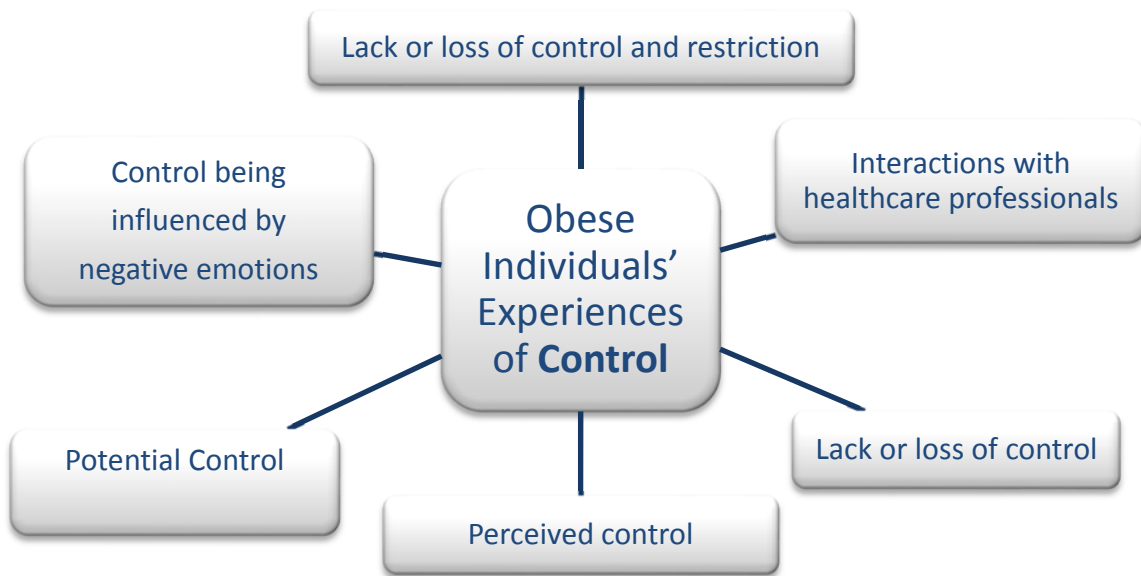
■ *Figure 3.* Corner angles flux in either becoming more obtuse or acute, which influences the other two corners angles

If at the same time the corner angle of the experience of acceptance is in flux, in either becoming more obtuse or acute, it has an influence on the other two corners, the experience of control and restriction. The same interplay applies to the theme of restriction.

With this in mind, although the first section of the following findings relate to the participants experiencing a restriction in life as a result of their excessive weight, being overweight potentially highlights participants' limited, or lack of control over their eating as a result of this consequence. In addition to this, although not explored or discussed in detail at present, it also then relates to the theme of the experiences of acceptance with obese individuals, which is later discussed, but which is also related and influenced.

The initial section explores the experience of control with obese individuals, although it will be discussed again in greater detail. The reason for this is to intentionally introduce the theme, experience of restriction, immediately. This is done so that as the discussions take place it is easier to start identifying the reciprocal relationships, as the two other themes of experiences, acceptance and restriction are only fully discussed later on.

5.2. Obese Individuals' Experiences of Control



■ *Figure 4.* Diagrammatic depiction of obese individuals' experiences of control

Potentially, many different aspects, or understandings, of control exist – and the researcher considers them to be equally valid and pragmatic. Before commencing with a discussion of control, a working definition is identified as employed in this research. The Penguin Dictionary of Psychology (2001) defines control as manipulation, or the ability to modify or change behaviour. Similarly, the Oxford English dictionary online (2012) defines control as the ability to restrain one's own emotions or actions; the ability to regulate or maintain an influence or authority over something. In essence, control is to exercise influence over or dictate the behaviour of something and is thus the power of directing or commanding. Another way to see this is to consider the power of restraint, especially self-restraint. The working definition of control in the context of this research is the ability for obese individuals to manipulate, modify, influence, or have power over themselves.

The theme of control relates to numerous aspects in the different research studies of obese individuals' experiences. Various subthemes are extrapolated: Lack or loss of control and restriction; interactions with healthcare professionals; lack or loss of control; perceived control; potential control; and control being influenced by negative emotions.

5.2.1. Lack or loss of control and restriction.

Control emerged as a prominent theme from the various studies. It is not a sense of control, but its opposite, which seem to predominated individuals' experiences of obesity. The theme of the experience of a lack or loss of control, and especially the lack or loss of self-restraint were present, and expressed in the life experiences of obese individuals. The experience of lack of control emerged in various manifestations in how obese individuals seem to be restricted in their life experiences. They described their experiences of a lack of or deficits in control, and how this lead, in some cases, to limited and restricted occupational, recreational, personal hygiene and freedom.

The studies conducted by Forhan et al. (2010) and Engstrom et al. (2011) describe the experience of a lack of control over obese individuals' weight, as influencing their participation and engagement in life. In Forhan et al. (2010) participants described their life experience before they became obese. They described their experiences of their participation in daily activities at a lower weight, and living in a slimmer body. These experiences were a reference point for them of their physical ability and personal choice. From this reference point, they described how various aspects in their lives were negatively affected by their inability to control their weight. Participants experienced restriction in their choices of work occupation due to their increased weight. Participants described their restricted participation

in family and social group activities such as hiking, camping, or other types of physical or moving activities. They also expressed diminished ability to perform personal healthcare activities, particularly bathing. This demonstrates that the physical consequences of their obesity restricts their ability to reach desired levels of participation in their lives, but also highlights their inability to control their weight.

The study by Engstrom et al. (2011) also highlights these issues. The participants experienced deficits in their ability to control their eating, and therefore experienced restrictions in several other areas of life. The participants expressed their desire to gain more control of their weight and this highlighted their lack or loss of control. The need for greater control was specifically expressed by participants scheduling bariatric surgery. Participants described that surgery could provide them with control so that they may experience more rewarding life opportunities. This would reduce their restriction because they may take control of their eating. Surgery, and the resultant control it would provide, was therefore seen as the experience of offering the hope of getting more out of their current restricted lives.

The participants in the study by Engstrom et al. (2011) felt they may be freed from various experiences of restrictions, to become more physically active, and they would then be able to obtain or keep a job stimulated by their experience of control due to surgery, and their experience of weighing less. In addition, the participants experienced their addiction to food and dependency on others for managing their daily lives as an encroachment on their freedom. Therefore, the participants' inability to control their addiction to food, or their sense of lack or loss of control, with the subsequent weight gain, robbed them of their freedom of choice. The hope of seeing their children grow up, the ability to socialise with friends, partake in various activities and keep a job, created a desire to lose weight via surgery. It also

created the belief that the participants may recover and regain their control over their eating, leading to freedom and independence.

To conclude this section, obese participants in the various studies experienced a lack of control over their weight, which in some instances restricted their lives. If obese individuals experience a lack of control, how do they then experience others' views of them? More specifically, what are their experiences of interaction with healthcare professionals? The following experiences were described by obese individuals and healthcare professionals regarding this.

5.2.2. Interactions with healthcare professionals

For many individuals, a visit to a doctor or a hospital can typically be anxiety-provoking and scary. In many instances, it can be made more bearable, or even positive, if the individual experiences positive interactions with healthcare professionals. For this section, healthcare professionals refer broadly to medical doctors, physicians, nurses, or any other medical practitioners who had contact with obese individuals in the various research studies. These potential positive interactions may buffer their anxiety, but seems to be absent for obese individuals. Obese individuals seem to experience negative interactions with medical professionals. The nature of these interactions may be either real or perceived by obese individuals. Health care professionals seem to be experienced as having an authoritarian relationship with the obese individuals, and seem to exercise more control over them in terms of power in their relationship.

Of particular importance to this section is that health care professionals seem to be experienced as prescribing. According to healthcare professionals, obese individuals should take control of their weight, and make the decision to eat less and be more physically active. Therefore, healthcare professionals seem to be of the opinion that obese individuals should be able to have the experience of exercising greater control. The healthcare professionals, according to obese individuals' experiences, seem thus to perceive the obese individuals as lacking self-control, which in many cases the obese individuals themselves already experience in some manner. In addition they feel prejudiced against, because healthcare professionals potentially see them as lacking control over their eating and exercising behaviours. As a result of their interaction with healthcare professionals, they describe feelings of being shunned, isolated, and humiliated. They therefore avoid treatment. The four studies by Engstrom et al. (2011), Nyman et al. (2010), Forhan et al. (2010) and Merrill and Grassley's (2008) evidence obese participants who described these experiences.

Participants in the study conducted by Engstrom et al. (2011) described the experience of helplessness due to their own lack of will power to stop overeating. Healthcare professionals, in their interactions with these participants, were experienced as having unrealistic expectations to control this behaviour, with which they themselves, felt helpless with. Participants felt prejudiced against and badly treated by healthcare professionals. Participants described that, according to the healthcare professionals, they lacked control over their eating, apparently something which they should exhibit. In the study by Nyman et al. (2010), participants described their experiences of being poorly treated by health professionals. They were left feeling humiliated and outraged when advice was doled out to them as to how they might lose weight. In some cases this only further increased their eating behaviour. Similar experiences are evidenced in the study by Forhan et al. (2010), where the participants

described avoiding medical care for fear of being reprimanded by healthcare professionals. They reported that they were told routinely to eat less and to be more physically active to lose weight. In the study by Merrill and Grassley's (2008), the findings are almost identical, because participants experienced a desire for respectful relationships with healthcare professionals. They dreaded seeking healthcare because they did not have good relationships with their healthcare professionals, and feared being scolded. This was the consequence of prior interactions where they had been scolded because of their weight. These interactions were seen as demeaning and embarrassing.

In conclusion, the participants in the above studies seem to have negative appraisals of their interactions with healthcare professionals. They describe how their healthcare professionals make them aware that they should be able to take control of their eating habits. Furthermore, obese individuals seem to experience a diminished self-control. The negative interactions with healthcare professionals seem to have high emotional and relational consequences for obese individuals. They feel prejudiced against and humiliated by them, in that they are scolded for their lack, or loss, of self-control. This only seems to reinforce their negative self-appraisal. Consequently, obese individuals' relationship with healthcare professionals and related services seems potentially restricted. These potentially restricted relationships with the healthcare professionals seem to have an influence over how obese individuals accept themselves, and are experienced as acceptable by others.

The difficulties that obese individuals experience with control have been explored in conjunction with the confounding theme of restriction with healthcare professionals. The following section describes obese individuals' encounters with lack or loss of control in greater detail.

5.2.3. Lack or loss of control.

Obese individuals have readily expressed their experiences of an apparent lack or loss of control. The previous sections explored control as it was experienced by obese individuals from healthcare professionals, and the consequent restrictions experienced. This introduces the idea of the interrelation and connectedness of the three main themes. This section specifically highlights and demonstrates obese individuals' encounters with their apparent lack or loss of control. This needs to be understood in relation to the other two themes, although it is not extrapolated in this section. The studies conducted by Engstrom et al. (2011), Forhan et al. (2010), Groven et al. (2010), Ogden et al. (2006), Merrill and Grassley's (2008), Wysoker (2005) and Goodspeed-Grant and Boersma (2005) evidence obese participants describing their experiences of a lack or loss of control.

In the study conducted by Engstrom et al. (2011), findings reveal that the decision to undergo bariatric surgery were due to experiences of a loss of control by the participants. The participants saw their relationship with food as a form of abuse, and made analogies with alcoholism, thus likening it to an addiction. They described how their lives were regulated by a dependency on food. The participants expressed the desire to be able to turn on a mechanism in the body that may help them control their eating behaviour. Losing weight and regaining it, made the participants feel hopeless. They felt that they were unable to exercise control over their current situation, and their future was viewed just as negatively.

Participants felt that the endless rollercoaster of unsuccessful dieting might only be stopped by undergoing surgery. Obese individuals described that they lost their own self-respect, and they felt guilty about being unable to control their weight. When the participants were booked

for surgery, they expressed a realisation that their survival and future health depended on a successful surgical procedure.

In the study conducted by Forhan et al. (2010), research participants described that they experienced no control over their eating behaviour. In the study by Groven et al. (2010), participants described their experiences of a lack of control over their eating, relating their consistent failed attempts with yo-yo dieting, and their continual struggle to control their weight. The participants in the study by Merrill and Grassley's (2008) all described their experiences of feeling defeated by their weight after failed attempts to control it by dieting. In the study by Ogden et al. (2006), the participants describe similar experiences. The participants described histories of weight gain, failed attempts at weight loss, and weight cycling. It emerged from these participants' histories that they experienced a lack of control. The participants described feeling out of control in relation to gaining weight, also due to many subsequent unsuccessful attempts at weight loss. They reported their realisation that they were not going to lose weight on their own, and stated that they wanted to hand over control and responsibility for their weight loss to someone else. These individuals also described a lack of willpower, a feeling of powerlessness and having no hope, and the need for external agents to control the problem.

In the study conducted by Wysoker (2005), similar findings are evidenced. Participants described surgery as the last resort, after numerous unsuccessful diets. The participants became resigned to allowing outside agents to assist in the control and regulation of their eating. This, in turn, would influence their body shape and consequently their self-perception. Unsuccessful sustained long-term weight loss and feelings of helplessness were the reasons for choosing the invasive surgical weight loss approach. Despite the risks, participants opted

for surgery because they were so desperate. Participants indicated that their weight would not change unless something drastic was done. In the study by Goodspeed-Grant and Boersma (2005), a similar experience of loss of control emerges. Participants blamed themselves for a loss of control of overeating, and acknowledged that they did not feel in control of their food intake. Nearly half of the participants made the analogy that food was an addiction. However, these participants simultaneously assigned blame to their genetic make-up for their loss of self-control; this is different to the other studies. The participants described experiencing internal contradictions, as they blamed themselves and their genes for their obesity.

In conclusion to this the section, it seems as if nearly identical story scripts are used in every single study explored, with a few minor variations. What this seems to highlight, is that across many different samples, individuals, cultures and countries, obese individuals' apparently experiences a loss or lack of control which seems universal. Although many obese individuals' encounters explored thus far have focused on a lack or loss of control, some individuals do seem to perceive a sense of control.

5.2.4. Perceived control.

Many obese individuals have described encounters of a lack or loss of control. There were also descriptions of experiences which, when interpreted, seemed to indicate perceived control for obese individuals. These experiences of perceived control may also be understood in relation to the other two themes of acceptance and restriction. This section explores participants' experiences of being obese which they attribute to their own failings. The section concludes by shifting focus to participants' description of their perceptions of future personal control. Three studies evidence obese participants' description of these experiences,

which include the studies conducted by Engstrom et al. (2011) Nyman et al. (2010) and Goodspeed-Grant and Boersma (2005).

By exploring the studies, the researcher interprets the participants' experience of obesity as a problem for which they assume personal responsibility. The participants express that their obesity is a personal failing, and the researcher interprets that these individuals attribute the perceived loss of control to themselves. This line of interpretation is reflected in the research conducted by Epstein and Ogden (2005) which concludes that doctors ultimately see the treatment of obesity as the patient's responsibility, because they feel that the primary cause of obesity are factors such as eating too much, of which the latter is in the patients' control. Following this line of logic, as a result of the obese individuals describing that they acknowledge responsibility for their failing, they acknowledge perceived control. Whether the control is real is another question, hence the researcher stressing the word "perceived". Whether responsibility and control is directly linked or not is another line of enquiry, but one which seems to fit logically.

If participants do not perceive that control was present for them in some way, then there would be no indication that they blame themselves. This, of course, is not the only line of interpretation possible. The researcher does make the interpretation that the participants in the studies experienced negative emotions due to their own failings, by not controlling their weight. This is a loss of perceived control. To illustrate, in the study by Engstrom et al. (2011), participants explained that their obesity had led to changes in their self-respect, as they felt guilty about being unable to control their weight. In addition, being overweight resulted in the participants experiencing negative emotions and withdrawing from society, which led to the experience of social isolation. In explaining the cause of their obesity, not

one participant attributed their guilt and other negative feelings to their genetic make-up. Rather, it is attributed to their own failings. Similarly, this view is shared in the study by Nyman et al. (2010), in which participants accepted the responsibility of being overweight, and therefore did not want to hear comments about it because it would elicit negative emotions. In the study by Goodspeed-Grant and Boersma (2005), participants blamed genetics, yet simultaneously blamed themselves for lacking self-control. This reflects these individuals' internal contradictions, they feel accountable for their obesity, but by blaming their genetics, this is seen as something outside of their control.

In conclusion, this section describes obese participants' experience of perceived control, and the negative emotions they subsequently experience as a result of their perceived failings. It is highlighted that together with the description of the experience of perceived control, the obese individuals also share their experiences of its influence on acceptance and restriction.

5.2.5. Potential control

The experience of perceived control highlights an interesting question: Can individuals control their obesity? This section explores this angle. Studies which illuminate potentially relevant experiences are described in Wysoker (2005) and Ogden et al. (2006). These studies explore obese participants who had bariatric surgery, and the consequences of their decision.

In a study conducted by Wysoker (2005), participants described that surgery meant they did not have to curtail or stop their eating habits. The physiological effects of the surgery would provide the structure and remove the need for controlling their food intake. However, the reality was that with surgery, lifestyle changes became necessary. There was a chance that

they may not lose as much weight as originally hoped, and the chance that they would regain the weight. Although they were prohibited from eating a lot after surgery, they described that they could still eat small amounts frequently, and this could lead to weight gain. Furthermore, the importance of proper eating and exercise to keep the weight off was a reality, and the participants reflected on their need to exercise. Therefore, despite surgery, participants described still needing to take control of their weight loss and weight maintenance. This raises the question of why these individuals sought surgery in the first place. These experiences may be interpreted in the notion that the participants may have needed to exercise some form of control alongside a food and lifestyle change. The individuals still experienced issues of control which existed before the surgery, and this lends credence to the idea of potential control. Realisation of potential control does not necessarily seem to translate into action for obese persons. It does, however, potentially demonstrate that obese individuals can take potential control of their weight, irrespective of whether it is genetic or not. The statement is made clearer by understanding that the structure which was initially provided by the surgery, eventually dissipates. The participants consequently still have to take potential control over their weight, just as they did before undergoing the surgery. Thus, they have to exercise potential control and use self-restraint.

An almost identical finding is evident from some of the participants in the study conducted by Ogden et al. (2006). Participants described their experience as follows, after the side-effects of the surgery had subsided, and they had adjusted to their new stomach size, they needed to relearn how to eat smaller portions. The surgery changed the size of the stomachs, and the individuals have to change their eating behaviour, or suffer unpleasant side-effects if they did not. Surgery had a profound effect on their eating behaviours. A consequence of over eating was that they may become sick which was a deterrent and provided negative

feedback. It seems that surgery gave the participants control over their eating. This description may also highlight a potentially different form of control for obese individuals, possibly enforced control. However enforced control does not seem to be an effective weight loss management tool when examined more closely with all the participants. Some participants, despite having undergone bariatric surgery, described experiences that after the negative consequences had subsided of becoming sick due to overeating, the individuals proceeded to gain weight just as before. In this sense, the negative experience that is initially provided by the surgery disappears and the participants again experience similar control-related issues as prior to surgery. This description is almost an exact copy of the experience of the participants in the Wysoker (2005) study which seem to emphasis potential self-restraint.

To summarise and conclude, these studies highlight that whereas some participants seem to respond to issues of control post-surgery from its enforced control, others do not. The difficulty lies in trying to determine whether the experience of potential control (or self-restraint) is internally present, or if it is due to the experiences provided by the surgeries and its enforced control. For some participants, surgery seems to initiate better self-restraint. However, if surgery does provide the experience of control in both studies, then why is it that not all the participants evidence the uniform experience of control? That is, why were the results mixed? This is an immensely complex point, and warrants much wider analysis than the scope of this dissertation. This discussion again highlights the interplay of the three themes of experience.

It seems that the control issue has a marked impact on the other two themes. This section does not directly answer the question asked in the introduction, that is, whether the

experience of control exists for obese individuals. However, it highlights the important experiences of obese individuals, which sheds light on the influence of control, and specifically, the influence of outside agents.

5.2.6. Control being influenced by negative emotions.

This section explores the notion that negative emotions may exert an influence on control. It seems as though the experience of control can be influenced by different factors or agents. This section describes obese participants' experiences of negative emotions which, similar to the description of undergoing surgery in the previous section, seem to have an influence over obese individuals' experiences of control. It is described that these negative emotions emanate from interactions with healthcare professionals. It is argued that obese individuals carry negative emotions already and that interactions with healthcare professionals merely bring these emotions to the fore. It is argued that obese individuals eat as a coping mechanism for their negative emotions. Four studies describe the obese individuals' negative encounters with healthcare professionals: Nyman et al. (2010), Forhan et al. (2010), Ledyard and Morrison (2008) and Goodspeed-Grant and Boersma (2005).

In the study by Nyman et al. (2010), participants described their experiences of being poorly treated by healthcare professionals, and that they are left with feelings of humiliation and outrage when given advice on how to lose weight. In some cases, this only further increased their eating behaviour. In a similar vein, the study by Forhan et al. (2010) showed that the participants described their experiences of a loss of control in their eating behaviour, and that they looked forward to eating for reasons of nutrition, instead of trying to cope with negative emotions, such as anger. The study by Ledyard and Morrison (2008) is almost a replica of the

other studies: Some participants experienced anger, and were passive aggressive, and they too had the experience of overeating. Lastly, the same theme is mirrored in the findings of the study by Goodspeed-Grant and Boersma (2005) in which the participants described a pattern that was characterised by cycles of emotional overeating. Their experiences began with a negative emotional reaction to stress, loneliness, or hurt, and these negative feelings were followed by overeating. The individual felt soothed for having eaten, but this was then followed by feelings of guilt and self-loathing. This created a vicious cycle. This cycle could become evident only in retrospect, but was not immediately conscious to the obese individual. When participants became aware of their eating behaviour, they berated themselves for not demonstrating greater personal control over their eating, but they repeated the pattern when they experienced another negative emotion.

In summation, for participants who experience demeaning interactions with healthcare professionals, they become aware of negative emotions which seem to influence their control over their eating. This section highlights the aspects which have been described in previous sections, that the theme of control is influenced by the themes of acceptance and restriction

5.3. Obese Individuals' Experiences of Acceptance

5.3.1. Introduction.

The theme of the experience of acceptance is discussed in the following section. The experience of acceptance is a fundamental human experience, be it accepting oneself or being accepted by others (Feldman, 2001; Gomez, 1997). Human beings are social beings, and companionship and acceptance is a central, and essential, component of our lives. The idea of

acceptance needs to be clarified because the experience of acceptance may have various connotations. Wikitionary Online (2012) defines acceptance as the act of accepting, or a state of being accepted. Similarly, the Oxford English dictionary online (2012) defines acceptance as the action of receiving something, or an agreement with the belief in an idea or explanation. More specifically related to this research, it may also be viewed as the process of being perceived as adequate. Acceptance, for the purpose of this research, is understood as obese individuals' need to be accepted as adequate.

The word "adequate" carries specific importance with regards to acceptance in this research. The theme of obese individuals' experience of no control may be associated with the many derivatives of control. In a similar vein, the word "adequate" implies its opposite of inadequacy and non-acceptance. For the purpose of this research, the two words are used interchangeably; also the words "acceptance" and "adequate".

This non-acceptance is evident in the experience of many obese participants. This theme is a discussion and exploration of obese individuals' various experiences of acceptance and their adequacies, and their experiences of non-acceptance and inadequacies. The various subthemes include obese individuals themselves encountering a non-acceptance of self with regard to their physical appearance. Their resultant feeling of inadequacy because of others' non- acceptance of them due to their appearance. They describe feeling inadequate as a result of their inability to control their eating behaviour. Other subthemes include obese individuals' interactions with other individuals, their need for acceptance, and other influences on their acceptance or non- acceptance of self. This theme, like the others, should not be seen in isolation, although, it too stands rightly on its own. Obese individuals' experience of acceptance is understood in relation to the other two themes of experiences of

control and restriction. The first section discusses obese individuals' experiences of non-acceptance of themselves.



■ *Figure 5.* Diagrammatic depiction of obese individuals' experiences of acceptance

5.3.2. Non-acceptance of self.

This section describes and illuminates how most obese participants experience themselves as inadequate in various ways. In feeling inadequate, obese individuals experience other negatively-related emotions. This non-acceptance, or inadequacy, of self is experienced by obese participants in their routine daily living, and stems from both their personal and interpersonal experiences. Six studies describe participants' experiences of this: Engstrom et al. (2011), Forhan et al. (2010), Groven et al. (2010), Nyman et al. (2010) and Merrill and Grassley (2008).

Participants in the study by Engstrom et al. (2011) encountered experiences about their bodies which evoked very negative and dissatisfied emotions. They avoided mirrors and rarely weighed themselves, in an attempt to avoid confrontations about their appearance. Negative emotions included hatred, disgust, shame, and guilt about themselves - these feelings were reinforced by nasty and inflammatory comments from surrounding individuals. In a similar manner, in the Groven et al. (2010) study, participants described feelings of shame because of their appearance, and were consequently socially avoidant, as they feared attracting negative social attention. Somewhat differently but, in essence, still the same, the participants in the Forhan et al. (2010) study, had the experience that they were less capable, and therefore inadequate. This inadequacy was encountered from their employers, when comparisons were made with other employees who were not obese. These participants had the experience of having less demands on them at work. Participants cited low self-esteem and poor body image satisfaction as reasons for also avoiding sexual activity with their partners, despite their partner's interest. They reported that as their weight increased, their credibility in social and professional situations became negatively affected. It was publically humiliating for them when they needed to ask for seatbelt extenders on aeroplanes. Incontinence difficulties, and limited access to narrow doorways and public washrooms, were also part of their experiences. For them, their experiences of fear and social isolation were associated with being obese.

Participants in the study by Nyman et al. (2010) shared similarities with the other studies, as they described the experience of not being able to use regular equipment at healthcare facilities. They required larger equipment because they were obese and, therefore, it was more difficult to examine them. They were humiliated because of this, and it gave rise to feelings of inadequacy. Experiencing the humiliation increased the participants' feelings of

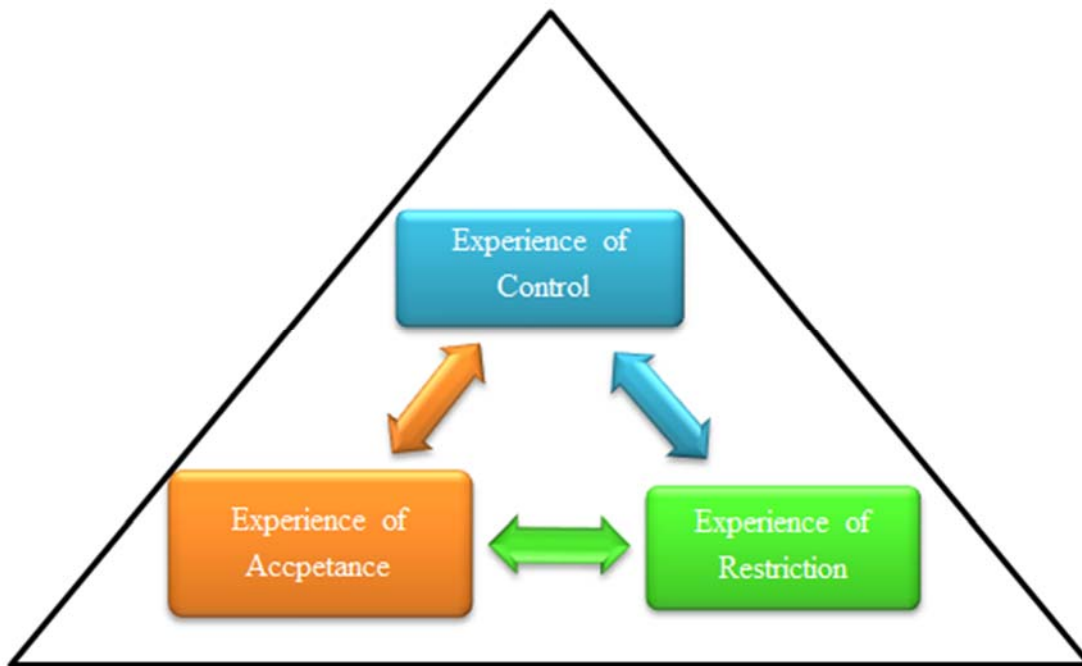
discomfort and heightened their negative emotions. Female participants also experienced that caregivers may be rude, angry, moody, abrupt, and bitter towards them. This enhanced their feelings of being less worthy than non-obese women, and it was felt that they were judged by their body size, which upset them. This created feelings of alienation and the feeling that they were different to other women in society; therefore not feeling accepted. Participants did not want their partners, or other people, to know about their weight or clothing sizes, as it also evoked feelings of shame, embarrassment, and frustration. For these participants, being obese and being forced to reveal their body was embarrassing. The participants described that they were permanently defensive, and constantly afraid that someone would comment on their weight. They experienced a constant awareness of their obesity, as it was something they could not hide. They were permanently scrutinised by others, which also created feelings of shame. Lastly, pregnant participants who were subjected to these examinations did not perceive these tests being performed on them, but rather that it focused on the progress of the pregnancy and the baby. The experience for obese women could almost be expressed as depersonalisation of the self.

Similarly, participants in the Merrill and Grassley (2008) study experienced not fitting in to the normal healthcare office space environment, due to their size. They required different gowns, blood pressure cuffs, scales, chairs, and other equipment, which were often not readily available. This caused delays, embarrassment, and a sense of shame and self-blame. They described the experience as a feeling that they were less human, that they were different to others, and that they were inadequate. The experience of being less human was expressed by participants in frequent comments which referred to their body in non-human terms.

It is mentioned numerous times about the interplay of the different themes. Up to this point, there has been no in-depth context to understand the exact experience of acceptance for obese individuals. This section partially addresses the problem by providing examples from which to work. The three themes and their reciprocal relationship are now explained in greater depth.

5.3.3. The interplay of the triangle of experiences.

It is described in the above section that feelings of inadequacy, or non-acceptance, of the self result in obese individuals encountering negative emotions. Referring back to the last section in the theme of control, it was described that negative emotions that obese individuals experience may have an influence concerning their experiences of control. Additionally in the previous theme of control, a loss of, or lack in control, is described as having an influence on obese individuals' weight gain. Obese individuals seem to experience weight gain, due to their deficits in control. This seems to have an influence on their various experiences of restriction, for example, physical restriction. The interplay between the different experiences thus becomes evident. Although this description follows a specific linear order, this does not imply that the experiences are experienced in this way rather that they are reciprocal. This example describes the interplay between the different themes of experience, namely control, acceptance, and restriction. The interrelation of the three themes is reproduced below.



■ *Figure 2.* Representation of the interrelationship and reciprocal dynamic interplay between the three themes of experience

In conclusion, the studies describe that obese individuals feel inadequate and non-accepting of themselves in their routine daily living, and in their personal and interpersonal interactions. In some instances, their experiences are influenced by their bodily experiences. This relates to their appearance, and the restrictions they encounter, which creates negative feeling states, prompting social withdrawal and isolation. The experience of being inadequate is also described as a feeling of not being quite human in many cases. In addition, certain interactions with other people result in negative experiences.

5.3.4. Interactions with other individuals.

An important aspect to explore is obese individuals' experiences of other people. As described in the main introduction of this theme, human beings are social beings and

companionship and acceptance is a central and essential component of our lives. When reviewing obese individuals' descriptions of their experiences with other individuals, in particular healthcare professionals and the general public, it appears that these interactions are very negative. This seems to be especially true for their interactions with healthcare professionals. Other individuals in numerous public arenas also seem to respond dismissively and may treat obese individuals in a condescending manner. These reactions seem to leave obese individuals with feelings of inadequacy, a feeling that they are unacceptable to themselves. In many instances, others experience them as obese, and nothing else. The studies by Engstrom et al. (2011), Forhan et al. (2010), Nyman et al. (2010), Groven et al. (2010) and Merrill and Grassley's (2008) highlight how obese individuals experience others.

Healthcare professionals seem to feature prominently in the social contexts of obese individuals. In study by Engstrom et al. (2011), participants described the experience that they had the impression that healthcare staff showed little interest in them. Many participants described their difficulty in seeking help for any illness, as irrespective of what disease they sought help for, they were inevitably advised to lose weight. Similarly, in the study by Forhan et al. (2010), participants described that they avoided medical care for fear of being reprimanded by family physicians due to their weight. They described a feeling of being dismissed by health professionals who never enquired about how they managed their daily activities. Participants also described everyday life activities as difficult, such as eating food, for which they felt scrutinised regarding their portion size and food choice. Lastly, participants acknowledged their need to overcome their fear of how others thought of them, to accomplish what they needed to do in a day.

Participants in the study by Nyman et al. (2010) shared similar research findings. Participants were afraid of not getting adequate care and did not question the humiliating treatment they received from medical professionals. In addition, the females felt anger and guilt about being advised not to become pregnant at all. Some obese individuals who were pregnant felt that their baby's birth plans were not taken seriously. This led to feelings of frustration because they were not recognised or respected in the same way as other pregnant women. The experience of going through different painful examinations also evoked feelings of being treated badly, along with care providers' scepticism about their experiences of contractions and their babies' kicks. In addition, participants experienced a sense of not being understood when health professionals required them to assume postures that were almost impossible for them to achieve due to their obese pregnant body. This left them feeling helpless and disappointed because their needs were not considered. Concomitantly, the participants in the study by Groven et al. (2010) described their experiences of usually getting bad looks and comments from strangers because of their weight. Some even had to endure experiences of derogatory judgements made with regards to their appearance in public situations. The participants' negative experiences of their own appearance seemed to be influenced by how other people reacted to them. Their exposure to negative comments reinforced and confirmed their own experience of themselves as unwanted and unattractive. Therefore it seems participants encounter self-stigmatisation; they perceive rejection, and anticipate negative evaluations from others.

The participants in Merrill and Grassley's (2008) study described a heightened awareness, almost as if they were guarding themselves when they walked into the clinics or examination areas. They encountered a sense of vulnerability associated with the stigma of being different from the cultural idea of being thin. Participants felt that they battled to be worthy and were

stigmatised because they did not fit into the healthcare environment, or the cultural expectation of being slim. Participants described how they were dismissed by healthcare professionals in many ways. These included for instance, not being believed, receiving no treatment for their health complaints, and instead, having their weight described as the problem. This corresponds with the experiences from the participants in the studies by Engstrom et al. (2011) and Forhan et al. (2010).

Participants in the study by Merrill and Grassley (2008) also described the feeling that they were less than human and different from others. Some more assertive participants described their experiences of revealing their dissatisfaction in the approach of the physicians to them, yet they too experienced negative outcomes despite their assertiveness. Some participants did have respectful interactions with medical professionals, and this increased their satisfaction about their relationship with the healthcare professional; and positively influenced their health status. In this sense, participants desired respectful relationships with healthcare professionals; they wanted to be free of the dread. This dread was a result of their poor relationships with healthcare professionals and the fear of being scolded. Lastly, participants described their experiences with professionals as generally demeaning and embarrassing, and they felt particularly vulnerable if they had to see someone new. This was because they usually encountered hurried staff who asked the same questions about their weight, height, and eating habits.

In conclusion, it is not difficult to establish that obese individuals seem to have negative experiences with other individuals. They have the experiences of being personally ignored, or dismissed, in many spheres of life. In many instances, they experience feeling inadequate or non-human when interacting with other individuals; this seems to be how they see

themselves. This potentially leads to, or further exaggerates, their experiences of inadequacy or non-acceptance of themselves. The interplay between the different themes is described and emphasised. In this section, the theme of acceptance from other individuals is explored.

5.3.5. Need for acceptance from other individuals.

It is discussed in the previous section how obese individuals, for the most part, describe feeling that others do not accept them. Acceptance from other people is a basic human need (Feldman, 2001; Gomez, 1997), and may be especially pronounced by individuals who suffer from obesity. This need is described by obese individuals in various contexts, such as healthcare environments and the work place. In these contexts, obese individuals describe a need for acceptance that seems so great that they may injure themselves in an attempt to prove their ability. An extreme example is that participants reported trying to change their appearance physically, either with surgical intervention, but mainly superficially with clothing. These individuals will try this to be more accepted by, and acceptable to, other individuals. Four studies highlight this experience: Engstrom et al. (2011), Forhan et al. (2010), Nyman et al. (2010), Groven et al. (2010) and Merrill and Grassley (2008).

The participants in the study by Nyman et al. (2010) experienced a feeling of respect, and felt calmer and more secure when shown kindness by healthcare professionals. They felt that the nurses understood their discomfort about undressing when the nurses concealed their bodies when they had to change clothes. The affirmative encounters reduced their discomfort and also provided a sense of well-being, and feelings of security. Participants felt that when their healthcare professionals were considerate and interested, feelings of discomfort were reduced. In addition to this, positive feelings were experienced by participants who were

encouraged to accomplish individual goals. The participants described that if they were considered beyond their superficial layer of fat, and that if they were listened to, they experienced similar treatment to others and this led to their surprise and enjoyment. They felt increased levels of joy and pride having become pregnant, and in their ability to give birth. It gave the participants strength and the power of self-assurance for their pregnancy and their baby's birth.

Participants in the study by Forhan et al. (2010) also described their experience of needing acceptance from others. For them, accomplishing tasks at work was driven by an internal pressure to prove to others that they could work despite their obesity. This work was often done at the risk of injury, increased pain, or fatigue. Participants identified the value of working and participating in daily life; as it provided them with the experience of being valued by others, and that they could make contributions to interpersonal relationships. The participants in the study by Groven et al. (2010) described their decisions to undergo surgery as motivated by their desire to become slimmer and more attractive, and thereby become more acceptable to others. Similar findings emerge from the participants in Merrill and Grassley's (2008) study, who describe that participants experienced a need to dress so that they could fit into society, become more accepted, and receive better treatment from healthcare professionals. The participants admitted preferring to dress casually, but felt that they had to prove to healthcare professionals that they were real people; so they tried to establish an identity that these healthcare professionals would accept. Some participants spoke highly of their relationships with healthcare professionals who took extra time to talk to them about their health problems. This made them feel respected, and thus accepted.

In conclusion, the experiences described by obese participants in various contexts, seem to be about pursuing the acceptance of others. The experiences described seem to demonstrate that participants need to be accepted, or be seen as adequate, in various ways. These include aspects of their ability to accomplish certain tasks, their appearance, but also the important validation of their feelings. In conjunction with the study by Merrill and Grassley (2008), certain experiences are described by participants which seem to demonstrate acceptance, such as positive encounters with healthcare professionals. These encounters seem to reduce obese individuals' negative emotions and promote positive emotions. In this section, the interplay of the different themes of control, acceptance and restriction becomes ever more evident. The theme of restriction is presented further below. Obese individuals described various experiences which seem to lead to feelings of acceptance and non-acceptance, or feelings of adequacy or inadequacy.

5.3.6. Other influences on acceptance or non-acceptance of self.

The last section of this theme describes experiences which do not fall under the previous sections, but also seem to have an impact on the feelings of acceptance, or adequacy, that obese individuals' experience. Some participants described that their experiences seem to influence the manner in which they accept themselves. These experiences vary in their presentation, from participants' experiences of hope to reasons as to why participants are obese. Seven studies were explored: Engstrom et al. (2011), Forhan et al. (2010), Nyman et al. (2010), Grassley (2008), Ogden et al. (2006), Goodspeed-Grant and Boersma (2005), and Wysoker (2005).

Participants in the Forhan et al. (2010) study described the experience of making use of physical supports to aid them with their obesity, alongside stating that they preferred not to use them, or did not see the point of purchasing devices that they would no longer need should they lose weight. Similarly, participants in the study by Nyman et al. (2010) described their experience of obesity as a temporary state that they themselves could, and about which they intended to, do something about in the future. Participants in Merrill and Grassley (2008) refused to give up, which was related to their persistence in trying to maintain control over their weight. All the participants described struggling with weight in the past, present, and anticipated the same challenges in the future. However, they still experienced looking to the future with hope, believing that an answer may be found for obesity and that they could achieve a normal size. Thus, they revealed their experience of determination to improve their health and to control their weight, despite many failed attempts. These three studies are similar in their description of the participants' experience of hope. The experience of hope seems to have a positive influence on obese individuals' self-acceptance.

Other studies highlight how the self-explanations of obese people potentially influence their acceptance of themselves. In Engstrom et al. (2011), none of the participants described that their genetic make-up was the cause of their obesity or illness. Participants in the Ogden et al. (2006) study differ. These participants described a history of weight gain, failed attempts at weight loss, and weight cycling - the majority attributed their weight problems to factors such as illness, pregnancy, or their genetics. Similarly, in Wysoker's (2005) study, participants described a preference for a biological model to explain the aetiology of obesity, which shifted responsibility away from a control over their own behaviour. Lastly, in the Goodspeed-Grant and Boersma (2005) study, participants described that the causes of obesity were due to their own behaviour, or because of their genes. Even when seen as genetic, the

participants experienced frustration with their weight loss failures and continued to blame themselves.

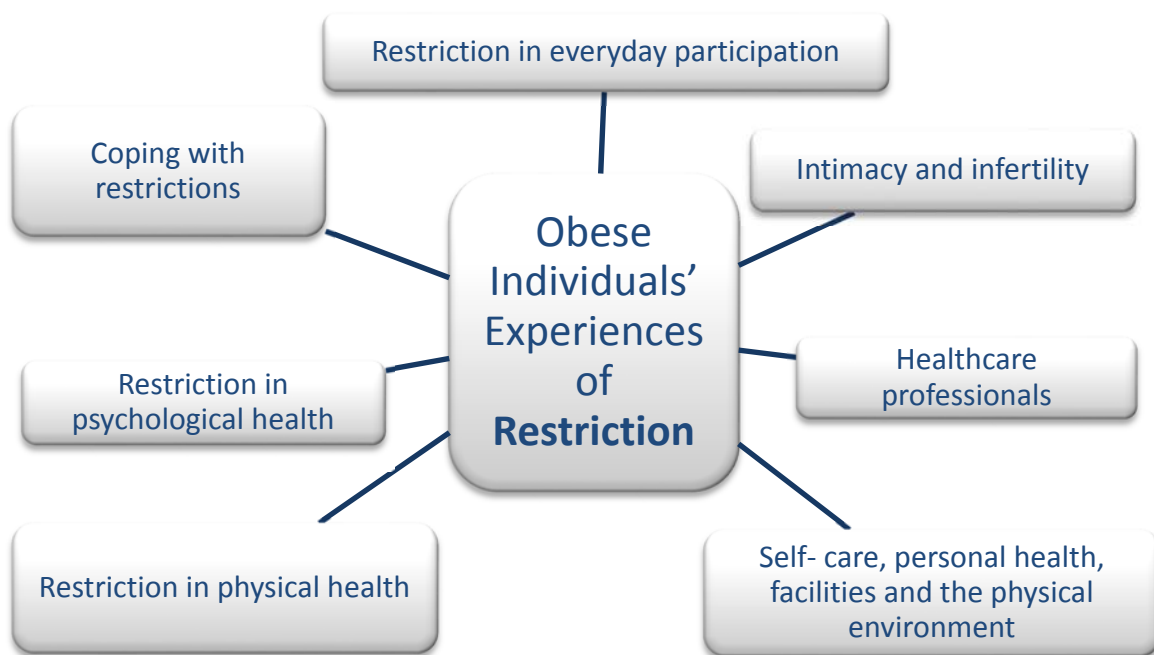
In conclusion, various experiences of self-explanations and hopefulness seem to influence how obese individuals accept or do not accept themselves. This theme should be seen in conjunction with the other two themes of control and restriction. How obese individuals accept or do not accept themselves through these influences and the emotional effect this has, seems to have a marked impact on the other two themes, control and restriction.

5.4. Obese Individuals' Experiences of Restriction

5.4.1. Introduction.

The last remaining theme, the experiences of restriction, is discussed forthwith. The themes discussed so far speak to obese individuals' experiences of control and acceptance. The theme of restriction is mentioned in the discussion around these two themes. This section aims to describe the experience of restriction in greater depth, and explores its interrelation with the other two themes. Although only briefly alluded to, the experience of restriction is present throughout the discussion above. Some of the sections which discuss the experiences of restriction may resonate from previous sections with the reader. Restriction seems to be inextricably associated with the experiences of obese individuals. As mentioned previously, it is essential to understand the importance of the interrelationship between one theme of experience and its simultaneous influence on the other themes of experience. For the participant, the theme of restriction may be explicitly stated whereas, in other instances, it is merely implicit.

To clarify, restriction refers to the regulations or limitation that restricts, according to Wikitionary Online (2012). The Oxford English dictionary online (2012) defines it as a limiting condition of someone or something, or the state of being restricted, keeping under control, or the deprivation of freedom of movement or action. In this research, the definition of restriction is that obese individuals experience limitation, constriction, confinement, and deprivation of their freedom of movement or action. The experience of restriction for obese individuals' varies in its description, from occupational, social and medical contexts, to various experiences of restriction in social interactions. Especially pertinent are ways of trying to cope with restrictive experiences in addition to immensely strong emotional reactions. The discussion commences with restrictions in the participation of everyday life.



■ *Figure 6.* Diagrammatic depiction of obese individuals' experiences of restriction

5.4.2. Restriction in everyday participation.

The settings of work, family outings, and medical environments, are not only important social environments for most individuals, but seem to be especially significant settings for obese individuals. There are everyday restrictions which seem to influence obese individuals' experiences and definitions of themselves. The following points refer to the settings in which obese individuals seem to experience this.

5.4.2.1. The occupational context.

The workplace has an influence on many spheres of an individual's life. This is because of the amount of time that is spent there. It is also in this setting that obese individuals experience numerous challenges and encounter restrictions. The studies by Engstrom et al. (2011), Forhan et al. (2010) and Ogden et al. (2006) describe numerous experiences.

In the study by Engstrom et al. (2011), participants who were obese shared the experience of being discriminated against in the employment market as a result of their obesity. In the study conducted by Forhan et al. (2010), participants did not describe discrimination per se, instead they experienced restricted choices of occupations because of their weight, and anticipated having more career choices if they would lose weight. The participants described limited career choices - some have had the experience of life at a lower weight, and ranges of accompanying occupational activities were greater at that weight. They thus had a different life experience to which they compared their current restricted situation. These individuals experienced restricted choices of activities that accompanied an increase in weight.

Therefore, they described that as their weight decreased, options for participation in the areas

of work increased. That was, until their weight increased again, and their options yet again diminished. This corresponds with the experiences by participants in the study conducted by Ogden et al. (2006). The participants in this study described that their weight led to their inability to carry out some work-related activities in their daily lives. Lastly, with reference to Forhan et al. (2010), some of the participants described their experiences of having to actually resign from their careers because they could no longer prepare for work, travel to work, nor complete the demands of their jobs because of their obesity.

To conclude, there are numerous challenges for obese individuals in an occupational setting, and to many obese people it is perceived as a massive uphill battle, accompanied by strong emotions.

5.4.2.2. Social restriction in outings and family activities.

Recreational activities form a part of most individuals' day to day living experiences. This includes partaking in leisurely activities or going on outings with family and friends. For many obese individuals, however, these activities do not seem to be experienced as carefree or fun. In many circumstances obese individuals seem to experience restriction in these activities and, in addition, also seem to experience strong negative emotions, discrimination, and be uninvolved in many activities. Restriction is not limited to activities, but there seem to be interpersonal and emotional consequences too. The studies by Engstrom et al. (2011) and Forhan et al. (2010) demonstrate this.

In the study by Engstrom et al. (2011), participants described that their obesity often lead to changes in their self-respect, and guilt, because of their inability to control their weight.

These experiences further resulted in sadness and shame that sometimes caused social isolation. Participants described how they avoided social interactions which involved physical activities, such as dancing, walking, and eating out because they were worried about slowing others down. Their lives were restricted with regards to their family, friends, and society, and they felt sorrow at being unable to play with their children. Participants expressed that they were subjected to social stigmatisation, and they reported receiving hurtful comments about their weight and looks. In the study conducted by Forhan et al. (2010), participants demonstrated similar experiences. They reported having an interest in social, recreational and work-related activities, but would often not take part as they were concerned about their inability to meet the expectations of others, or the demands of the task. These participants were also not as active in their family contexts, and had to limit their options for leisure activities. Furthermore, participants described feeling anxious about eating in restaurants, and often sent someone to the restaurant beforehand to assess the seating, or would call beforehand to request a table and chair which could accommodate their weight and size. Participants described feeling as though they were not good parents/grandparents because they could not move about in public places due to physical challenges or the fear of embarrassment. In an effort to have energy to complete work tasks, they organised the day to minimise walking and often declined work-related social activities or optional off-site meetings.

When focussing on the interrelation of the three themes, it seems evident in the participants' subjective experiences that the ensuing negative emotions which sometimes accompany obesity, seem to cause social withdrawal. On the other hand, they are also confronted in a more direct manner through discrimination and stigmatisation. It is identified from the experiences described above that there is difficulty in only seeing one theme of experience

(restriction) as important, or in isolation. It is critical to take the other two themes (acceptance and control) into consideration. Although this section highlights the social experience of restriction, there is inherent influence on the theme of control and the theme of acceptance. The difficulty in social situations, however, does not end there for obese individuals. There are ranges of restrictions and emotional experiences for obese individuals who want to experience intimacy, including infertility for couples trying to start a family.

5.4.3. Intimacy and infertility.

From the studies which were analysed, it seems that obese individuals attribute their sexual desirability directly to their weight. Furthermore, it appears that the more obese an individual is, the less desirable they feel. It seems that the greater their body mass, the less desirable the obese individuals perceive themselves to be. This may have a significant impact on the emotional worlds of the individuals as they fear rejection, and they endeavour to accept their own abilities – this seems to result in experiences of restriction in intimate relationships. Restriction is not limited to intimacy. It is also described by couples who had difficulty in having children, as the obesity seems to have an influence on an individual's fertility, or the ability to become pregnant. This is apparent in the studies by Engstrom et al. (2011), Forhan et al. (2010), Ledyard and Morrison (2008) and Ogden et al. (2006).

In the study by Engstrom et al. (2011), participants described their fear of losing their spouse because of their weight. This finding corresponds with study findings from Ledyard and Morrison (2008). Participants experienced a similar fear and worried about the potential of infidelity, and being abandoned. These fears hindered sexual and emotional intimacy for some of the participants, and caused sexual and emotional distance from their partners. The

frequency of sexual intimacy was higher when the participants' weight was lower, and participants also believed that they would engage in more sex if they weighed less. Participants described that they felt they would be more attractive at a lower weight. It is also indicated that most couples were more focussed on their own weight than that of their spouses. Certain participants also experienced concerns about whether their partner would be attracted to them if they weighed more and had less energy. Experiences in difficulty in manoeuvring during sex resulted in lower frequency of sex for nearly two thirds of the couples; due to their body being in the way. Similarly, in the study conducted by Forhan et al. (2010), participants described having low self-esteem and poor body image because of their weight, and experienced this as reasons for avoiding sexual activity with their partners, even when their partners wanted to have sex.

Lastly, in the study by Ledyard and Morrison (2008), the process of triangulation with regards to the experience of weight was described. Weight was a third dimension which divided spouses. The experience of weight as a third partner seemed to create the experience of emotional distance between partners. This, in turn, negatively influenced their experience of sex. Participants also experienced concern about their weight, or their partner's weight, in relation to the potential for health problems and weight-related death. This also physically divided some couples. These fears, at times, lead to controlling behaviours of the affected spouse's health. Participants were questioned by their partners regarding eating behaviours and their choice of food, eliciting anger. For some participants, weight sometimes brought comfort and closeness, at other times, pain and distance to the relationship. Lower weight seemed to indicate good news for some couple's marriage, whereas for other couples, a lower weight detracted from the comfort and negatively influenced the trust level between the spouses.

Difficulty is also encountered for obese partners who may be concerned about infertility and difficulty having children. Obesity seems to influence an individual's fertility and the ability to become pregnant. In the study conducted by Ogden et al. (2006), participants described their experience of a desire to become pregnant, yet they struggled because of their weight. This is also found in the study by Ledyard and Morrison (2008), where participants described the battle they encountered with infertility. This may also be understood as the restriction on their family's growth.

To conclude, it seems evident that obese individuals not only face social restriction in numerous ways, but they also apparently experience restriction in their intimate relations and the ability to have children. An aspect that seems of particular importance is the emotional turmoil obese individuals are subjected to because of the restriction they face in these various contexts. Negative emotions experienced range from changes in self-respect, to guilt, sadness, shame, social isolation, social stigmatisation, and anxiety.

5.4.4. Healthcare professionals.

Another important domain in which obese individuals are subjected to a sense of restriction, is with healthcare professionals. This section is familiar in that it is discussed within the theme of the experiences of control and acceptance. Yet again the difficulty in separating the themes of experiences from one another is highlighted. As obese individuals endeavour to control their eating behaviour, they describe their interactions with healthcare professionals as inadequate and as non-accepting. These interactions in certain circumstances result in experiencing a restriction in adequate healthcare, and these individuals experience

accompanying negative emotions. The studies by Engstrom et al. (2011), Nyman et al. (2010), Forhan et al. (2010) and Merrill and Grassley (2008) describe these experiences.

In the study conducted by Engstrom et al. (2011), participants described experiencing prejudice by healthcare professionals. Similar findings are echoed in the study by Nyman et al. (2010) where participants experienced feeling dismissed. They described being treated badly by healthcare professionals because they were spoken to in a sarcastic and negative manner. Pregnant participants experienced humiliation and this caused them to become upset. In addition, they worried more about the experience of the humiliating treatment they may receive, than about the welfare of their baby. Participants feared that they would not receive adequate care, however they did not question the humiliating treatment received by medical professionals. Similarly, these experiences are evident in the study by Forhan et al. (2010), wherein the participants described that they avoided medical care for fear of being reprimanded by healthcare professionals who routinely gave them the so-called panacea to eat less and to become more physically active.

In the study by Merrill and Grassley (2008), participants felt uncertain about what they would find when seeking healthcare. They were specifically uncertain about their experience regarding specialist healthcare professionals, for whom they were referred to for specific health conditions. Interactions with specialist healthcare professionals were described as insufficient, as minimal time was allocated for these visits. Frequently, the experience was that the doctor was rushed. In addition, participants felt unheard, as their healthcare professionals did not take adequate time to hear what they were saying. Participants experienced feeling dismissed. They dreaded the experience of seeking help because of the poor interpersonal relationships with these healthcare professionals, and especially feared that

providers would scold them because of their weight. Some participants, however, described positive relationships with healthcare professionals who were more likely to be friendly and take extra time to talk about their health problems. This made participants feel respected and accepted.

The reader is reminded, yet again, of the interrelation of the three themes of experiences, and that they interplay with one another in multiple ways. The experience of restriction by obese individuals from healthcare professionals seems to be influenced by these healthcare professionals' idea of control and that obese people should exercise more of it. The obese individuals, themselves, therefore seem to struggle with acceptance from their healthcare professionals and apparently feel inadequate. Consequently, the obese individuals experience restriction and this, in turn, potentially influences their control.

In summary, obese individuals describe the experience of social restriction. However, in this instance, it also seems to influence their health, as they report that they receive poor healthcare service from healthcare professionals. The participants' describe that their needs and descriptions are not taken seriously by healthcare professionals, and they are subjected to biased views; even from some specialist healthcare professionals. Potentially biased healthcare professionals may miss crucial health-related issues, or symptoms – especially as the obese individuals feel that they do not have a voice. The emotional component of being seen as a fat body instead of as a person by healthcare professionals cannot be overlooked. They experience feeling dread, feeling dismissed, being humiliated, uncertainty, being unheard and scolded; all of which seem to compound their experience of restriction.

5.4.5. Self-care, personal health, facilities and the physical environment.

Obese individuals are not only seemingly restricted in terms of adequate healthcare, there is evidence which suggests restriction in other life contexts as well. Take, for example, a few daily tasks after an individual wakes up. Firstly, obese individuals describe finding clothes which fit them difficult. Secondly, with personal hygiene, obese individuals describe being confronted with the challenge of trying to use equipment which may be too small. Restriction for the obese individual is also described in bodily movements and the built environment. The studies by Engstrom et al. (2011), Forhan et al. (2010), Nyman et al. (2010), and Merrill and Grassley (2008) describe these experiences.

The participants in the study by Engstrom et al. (2011) described feelings of helplessness in being unable to find appropriate clothing. This is mirrored in the study by Nyman et al. (2010), where participants described experiences of unsuitable clothing and equipment not being big enough at healthcare facilities; and the ensuing worry and frustration. Similarly, participants in the study by Forhan et al. (2010) described requesting help from family members for tasks such as tying their shoes. This led the participants to finding other ways to dress their lower extremities by, for example, avoiding lace-up shoes and not wearing socks, or wearing long skirts to avoid the need for pantyhose. In addition, the effort and amount of energy consumed to shower, dry hair, and dress also caused them concern. To make it to work on time, many participants needed to start their day two to three hours before work to complete self-care. In the study by Merrill and Grassley (2008), participants described that there were no suitable clothing and equipment at healthcare facilities - their size and weight required different gowns and blood pressure cuffs, scales, chairs, and other equipment. These necessary supplies and equipment were also often not readily available.

Male participants in the study conducted by Forhan et al. (2010) experienced restrictions in using male restrooms, because they needed to sit down for urination. This was challenging when public washrooms did not always have a seated option. Similarly, in the study by Merrill and Grassley (2008), the built environment limited participants' ability to utilise healthcare facilities. They did not fit into normal healthcare office spaces because of their physical size. They also anticipated difficulty because of their size and needing to find suitable sitting spaces in the waiting room. This restriction was also experienced in recreational and social contexts, which included seating in cinemas, restaurants, or transport services, where seating was too small for an obese person. Other barriers included parking spaces located far from entrances, and access to elevators and stairs without adequate depth for every step. The consequence of these restrictions of the physical environment was participants avoiding dining out, visiting amusement parks, or using transport other than their own vehicles.

Obese individuals' do not only seem to experience restriction in terms of social restrictions, as is previously explored. This section demonstrates how obese individuals' physical size contributes to restriction in their choice of clothing, limitations in the built environment, and restrictions to their body's mobility, all of which seem to lead to social restriction.

5.4.6. Restriction in physical health.

Obese individuals' encounter health-related challenges which form another major element of their experience of restriction. Health-related challenges seem to restrict healthy living physically, as obese individuals describe numerous illnesses experienced as a result of their

obesity. The studies by Engstrom et al. (2011), Forhan et al. (2010), Nyman et al. (2010), Ogden et al. (2006), Ledyard and Morrison (2008), and Wysoker (2005) highlight this.

The experience of restriction is described in the study conducted by Engstrom et al. (2011). Participants described bodily pain including the back, the knee and the feet (or foot strain). This was also evidenced in the study conducted by Forhan et al. (2010), in which the experience of restriction was described by their diminished ability to control their bladder functions. Urinary incontinence was identified as an issue that limited participants' ability to engage in activities. In addition, pain and fatigue were described in a range of activities participants performed at work. Similarly, participants in the Nyman et al. (2010) study experienced difficulties in being active and mobile. Obese individuals complained about physical problems, such as pain and discomfort. These participants also described their concern about the risks of their obesity on reproducing, and whether it would risk their own and/or their baby's life.

Participants in the study by Ogden et al. (2006) described their physical and general health deterioration due to their increased weight, and this was their motivation for wanting bariatric surgery. Similarly, participants in the study conducted by Wysoker (2005) described health concerns as a major influence in their decision to undertake surgery. In the studies by Ogden et al. (2006), and Wysoker (2005), participants made the decision to undertake surgery because of the onset of symptoms such as obesity-related heart problems and diabetes. In summary, obese individuals experience restrictions with a healthy physical life. This is due to their potentially debilitating physical health.

5.4.7. Restriction in psychological health.

Obese individuals also describe experiences of psychological restrictions. For psychological restrictions, obese individuals describe encountering the compounding anxiety of facing their own mortality due to these experiences. The experiences of the participants in the studies range from worries and fears about developing illnesses, to how this restricts their participation in daily living. In addition to this, some obese individuals experience negative views about themselves, that is, negative emotions, contemplation of their own death, and suicidal ideation. Obese people therefore describe themselves in terms which are not psychologically healthy. The studies by Engstrom et al. (2011), Nyman et al. (2010), Forhan et al. (2010), Groven et al. (2010), Ogden et al. (2006), Wysoker (2005) and Merrill and Grassley (2008) demonstrate this.

In the study by Engstrom et al. (2011), participants described their thoughts about their bodies and reflected on their negative feelings and overall dissatisfaction. They avoided mirrors and rarely weighed themselves, as these were reminders of their appearance. Participants experienced shame, guilt, hatred, and disgust in describing themselves. Participants described their fears of potentially developing diseases such as cancer, which elicited feelings of anxiety and hopelessness. In the study by Forhan et al. (2010), most participants explained feeling that they were not good parents or grandparents because of their immobility. They feared continual embarrassment. They described having low self-esteem and being dissatisfied with their body image. They, therefore, avoided sexual activity with their partners, even if their partners showed interest. These participants described that as their weight increased, their credibility in social and professional situations became negatively affected; they felt as if they were taking up more public physical space. They

avoided going out and rather stayed at home. Obese participants in the study conducted by Groven et al. (2010) described feeling miserable and unhappy with the way they saw themselves. They also described their experiences of on-going worry about their future health, and the health risks of serious illness, disability, or health decline that accompanied their obesity. Concerns ranged from heart disease to an excessive worry about their health.

Similarly, in the study by Ogden et al. (2006), participants depicted experiences of the impact of their weight on their psychological wellbeing. They described how their weight affected their self-confidence, how it made them feel miserable, depressed, and upset. This in turn, lead to their feelings of worthlessness and sometimes, suicidal ideation. They felt dissatisfied with their body image and their overall physical appearance. In the study conducted by Merrill and Grassley (2008), participants experienced that their obesity led to negative changes in their self-respect. They felt guilty about being unable to control their weight. They felt sadness and shame because they were overweight. In the study by Ledyard and Morrison (2008), participants expressed feeling emotionally better at a lower weight. They expressed that they felt negative emotions and had a low level of self-confidence when obese. Others' judgements about their body size also created a feeling of alienation and not being viewed similarly with other people in society. Lastly, the participants in the Wysoker (2005) study described that the onset of symptoms such as heart problems and diabetes were related to their obesity. This made them aware of the threats of obesity. However, in this particular study, their thoughts about their physical bodies caused them to become even more fearful of sickness than before.

Thus far, has been discussed that numerous obese individuals described experiencing a restriction in their psychological health. Some participants described desperation with regards

to their obesity. For them, the notion of death due to the restrictions in life was emphasised. Their psychological health seemed to deteriorate due to their pessimism, fear, anxiety, and concern about their physical health. This is described in the study by Engstrom et al. (2011), where participants' described experiences of pessimism regarding their own future life; and they predicted their own premature death because of their failure to lose weight. In the study by Nyman et al. (2010), participants echoed similar experiences – they described the prospect of death for them as real due to their obesity, some felt that they were not going to be able to be there for their offspring. In the study conducted by Ogden et al. (2006), participants described that death, for them, was a real possibility. This was sometimes the case because of the severity of their obesity, and it added to their fears of illness and the prospect of their own death. This is reiterated in the Ledyard and Morrison (2008) study, in which obese participants were concerned about the potential for personal health problems and death. Lastly in the study by Wysoker (2005), participants described living in fear of prospective sickness and death.

The manner in which restriction in psychological and physical health can impact and influence obese individuals' experiences of control and acceptance can be teased out in terms of the interrelation and dynamic interplay of the three themes mentioned previously. It seems apparent that obese individuals experience restriction in terms of both their physical and their psychological health. This is described by their experiences of negative descriptions of self which includes alienation and feeling different or inadequate; the pessimism and fear of their own health; and confronting the possibility of their own death, or suicidal ideation. However, in spite of these physical and psychological experiences of restrictions, obese individuals still find ways of coping with their experiences. This is explored in the final section of this theme.

5.4.8. Coping with restrictions.

Although obese individuals have described being hampered and restricted in various spheres of life, they still find ways and means of coping with these restrictions in their lives. These coping experiences include creative adaptations to the environment in their use of physical objects, or they receive instrumental help and emotional support from their family and friends. Other ways of coping are humour, perseverance, and hope. The following studies by Forhan et al. (2010), Nyman et al. (2010), and Merrill and Grassley (2008), demonstrate these experiences and how obese individuals attempt to deal with the restrictions of obesity.

In the study by Forhan et al. (2010), the participants described adopting creative strategies to cope with their life restrictions. Participants described using assistive devices such as canes, walkers, scooters, or adapting to the environments in which they participated. Participants also requested instrumental help from family members to tie their shoes, and identified other ways to dress their lower extremities, by avoiding lace-up shoes. In addition, they also described wearing socks, or long skirts, to avoid the need for pantyhose. The participants experienced emotional support which included verbal encouragement as a source of empathy and understanding from others (Forhan et al., 2010). In addition, despite their feelings of anxiety and self-consciousness, they described their perseverance to be as physically active as possible in public spaces and fitness environments. They managed the challenge by taking frequent breaks and prioritising tasks. By doing what they felt needed to get done first, by organising their day to minimise walking, and by declining work-related social activities, they were successful in managing their day.

In addition, participants in the study by Forhan et al. (2010) described that they planned ahead. This was a key strategy, which involved seeking out accessible environments for socialising and finding businesses. In the study by Nyman et al. (2010), participants joked about their sizes which seemed to help to generate relief in uncomfortable and nervous situations. Participants described the coping strategy of trying to ignore the experience of bad treatment, and interpreted that nurses may have a lot of work to do. Participants also often involved others to accompany them to hospitals as a means of support.

Another coping mechanism described by the participants is hope. In the study by Forhan et al. (2010), participants described that they made use of physical supports. Some participants described that they preferred not to use such devices, nor did they see the point of purchasing such devices as they planned to lose their surplus weight. Similarly, in the study conducted by Merrill and Grassley (2008), individuals described refusing to give up. This is interpreted by the researcher as persistence in striving for control, in the hope that they will lose weight. These participants still continued to look to the future with hope, and believed that an answer for their obesity could be found. They described their determination to improve and control their weight, despite many failed attempts. In the study by Nyman et al. (2010), participants viewed obesity only as a temporary state that they themselves could, and intended to, do something about in the future.

To conclude, it seems evident that, in spite of all the challenges and numerous restrictions obese individuals encounter, they are still able to experience ways of coping with their uphill battles. These uphill battles which obese individuals face are steep and many. Added to this, these uphill battles carry a very high emotional cost for those who experience them.

5.5. Findings Conclusion

In summarising the findings, this chapter discusses the three main themes that obese individuals experience. The researcher has provided details of subthemes within each of the larger themes. It is explained that each theme interconnects in a dynamic interplay with the other to understand the totality of obese individuals' experiences. It may have been simpler to see the themes in isolation. However, every one of these central themes brings with it a connected understanding to obese individual's experiences. In understanding one of the themes, one perceives the influence it has on the other two themes, such that a complete picture is developed with regards to obese individuals' experiences. For example, viewed in isolation, the theme of their experience of control describes that obese individuals experience deficits in control. It may be interpreted that newer treatment modalities for obesity should encourage greater control for obese individuals, and this would be the main focus of this research. This however is a linear and myopic view, and the researcher is aware of its deficiencies.

It is shown here that if a linear argument is followed, then control in obesity is interpreted as the significant factor which influences obese individuals. However, the Berman study shows that other experiences may also influence an individual's control. Other themes interplay with the control, and therefore they need to be considered to provide greater clarity in understanding the participant's experience of obesity. This is why the interplay of the three different themes is made clear from the outset and throughout the chapter. The three themes are in a reciprocal triangular relationship with regards to obese individuals' experiences. To unpack, and bring greater clarity to this statement, another example is provided to further enhance understanding of the dynamic interplay, and flux, of the three themes of experience.

Fromm (1994) compares a game of chess to that of the dynamics of an individual's psychic development. For the purpose of this research, psychic development is exchanged for obese individuals' experiences. Initially, when the two players commence the game of chess, they are potentially on even terms. As a series of moves are executed, either player may make a series of mistakes, or either may make brilliant executions. As the game continues, either player's chances of winning are greatly diminished or improved. However, the same players, no matter how they have played up to that point, can still either win or lose the game. Most importantly, both players' chances of being checkmated or winning the game are influenced at the same time by each other. The game of chess is not static as it is dictated by both players on a continuous basis.

Similarly, there is a continuous dynamic interplay with the other related themes which must be taken into account and understood. This is clearly demonstrated in the two examples provided by the triangles and the chess game. This concludes the analysis. The final chapter is a discussion of the analysis, including insights on other aspects.

Chapter 6: Discussion

6.1. Introduction

The discussion chapter is the final stage of this qualitative systematic review. The aim of this research is to answer the research question: “What would a qualitative systematic review elucidate about phenomenological research on adults’ experiences of obesity?” The chapter commences by recapping the research methodology. Thereafter, the themes that are analysed in the previous chapter through the qualitative systematic literature review are reflected upon. Themes which are identified through the analysis are linked to the relevant literature. By linking the themes to the literature review, the researcher enriches the analysis of this study. The discussion then proceeds to review the contexts of the studies analysed, to try to avoid the pitfall of decontextualised findings. According to Paterson et al. (2001), a potential pitfall of a qualitative systematic review is that data may be stripped from its original situated context. Simply put, the data may potentially lose its essence. The researcher highlights this point to ensure the soundness of this research as discussed in Chapter 4.

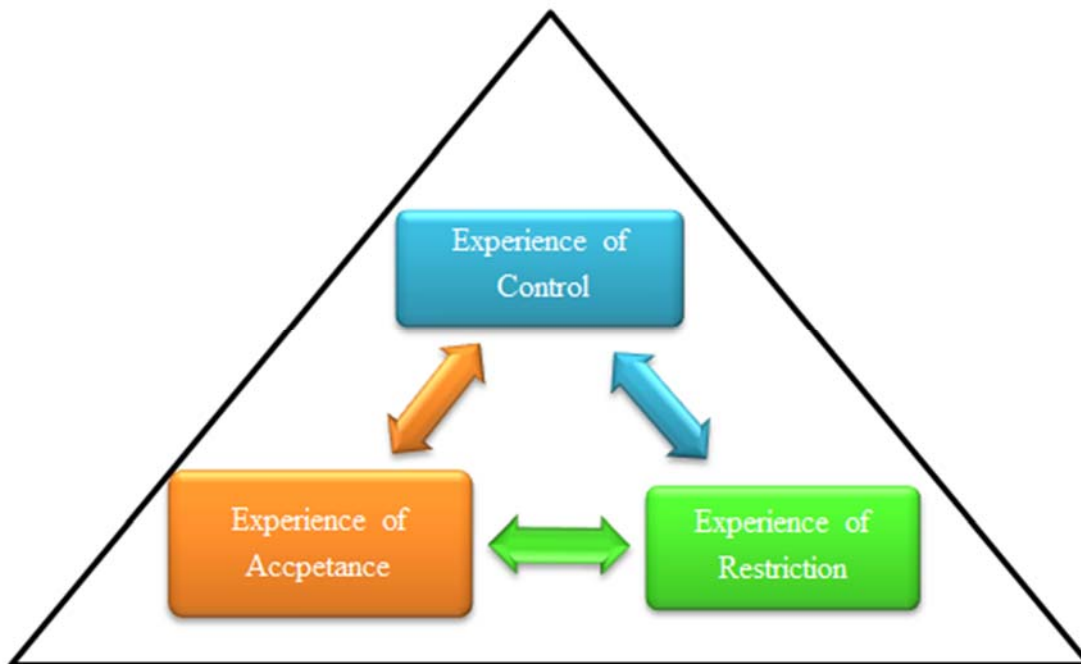
The information from the different studies were analysed to create a deeper understanding of potential contextual influences which may have impacted on the three themes of control, acceptance and restriction. Possible explanations relating to the contextual information were cross-referenced with the literature review. If the context were found to hold no bearing on the analysed themes, the researcher reflects upon this. Within these contexts, a temporal analysis was also conducted. The reason for this is that the analysed themes are situated in time within these specific contexts. Different themes emerged at different times, and through the researcher conducting a temporal analysis any shifts in the context which may potentially

have influenced the analysis of the three identified themes can be identified. The analysed contexts are: the participants' BMI, age, gender, and race. In addition, the original location of the study was considered, the type of journal in which the studies were published, the faculties from which the researchers came, and the research methodology which was employed. The chapter also reviews possible shortcomings of this research and areas for future research are identified. The chapter concludes with a summary of this study's findings.

6.2. Review of Research Methodology

The following section provides a brief review of the research methodology employed to place the analysis into context and to provide a platform for the discussion of this chapter. This qualitative systematic review adopted the progressions of steps outlined by Tricco et al. (2011). The study began with the development of a review question; it then progressed to finding relevant studies. From these studies, inclusion and exclusion criteria were employed and only the studies applicable for the present research were selected. These studies were then read numerous times in different ways, followed by the process of identifying and extracting relevant findings. From these findings, groupings were compiled. The process of grouping findings was aided by the concept of reciprocal translation (Noblit & Hare, 1988). The final phase of analysis involved the abstraction of findings, in which grouped findings were revised, similar findings were combined, and subthemes sifted. This was done with the aim of strengthening the understanding of the themes and the dynamic interaction between and within studies. The findings were grouped into three themes with related subthemes.

6.3. Themes and Subthemes Analysed



■ *Figure 2.* Representation of the interrelationship and reciprocal dynamic interplay between the three themes of experience

Three main themes are described, everyone with associated subthemes. The first theme is how obese individuals experience control; the subthemes are: lack of control and restriction; healthcare professionals; lack or loss of control; perceived control; potential control and control being influenced by negative emotions. The second theme is obese individuals' experiences of acceptance, and the sub themes are: non- acceptance of self; interactions with other individuals; need for acceptance from other individuals; other influence on acceptance or non-acceptance of the self. The third theme is obese individuals' experiences of restriction, including these subthemes: restriction in everyday participation which includes the occupational context and social restriction in outings and family activities; intimacy and infertility; healthcare professionals; restriction in self-care, personal health, facilities and the physical environment; restriction in physical health; restriction in psychological health; and

coping with restrictions. The following section explores the research analysis and meaning is educated about what it is like to be an obese individual. This is followed by linking the literature review to the analysis, to highlight similarities, discrepancies, or both, so as to deepen and enrich the analysis of this qualitative systematic review.

6.3.1. Research analysis of obese individuals' experiences.

Parker (2005) explains that there are no findings in qualitative research, only analyses. This means that there are sequences of explanations, which can be exposed to scrutiny. This qualitative systematic review is no different. The researcher provides his interpretation of the various themes and subthemes taken from the analysis. The researcher reviewed studies of various researchers who had direct contact with the participants' and who wrote descriptions of their understandings and experiences. Therefore, the researchers in the analysed studies had the opportunity to directly explore and encounter the participants' lived experiences. The researcher's impression and interpretation therefore entail a three way, or triple, hermeneutic interpretation. Thus, the researcher's interpretations relates to the other researchers' interpretations of their participants.

To briefly outline the phenomenological approach in its theoretical and methodological contexts, and to refresh the reader, Zambardo's (1995) description is useful. Zambardo (1995) summarises that phenomenology comes down to achieving an understanding of the lived experience of the individual. The researcher immersed himself into various researchers' interpretations of the obese individuals' experiences of their lived world and life space. The researcher was struck, by the participants' emotional, physical, and cognitive worlds, from

which the researcher deduced a subjective, descriptive, framework. From this, a triple hermeneutic interpretation was gained and is explored (Malpass et al., 2009).

6.3.2. An obese existence.

As this is a qualitative systematic review study, the researcher had no direct contact with the participants in the explored research studies. However, the chosen studies are all phenomenological, and therefore provided the researcher with a vivid, rich view, of what it may be like to live the life of an obese individual. The researcher immersed himself in the various interpretations of the participants' experiences. This experience did not just elicit understanding. The research affected the researcher, and these impressions are described forthwith. For an obese individual, living is experienced as an uphill emotional climb. This climb seems to be an insurmountable mountain, with no summit in sight at present. The mountain is insurmountable because of the difficulties en route with the world and with themselves.

The experience for an obese individual is described by understanding their internal worlds and then shifting to the external world. Firstly, the obese individual feels out of control with regards to weight concerns, and there may have been many unsuccessful attempts at weight loss. With every failed attempt, the individual experiences changes in self-respect, guilt for not controlling one's weight, and accompanying feelings of hopelessness and powerlessness. The obese individual feels the need to obtain an external agent to control the problem, and the belief held is that nothing in one's current situation will change unless something drastic is done. The obese individual experiences him/herself as inadequate in various ways, accompanied by intensely negative emotions. This non-acceptance, or inadequacy, is

experienced in routine day-to-day living, in both personal and interpersonal domains; ultimately one feels like a failure. The experience is a very negative set of emotions, and overall dissatisfaction including feelings such as hatred, disgust, shame and guilt. The obese individual avoids being confronted with the body's appearance, and these individuals face social isolation as they withdraw. Furthermore, the obese individual flees from individuals who really matter, they feel less capable than others at work, and they may hold perceptions that their credibility in social and professional situations is negatively affected by their increasing weight gain. Therefore, feelings of public humiliation, shame, embarrassment, and frustration are experienced. The extra weight and larger clothing sizes contribute to further feelings of inadequacy. In addition, larger equipment is required because it is more difficult to medically examine obese individuals with available equipment. This perpetuates shame and self-blame. These factors combine to construct the experience of feeling less than human, being different to others, and being inadequate.

To compound the situation, the obese individual sits with the notion of whether or not there is control, which manifests through different experiences between oneself and other individuals. This is accompanied by consequent negative feelings, which intensifies the inner conundrum and turmoil. Further complexity is added as one struggles with post-surgery experiences as the conundrum around control intensifies and does not seem to abate.

One feels negative emotions which are due to demeaning interactions with other individuals, such as healthcare professionals. Through these poor interactions, one is left feeling humiliated and outraged. Control over eating is affected by these emotions. One experiences the contradictions of feeling both accountable and not accountable for the extra weight; contradictions which remain unresolved. These contradictions influence interactions with

oneself and others. Due to these unresolved contradictions, interactions with healthcare professionals are experienced as demeaning, condescending, scrutinising, and scolding. There is a sense of prejudice. One experiences feelings of inadequacy, especially because there is a lack or loss of control over one's weight, and this is reinforced by healthcare professionals. One does not feel that greater control is possible, an experience that leaves one feeling dread, shunned, isolated, humiliated, unheard, and helpless. All of this contributes to the avoidance of seeking necessary medical treatment.

Other feelings of inadequacy or unacceptability are when an obese individual is seen as obese, and nothing else. This creates the feeling of being less than human and different to others, or inadequate. One feels helpless and disappointed that the needs are not recognised, or respected in the same way as others, or even not considered. Negative comments reinforce and confirm the experience of being unwanted and unattractive.

In some instances, obese individuals become more assertive, and they reveal dissatisfaction about the healthcare professionals approach, yet the negative outcomes remain the same. Some medical professionals do respect the obese individual. When this happens, they feel personally satisfied and of worth, and it positively influences their health status. Respectful relationships with healthcare professionals are desired in the place of dread. This need to be accepted and adequate is wanted in various contexts, not only healthcare environments. In the work context, the need to be accepted is so great, the obese individual will work despite potential injury, in an attempt to prove ability. Some obese individuals try to change their appearance physically, superficially through clothing, or through the aid of surgical intervention. This is done in the hope of becoming more acceptable to other individuals, and

oneself. Self-explanations of obesity seem to have an influence on hope and general acceptance of self.

The obese individual defines his/her own understanding in settings such as work, on family outings and in medical environments. These contexts bring various forms of restriction. For example, there is discrimination against obese individuals in the employment market, and they have restricted choices for participation in their preferred type of occupation. The obese individual experiences an inability to carry out some work related activities, and because of these limitations, resignation is usually the only option. This is compounded by the longer periods of time that it takes the obese individual to prepare for work, travel to work, or complete the demands of their job, as compared to normal weight individuals.

The restrictions continue for social activities, which have interpersonal and emotional consequences. The obese individual experiences guilt over the inability to control weight gain, which surfaces as sadness and shame. This sometimes leads to social isolation and the avoidance of social interactions which involves physical activities such as dancing, walking, and eating out. There are other restrictions on life experiences such as activities with family, friends, and society, in which the obese individual cannot partake.

Sexual desirability is directly attributed to weight - the more obese one is, the less desirable one feels, and this contributes to a low self-esteem and poor body image. The direct and significant consequence for an obese person is to fear rejection, have difficulty accepting one's own ability, and to avoid sexual activity despite the others' interest. This causes experiences of restriction in intimate relationships, however, there are rare occasions when

being obese helps one to feel closer to his/her spouse. Restriction is not limited to intimacy. It is also encountered in the difficulty of trying to have children, as obesity influences fertility. In the medical context, it is not only experiences with healthcare professionals' that are negative and restrictive; there is a restriction in adequate healthcare too. Needs and descriptions are not taken seriously, and they are subjected to what seems to amount to biased views from medical professionals. Crucial health-related issues or symptoms may be missed by biased medical professionals. Furthermore, there is the challenge in trying to use equipment or facilities which are too small.

Restriction is experienced personally - not only in terms of clothing, but also in accomplishing basic personal hygiene. Health-related challenges are faced daily, and psychological health is likewise affected. The obese individual worries about and fears developing illnesses, negative experiences lead to the emergence of negative emotions, and one is confronted by existential anxiety concerning death and, in some instances, suicidal ideation is considered. Although hampered and restricted in various experiences, there are some ways and means of coping for obese individuals with these restrictions in life. Some creative ways to cope are to adapt to the environment, to get instrumental help, and emotional support from family. Lastly, humour, perseverance, and hope are key to coping with the restrictions of being obese.

To conclude, the researcher makes reference to Buber's (1958) description of the I-it relationship of human interaction. The I-it relationship may be described as occurring when an individual is treated as a thing in relationship, based on prior experiences, with no presence or recognition as a total human being (Buber, 1958). For the researcher, being obese means being treated as things or as an object. Schneider and May (1995) describe that in this

type of relationship, individuals are made to play into roles, and listen to one another in mechanistic-like performances. For the researcher, obese individuals are treated in a mechanistic way in society, especially with regards to their relationship with healthcare providers. They are consequently left feeling emotionally damaged and inhuman. Buber's (1958) I-thou level of interaction makes it clear that it is necessary to treat obese individuals as unique and multifaceted human beings, which seldom transpires. There is no level of interaction for obese individuals which promotes coexistence, within self-other interactions. The obese individual is reminded of this by various confrontations with restriction, alienation, and inadequacy with which they see themselves. Topped by the perplexing contradictory experiences of control, obese individuals feel inadequate within themselves and society at large. The obese individual is replaced by the construct or concept of obesity, which marginalises them, and further distances them from others.

6.4. Literature Review with Research Analysis

This section links the analysed themes to the literature review, to highlight similarities, discrepancies, or both. In the research analysis, the three themes of control, acceptance and restriction are discussed as prevalent within obese participants' experiences in life. These themes are described as inseparable from one another and they exist in a dynamic interplay. In certain instances this is similar when linking the three themes with the literature review. The section highlights the literature that pertains to the analysis. Similarities and differences were highlighted with the literature. The interplay of three themes of experiences are discussed first.

6.4.1. Interplay of three themes of experiences.

The literature demonstrates the interplay of the three themes of experience and these are considered to be significant in the lives of obese individuals. Gard (2004) stresses the importance of environmental factors, and highlights that the obesity epidemic is best conceptualised as a complex social movement. It is not to be viewed as a simple sum total of small changes, or the manner in which individuals exercise their body, or their dieting habits. This seems to support the notion of the interplay of the three themes.

6.4.2. Healthcare professionals' interactions with obese individuals.

Chaing and Christakes (2002), Strong (1970) and Verweij (1999) provide some clues with regards to obese individuals' interactions with healthcare professionals. Chaing and Christakes (2002) describe the concept of the medicalisation of obesity. Medicalisation takes place across three tiers: the conceptual, institutional, and the doctor-patient relationship. More specifically, this discussion speaks to the first and third tiers. On the conceptual tier, it seems as if some doctors understand obesity and obese individuals in a medical manner (Barlow & Dietz, 2002; Brown, 2005; Epstein & Ogden, 2005). On the third tier, the doctor-patient relationship becomes manifest through the consistent application of medical practice (Barlow & Dietz, 2002; Epstein & Ogden, 2005).

However there are discrepancies. Many doctors view the conceptual tier of obesity with scepticism, which leads to discrepancies and inconsistent application of medical practice in the doctor-patient relationship (Strong, 1970; Verweij, 1999). This inconsistent practice is described in various research involving medical professionals and obese individuals (Barlow

& Dietz, 2002; Brown, 2005; Epstein & Ogden, 2005). In these different studies, medical professionals do not recognise the conceptual tier of obesity. In the doctor-patient relationship tier, obesity is seen to fall under the patient's responsibility and control, and not that of the medical professionals. Strong (1970) and Verweij (1999) explain why: Medical professionals manage simple illness straightforwardly, in a biological manner, which are clear-cut in terms of cause and treatment. Obesity has no clear cut aetiology (Shelley, 2012; Vogele, 2005), and there is no long-term effective treatment for obesity (Ayyad & Andersen, 2000; Byrne, Cooper, & Fairburn, 2003; Henderson & Brownell, 2004; Jeffrey et al., 2004; Wadden, 1993; Wilson, 1995). This seems to explain medical professionals' scepticism. This seems to highlight the discrepancy in the two tiers of the medicalisation of obesity and sheds some light on obese individuals' experience with medical care professionals in the analysed studies. These are evidenced in the subthemes of perceived control, healthcare professionals' interactions with other individuals, and restriction with medical professionals.

The analysis of findings revealed that the three subthemes: healthcare professionals, interactions with other individuals and, restriction in self-care, contradict the findings by Amesbury and Triggerman (2000). This latter research concludes that if a medical explanation is provided for an individual's obesity, it reduces the individual's perceived controllability, making them more likeable by medical professionals. However, this is not the case in this research analysis. Almost the opposite is described, as the healthcare professionals, although they understood obesity as a medical concept continued to, desire that the obese participants take responsibility, and therefore control, their weight. Obese participants therefore evidenced very negative discriminatory interactions with the medical profession.

Bray (2002), a prominent medical expert on obesity states “the idea that gluttony and sloth, two of the ‘deadly sins’ are the cause of obesity is, sadly, a widely held view. This viewpoint hampers every aspect of the problem, producing real hurdles to research and treatment” (p. 386). This statement is rather ironic in reference to the analysis and literature review chapters. It seems that this is the manner in which a majority of healthcare professionals still conceptualise and understand obesity.

6.4.3. Control.

In reviewing obese individuals’ experiences, a mixed picture emerges regarding the issues of control. Obese individuals’ experienced having either perceived control, or a lack of control and potential control. To link these experiences to the literature, it seems as if there is support for this idea. Research has been conducted on locus of control, self-efficacy, self-regulation, and attribution tendencies. The literature supports the notion of some form of control for obese individuals (Baranowski et al., 1997; Degher & Hughes, 1999; Scoffer et al. 2010), which potentially supports and correlates with the experiences in the analysis of perceived control and potential control. The notion of control is also supported by Adolfsson et al. (2005) and Gard (2004). According to Adolfsson et al. (2005), the success of behavioural change programmes comes down to obese individuals taking responsibility for the outcome. Successful programmes emphasise control of the outcome, in lieu of any one specific aspect of treatment. This is also expressed by Gard (2004), who comments that individuals find it difficult to adhere to the interventions. This is the main problem with obesity. This seems to provide support for the sub theme perceived control. The theme emphasises that obese individuals feel responsible for their weight and exercising some form of control. This correlates with the research.

6.4.4. Non-acceptance of self.

Research describes that obese individuals view themselves as socially unattractive (Wechsler et al., 2005). They also suffer from low self-esteem (Turconi and Cena, 2007) and are also often severely self-deprecating (Yager, 2000). This provides possible support for the subthemes of restriction in psychological health, and non-acceptance of self, as similar thematic experiences were described by the participants in the analysis. Supporting literature from the research by Wang et al. (2004), and Durso and Latner (2008) shed some light on possible explanations for the thematic experiences of obese individuals. These scholars described that obese individuals appear to internalise the powerful social stigma that is evident in society. Consequently, obese individuals hold strong and consistent implicit negative associations about their extra weight, and this, in turn, mirrors stigmatising social views.

Research by Degher and Hughes (1999) provided interesting comparisons, as this research differs from certain subthemes in this research analysis. These scholars described the types of attribution strategies used by obese individuals. Of particular interest is the attribution strategy of obese individuals who admitted that their weight status was unacceptable, but who denied responsibility for being overweight. In this qualitative systematic review, the majority of participants admitted that their weight was their fault and did not deny responsibility. These experiences are evident in the subthemes: other experiences may influence acceptance or non-acceptance of self, non-acceptance of self, and perceived control.

Two recent studies have described how both society and the obese individuals have become somehow accustomed to obesity. The research by Gard (2011) argues that society has

become so accustomed to the sight of obese individuals that we no longer recognise ourselves as dangerously overweight. In support of this, Lewis et al. (2010) elaborated that there have been numerous studies which identify health beliefs and behaviours of obese individuals. Research reveals that obese individuals, in many circumstances, underestimate their weight. This contributes to the minimisation of, or the denial, that their weight is a health risk. In the experiences of obese individuals in this qualitative systematic review, there is no evidence to support this; if anything, the opposite. The obese participants described their experiences of being aware of the health issues which they potentially faced, and that their own life may be at risk. This causes them anxiety and therefore seems to restrict them in terms of their psychological health. Their described experiences are evident in the subthemes: restriction in physical health, and restriction in psychological health.

6.4.5. Discriminatory practice.

Research by Colditz and Stein (2007) describe that due to discrimination, obese individuals are more likely to have poor quality of life and a decrease in social mobility. Similar results arose in this study's analysis, in that obese individuals described being restricted with regards to their psychological health. In addition, this was described in their difficulty in trying to integrate with other people. Obese individuals seem to experience discrimination in various contexts. In some instances, this leaves left them socially isolated. These experiences are evident in the analysis when grouped into the following subthemes: restriction in psychological health, and interactions with other individuals. Research from the literature also describes that because of the discriminatory practice against obese individuals, they face limited access to healthcare, compared to normal weight individuals. It is evident that obese individuals receive biased diagnoses and treatment from both medical and mental health

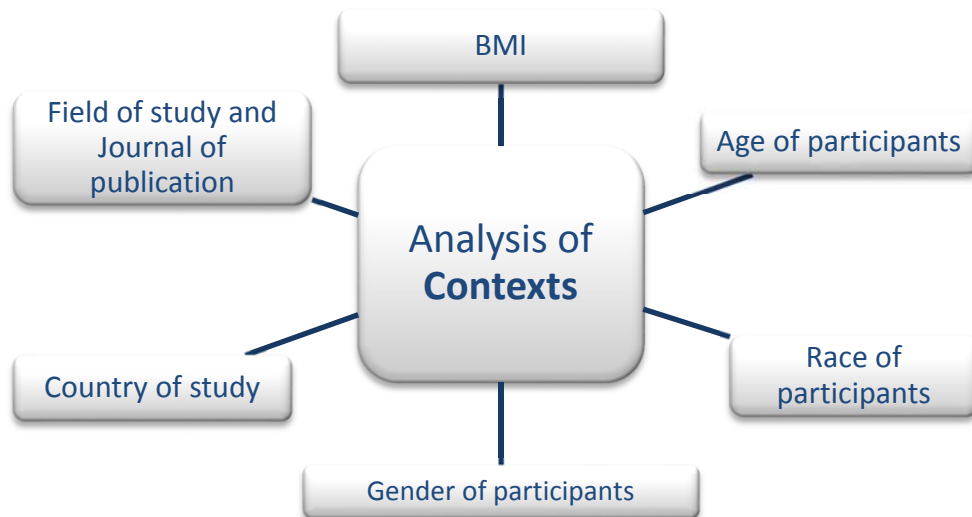
providers. They are also seen to lack self-discipline (Colditz & Stein, 2007; Friedman & Brownell, 1996; Henderson & Brownell, 2004; Kruger et al., 2005; Muller & Weber, 2005; Puhel & Brownwell, 2003; Puhel & Heuer, 2009; Neumark & Haines, 2004; Sadock & Sadock, 2007; Wang, Brownell, & Wadden, 2004). This corresponds to the findings of this study, as discrimination was described by obese individuals in their relationships with healthcare professionals, and interactions with other individuals. Linking to the research by Baum and Ford (2004) on occupations, obese individuals are also paid lower wages. Neumark and Haines (2004) support this by remarking that obese individuals seem to earn less than normal weight individuals. In the obese individuals' experiences in this qualitative systematic review, they do not describe being paid less, but described the loss of job opportunities, and that fewer tasks were delegated to them at work. This is described within the analysis within the subtheme restriction in the occupational context.

6.5. Analysis of Contextual Information

This section explores the contextual information of the various studies used in this qualitative systematic review and the researcher reflects on the potential influence. The introduction of this chapter highlights that the context of the various studies needs to be analysed. Contexts refer to the primary research and the participants' characteristics within the studies used in the qualitative systematic review (Paterson et al., 2001). They are, therefore, aspects of the primary studies which are not part of the findings of those studies. The objective of this section is to explore the potential impact the context may have on the themes, and to understand the situatedness of the original, primary studies. This helps to avoid data and findings being decontextualized (Paterson et al., 2001). Possible explanations linking to the contextual information were cross-referenced from the literature review. If it was interpreted

that context had no bearing on the analysed themes, this is also remarked upon and reflected upon. A temporal analysis was also conducted on the context of the studies. This is done because the different studies are qualitatively systematically reviewed but the studies themselves were conducted at different times, which may have potentially influenced themes. Only the context of BMI seemed to have a temporal significance - meaning that it has an impact on the analysis of the themes from the various studies systematically reviewed.

Despite there being no time limitation which was employed with the inclusion-exclusion criteria, only studies between 2005 and 2011 were reviewed. The contexts that were analysed were the participants' BMI, age, gender, and race. In addition, the following contexts were employed in the analysis of the data: the origin of where the studies were conducted, the type of journal that the studies were published in, the respective faculties from where the researchers came, and the types of research methodology employed. These are referred to below.



■ *Figure 7.* Diagrammatic representation of the analysis of contexts of the studies in the systematic literature review

6.5.1. BMI.

The researcher explored the concept of BMI contextually and chronologically in the nine research studies and what becomes apparent between all the studies are that most of the participants have an extremely high BMI (see Appendix 1). Temporally, the most recent study shows a markedly higher BMI in comparison to older studies. This is even more significant when one considers that the timeframe of the different studies fell within a six year period. The BMI played a significant influence contextually and temporally in the analysis of the following subthemes: lack of control and restriction; non- acceptance of self; social restriction in outings and family activities; intimacy and infertility; self-care; personal health; facilities and the physical environment; restriction in physical health; and restriction in psychological health. It is evident that the similarities of these subthemes with one another are reflected by the high BMI's of the participants.

When analysing the studies chronologically, the latter studies in 2010 and 2011 evidenced more subthemes than earlier years. The studies by Engstrom et al. (2011) and Forhan et al. (2012) each respectively evidenced 14 and 15 subthemes. In comparison, the studies conducted by Wysoker (2005) and Goodspeed-Grant and Boersma (2005) each respectively evidenced only four sub-themes. This suggests that individuals with much higher BMI's, may have had a greater impact on the analysis of themes, that is, their contribution of themes are more prominent. It is thus speculated that the higher the BMI of the obese individual, the more they encounter life experiences of control, acceptance, and restriction. In summary, the more recent the studies, the higher the participants' BMI scores and, therefore, the more areas of the participants' lives are affected.

6.5.1.1. Reflection on the analysis of BMI.

The increase shown in the temporal analysis of the BMI is supported by other research studies. The literature reveals that the change in the environment over the years plays a significant contribution to obesity (Shelley, 2012; Vogeles, 2005). The obesity epidemic is a modern phenomenon, particular of the last two decades, and points to a greater contribution from environmental factors (Campbell & Haslam, 2005). This observation is supported by a number of researchers, who highlight that contemporary society consumes higher amounts of fat and energy rich foods, and live a far more sedentary life style (Beamer, 2003; Campbell & Haslam, 2005; Hill & Peters, 1998; Epstein & Ogden, 2005; Freidman & Brownell, 1996; Henderson & Brownell, 2004; Leach, Kalamara, & Shayeghi, 2001; Shelley, 2012; Vogeles, 2005; Wilding, 2001).

6.5.2. Age of participants.

In the analysis of the age of participants, three potential influences were identified. Age seems to have an impact on the theme of perceived control. The average age of participants is 30 to 40 years, represented in three studies (Engstrom et al., 2011; Nyman et al., 2010; Ledyard & Morrison, 2008). This means that participants in young adulthood seem to potentially hold different views with regards to perceived control, in comparison to middle adulthood (ages 40 to 65) and late adulthood or old age (Carr & McNulty, 2007; Sadock & Sadock, 2007). Reflecting on this, it may be a result of societal beliefs within their age cohort, or a multitude of other cultural, educational, or societal factors. It seems that participants in young adulthood contribute more to the theme of perceived control. The studies by Ogden et al. (2006) and Ledyard and Morrison (2008) contribute mostly to the subtheme of intimacy and infertility. These two studies demonstrate that there could be other reasons besides obesity that may lead to potential infertility - the mean age of the sample in the first study (Ogden et al., 2006) is 41 years of age, and in Ledyard and Morrison (2008) the mean age is 46 years. Age affects the fertility of typical normal individuals in this age range, therefore definite conclusions that fertility is linked to obesity is not possible.

In the theme of occupational context, there is similarity in these studies as the ages of the participants range from 30 to 60 years of age. The average age range in the study by Engstrom et al. (2011) is 41 years; the participants in the Forhan et al. (2010) range from 30 to 60 years of age; and the average age of participants in the Ogden et al. (2009) study is 41 years. This makes sense as the sample in the studies were adults. Adults are expected to have an established career, as it is an important context for most adults in terms of their identity and survival.

6.5.3. Race of participants.

Race is not significant in any study. Only three studies indicated the race of their participants. The omission of race is potentially due to page restriction standards enforced by journals. In the three studies which do indicate race, the participants seem to be predominantly Caucasian. In the sample by Goodspeed-Grant and Boersma (2005), there were nine Caucasians and two Africans; in the study by Ledyard and Morrision (2008) the sample included nine Caucasian couples and two African couples. Lastly, in the study by Merrill and Grassley (2008) there are only Caucasian participants.

Although race is not represented in most of the studies, based on the countries geographical location and race demographics, the researcher hypothesises that there is the probability of a higher number of Caucasian samples. Nyman et al. (2010), Groven et al. (2010), and Engstrom et al. (2011) studies originated from Scandinavian countries, and Forhan et al. (2010) from Canada. Other studies represent particularly mixed samples: Wysoker (2005) is a potentially a mixed sample as it was conducted at the University of Brockville, New York and the study by Ogden et al. (2009) was conducted at the University of Surrey Guildford in the UK. The context of race raises the potential to provide some insight into cultural values about the experience of control, acceptance, and restriction. Race is not explored in this study, because the majority of the studies did not provide the participants' race in their study. A credible comparison across studies is not possible.

6.5.4. Country of study.

All the studies originate in the United States of America (USA) and Europe. There are no studies from the Southern Hemisphere, Middle East or Far East. This is probably so because this qualitative systematic review only referenced English publications. Despite this, no studies from Australia were located.

The country of the studies potentially influenced the subtheme of others' influence on acceptance or non-acceptance of self. The differences in the subtheme may be a result of cultural or societal ideologies. More specifically, the studies represent Westernised thought regarding the self - the Engstrom et al. (2011) study was conducted in Sweden, the Ogden et al. (2009) study was conducted in the United Kingdom, and the Wysoker (2005), Goodspeed-Grant and Boersma (2005) studies were conducted in the USA. In terms of the temporal analysis, the earlier studies originate in the USA, whereas the more recent studies originate in the Scandinavian countries. The prominence of obesity in the USA may be due to this country's early identification of obesity as a serious health problem, which explains the heightened investment in research. The rest of Europe seems to have only recently started to realise the serious implications of obesity. Hence more studies have started to be produced as their economies have become ever more affected by obesity. The more recent research interest, especially from Scandinavian countries may be indicative of either obesity as an emerging problem, or that research has only recently taken an academic interest in this population.

In reflecting on the varied origins of the different studies, some potential explanations emerge. According to Turconi and Cena (2007), in last two to three decades, an environment

has been created which promotes a sedentary lifestyle and consumption of high fat, and energy dense diets. The USA is known to be the fattest country in the world (Turconi & Cena 2007), which is supported by the predominance of analysed studies from that region. As the years have progressed, obesity has become a worldwide problem - seen in the various locations of the studies. To place these descriptions into context, obesity is a real concern and problematic to affluent Westernised countries (Sadock & Sadock, 2007; Turconi & Cena 2007). This seems to be in line with the WHO (2010) estimates that 2.3 billion adults will be overweight in 2015, and that 700 million adults will be obese.

6.5.5. Gender of participants.

In reviewing the contextual aspect of gender, the majority of the studies demonstrate a higher number of women in their samples. Temporally, this also means that women partake in research more than men, across the time-span of the studies. Whether more women are obese than men, or are more willing to take part in research studies, needs further investigation - it raises important questions. Pain (2007) reflects on existing literature regarding the demographics of the gender in the studies. He explains women, in general, appear to have a higher rate of obesity than men. Ogden (2003) supports this and elaborates that it is specifically working class women who have higher incidences of obesity. The female majority in obesity rates also holds true for South African women (Van der Merwe & Pepper, 2006). In reviewing these findings, a heightened female prevalence is confirmed contextually and temporally in the studies used in this qualitative systematic review (Ogden, 2003; Senekal et al. 2003; Pain, 2007; Van der Merwe & Pepper, 2006).

6.5.6. Field of study and journal of publication.

This section turns its attention to field of study of researchers and of journal of publication. In terms of the researchers' professional fields of study, and the journals in which the studies are published, both seem heterogeneous. On reflection, the heterogeneity of both contexts seem to have a far reaching impact on, and consequences for, present society. It draws attention to diverse researchers and the results are presented to a wide scholarly audience.

Campbell and Haslam (2005) state that to understand the development of obesity, an examination of a variety of factors must be taken into account, such as genetic, environmental, neurological, physiological, psychological, biochemical, cultural, and socioeconomic issues, which all have an impact on individuals developing obesity. This notion is supported by Gard (2004), who states that although there is widespread passion in terms of action taking place, it is coupled with a lack of widely accepted clear solutions. Therefore, obesity concerns call for involvement from different academic disciplines and the analysis of the literature reinforces this.

To conclude, Agger (2000) comments that a different line of explanation in scientific texts are the result of the conscious choices of the author, and certain areas are chosen over others. Therefore, it is difficult to establish whether the identified research studies which were used in this qualitative systematic review, are representative of a shift in research focus from 2005 to 2011, or whether the studies are simply different researchers' interests regarding obesity. The research may reflect on the researchers themselves; wider social-political; or cultural factors.

6.5.7. Research methodology.

There was no significant influence with regards to the contextual analyses of the studies' various research methodologies. Seven out of the nine studies used for this qualitative systematic review employed interpretative phenomenology methodologies. Wysoker (2005) delineated his research methodology as phenomenology specifically, and Forhan et al. (2010) described their research methodology as descriptive phenomenology. All nine studies fall within the ambit of phenomenology and may thus be combined. Sandelowski, Voils and Barroso (2007) explain this concept as comparability work. They explain that when conducting a qualitative systematic review, the aim of comparability work is to make findings of different studies of the same field of research sufficiently comparable so as to unite them. Although two studies out of the nine may have different research methodologies, they are still phenomenological, much like the other seven studies. Consequently, all the studies explored the lived experience of the participants, which make them similar, and thus comparable.

6.6. Potential Shortcomings and Areas of Possible Future Research

This section highlights possible shortcomings of this research and areas of potential future research. This research attempted to bring a new understanding to the experiences of obese individuals, based on the researcher's interpretation of the various studies in this qualitative systematic review. Parker (2005) explains that in qualitative research, there are no findings, only analyses, which are actually a sequence of explanations which may be exposed to scrutiny. This analysis is no different in the researcher research.

6.6.1. Potential shortfalls.

In determining the potential shortfalls of this research, difficulties may lie in its methodological approach. There may have been a shortfall with the inclusion and exclusion criteria used in this research. The linguistic constraints of the research (Xu, 2008) are a shortfall, as the inclusion criteria limited studies to only the English language. This aspect could not, unfortunately, be altered for pragmatic reasons: the researcher is English, this is a minor dissertation, and time and financial resources were limited.

Another potential shortfall of this research was that of grey literature, which refers to studies produced which are not distributed or indexed by commercial publishers and are, therefore, difficult to find or even identify as a result (Tricco et al. 2011; Xu, 2008). The notion of publication bias suggests that studies which are not published may be overlooked and, therefore, missed (Tricco et al. 2011; Xu, 2008). Because this is a minor dissertation, with limited time and financial resources, the researcher did not look exhaustively for all available grey literature. To address this issue, the researcher was aided by his supervisor and the subject librarian in psychology. These two resources are recommended by Sandelowski and Barroso (2006) to minimise any studies potentially missed.

This research also only included peer-reviewed studies, to try to ensure a higher quality of data, and therefore other potentially rich descriptive studies may have been missed. This is incorporated to address the thorny issue of quality appraisal to ensure a higher quality of research studies used in this qualitative systematic review (Dixon-Wood et al., 2006; Sandelowski, 2007; Tracy, 2010). In keeping with this notion of quality appraisal, no quality criteria regarding the methodologies of the studies were exercised. Therefore, there is the

potential that the quality of some of the findings from the studies in this qualitative systematic review may have substandard research methodologies, and this may, therefore, have influenced the study's findings (Tricco et al. 2011; Xu, 2008). However, this problem is addressed in this research in that this qualitative systematic review only included peer-reviewed studies. This was done to try to ensure a higher quality of research methodology, as the studies were examined and scrutinised by peers to ensure a higher quality of data.

In terms of the contextual analysis, it was revealed that most studies did not describe their participants' race. Of those which do, they reflect only on the experiences of Caucasian participants - this is a potential limitation of the research as there is the possibility that the analysed studies only represented a homogeneous group and are not generalisable.

6.6.2. Areas of future research.

It is considered that potential future research needs to focus on a deeper and wider analysis regarding the interplay of the three themes of experience. This may help to identify more treatment modalities in the management of obesity. It is recommended that future research be undertaken to determine whether the experiences of obese individuals may supplement and enhance different treatment modalities to provide a different understanding or focus in treatment. Future research may also explore whether there are interplays of other experiences of obese individuals which may already be established but which are not explored in this research. Potential future research may also explore the impact of race on obesity. The research may focus on the themes of experience identified in this research, and also on the influence of race and culture. Forthcoming research may also conduct a comparison of how these experiences and their interplay vary with childhood and adolescent obesity. Upcoming

research may also conduct the same study, but use primary studies with different methodologies, for example, discourse or narrative analysis.

6.7. Conclusion of Research

This research is a qualitative systematic review on phenomenological studies regarding adults' experience of being obese. To achieve its aim, it justified the rationale for this study and the process of steps needed to achieve this aim. In terms of this process, a literature review was conducted; phenomenology was explored and discussed in relation to the studies which were used for this qualitative systematic review; the research methodology was described and the research process delineated; the studies were analysed to produce various themes, and subthemes; and the process has concluded with a discussion of the analysis of the themes and contexts which were used in this qualitative systematic review.

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APPENDICES

BMI

Name of authors	Year	BMI of participants
Wysoker	2005	Mean BMI >35
Goodspeed & Boersma	2005	Mean BMI >40
Ogden et al.	2006	Mean BMI 47.47
Ledyard & Morrision	2008	Mean BMI 34.4
Merrill & Grassley	2008	Mean BMI not specified, BMI bigger than > 30
Nyman et al.	2010	Mean not specified ranged between 34-50
Groven et al.	2010	Mean not specified ranged between 43-54
Forhan et al.	2010	Mean BMI 45.2
Engstrom et al.	2011	Mean BMI 52.2

Study by	Year	Assigned Number	Study by	Year	Assigned Number
Engstrom et al.	2011	9	Ledyard & Morrision	2008	4
Forhan et al.	2010	8	Ogden et al.	2006	3
Groven et al.	2010	7	Goodspeed-Grant & Boersma	2005	2
Nyman et al.	2010	6	Wysoker	2005	1
Merrill & Grassley	2008	5			

Subthemes

- C.1) Lack of control and restriction
- C.2) Health professionals' regarding control
- C.3) Deficits in control
- C.4) Perceived control
- C.5) Potential control
- C.6) Control being influenced by negative emotions
- A.1) Non- acceptance of self
- A.2) Interaction other individuals
- A.3) Need for acceptance from other individuals
- A.4) Other experiences which could influencing acceptance or non- acceptance of self
- R.1) Restriction in the occupational context
- R.2) Social restriction in outings and family activities
- R.3) Medical professionals.
- R.4) Self- care, personal health, facilities and the physical environment
- R.5) Restriction in physical health
- R.6) Restriction in psychological health
- R.7) Coping with restrictions

Study	C1	C2	C3	C4	C5	C6	A1	A2	A3	A4	R1	R2	R3	R4	R5	R6	R7
9	*	*	*	*			*	*	*	*	*	*	*	*	*	*	
8	*	*	*			*	*	*	*	*	*	*	*	*	*	*	*
7			*				*	*	*						*	*	
6		*		*		*		*	*	*			*	*	*	*	*
5			*		*				*	*	*	*			*	*	
4		*	*				*	*					*	*		*	*
3				*		*	*					*			*		
2			*	*		*				*							
1			*		*					*					*		

AGE OF PARTICIPANTS

Name of authors	Year	Age of participants
Wysoker	2005	38-57
Goodspeed-Grant & Boersma	2005	33-62
Ogden et al.	2006	Mean 41
Ledyard & Morrision	2008	Mean 46
Merrill & Grassley	2008	20-61
Nyman et al.	2010	24-37
Groven et al.	2010	20-55
Forhan et al.	2010	30-60
Engstrom et al.	2011	Mean 40.9

RACE OF PARTICIPANTS

Name of authors	Year	Race of participants
Wysoker	2005	Race not specified
Goodspeed-Grant & Boersma	2005	9 Caucasian, 2 African
Ogden et al.	2006	Race not specified
Ledyard & Morrision	2008	9 Caucasian couples, 2 African couples
Merrill & Grassley	2008	Only Caucasian
Nyman et al.	2010	Race not specified
Groven et al.	2010	Race not specified
Forhan et al.	2010	Race not specified
Engstrom et al.	2011	Race not specified

COUNTRY OF STUDY

Name of authors	Year	Country
Wysoker	2005	USA
Goodspeed-Grant & Boersma	2005	USA
Ogden et al.	2006	UK
Ledyard & Morrision	2008	USA
Merrill & Grassley	2008	USA
Nyman et al.	2010	Sweden
Groven et al.	2010	Norway
Forhan et al.	2010	Canada
Engstrom et al.	2011	Sweden

GENDER OF PARTICIPANTS

Name of authors	Year	Gender of participants	
Wysoker	2005	8 participants:	5 Women 3 Men
Goodspeed-Grant & Boersma	2005	11 participants:	9 Women 2 Men
Ogden et al.	2006	15 participants:	14 Women 1 Men
Ledyard & Morrision	2008	22 participants:	11 Women 11 Men
Merrill & Grassley	2008	8 participants:	8 Women
Nyman et al.	2010	10 participants:	10 Women
Groven et al.	2010	5 participants:	5 Women
Forhan et al.	2010	10 participants:	7 Women 3 Men
Engstrom et al.	2011	23 participants:	14 Women 9 Men

FIELD OF STUDY AND JOURNAL OF PUBLICATION

FIELD OF STUDY OF RESEARCHERS

Name of authors	Year	Faculties or institution of authors
Wysoker	2005	Nursing, Long Island University
Goodspeed-Grant & Boersma	2005	Counsellor Education Department, School of Nursing
Ogden et al.	2006	Department of General Practice, Health Psychology
Ledyard & Morrision	2008	Children's Psychiatric Hospital
Merrill & Grassley	2008	Department of Family and Community Medicine,

		College of Nursing
Nyman et al.	2010	Department of nursing, Health and Culture, Department of Obstetrics and Gynaecology
Groven et al.	2010	Faculty of Medicine, Department of Public Health and Primary Care, Department of Physical Education
Forhan et al.	2010	School of Rehabilitation Science, Faculty of Health Science, Psychiatry and Behavioural Neurosciences
Engstrom et al.	2011	Department of Gastrosurgical Research and Education, Department of Neuroscience & Physiology ,Institute of Health and Caring science

JOURNAL OF PUBLICATION OF STUDY

Name of authors	Year	Journal of publication
Wysoker	2005	Journal of American Psychiatric
Goodspeed-Grant & Boersma	2005	Counselling and Psychotherapy
Ogden et al.	2006	Psychology and Health
Ledyard & Morrision	2008	Journal of Couple and Relationship Therapy
Merrill & Grassley	2008	Journal of Advanced Nursing
Nyman et al.	2010	Midwifery
Groven et al.	2010	International Journal of Studies Health Well Being
Forhan et al.	2010	Canadian Journal of Occupational Therapy
Engstrom et al.	2011	The Open Nursing Journal

LIST OF DIAGRAMS AND TABLE

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Table 1 *List of Studies Used in the Qualitative Systematic Review*